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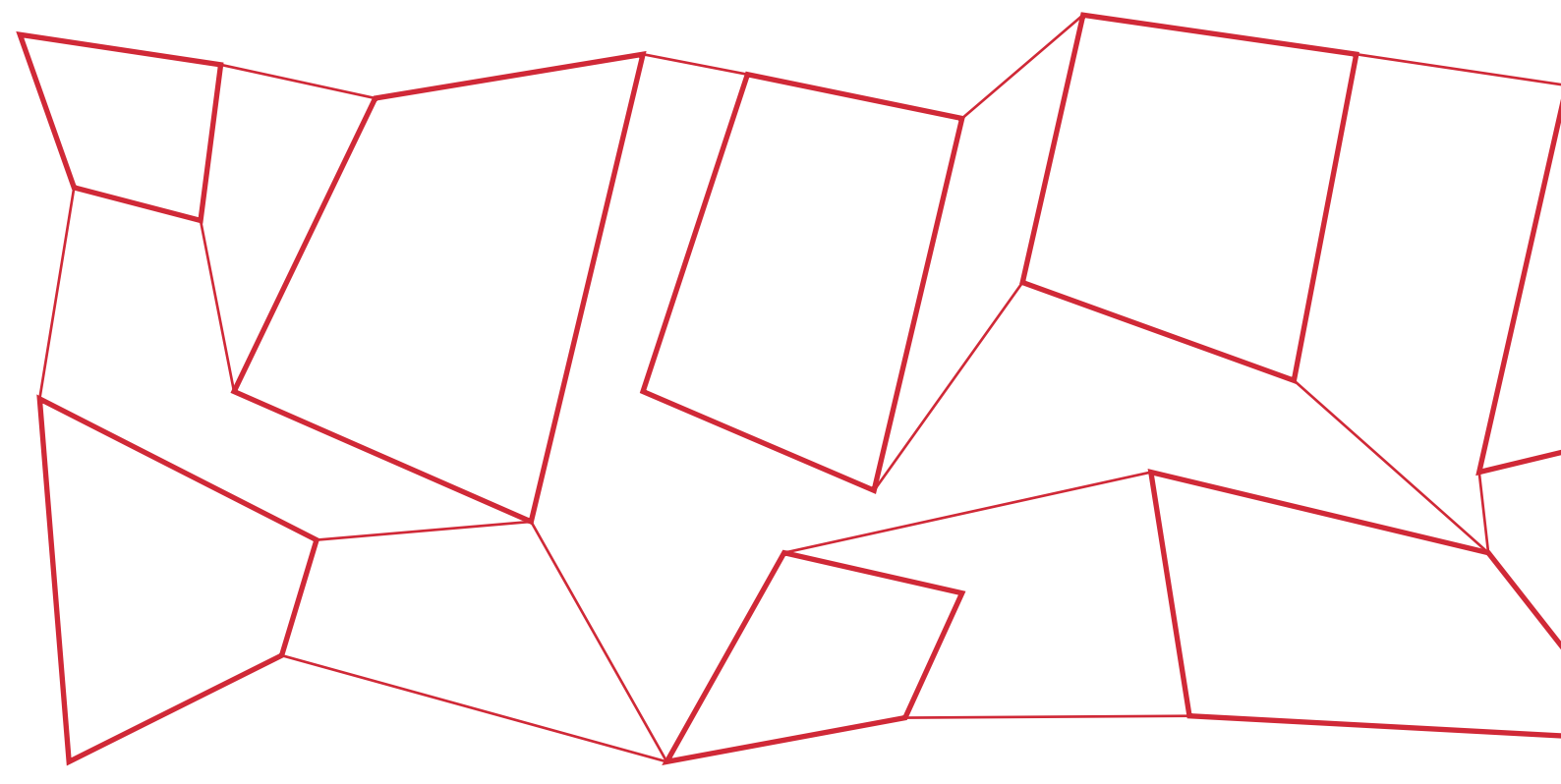
Boosting implementation of Health 2020 and the 2030 Agenda: the WHO Small Countries Initiative



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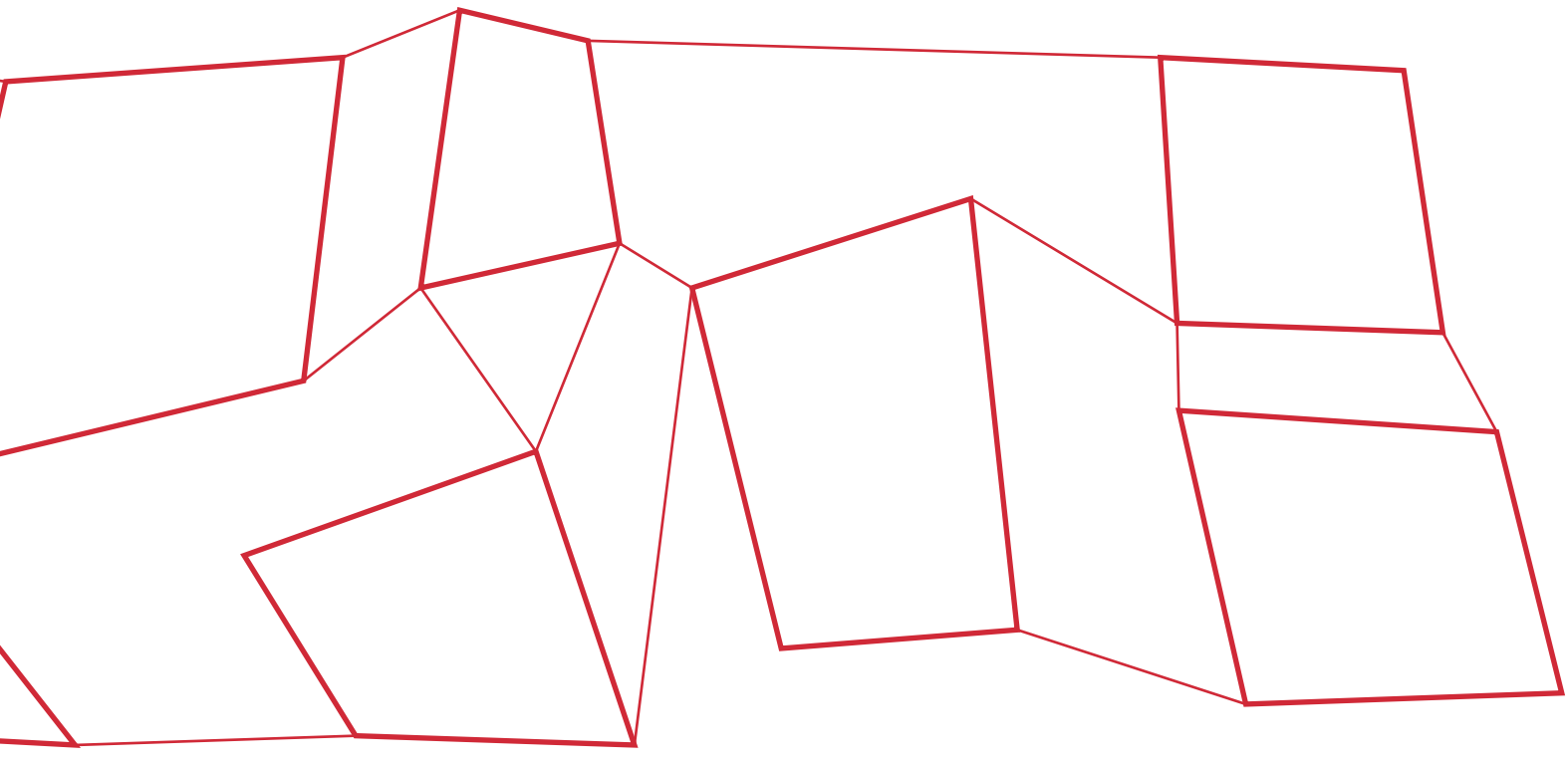

Abstract

This three-part report provides information on the WHO Small Countries Initiative and how, through participation in its network, countries have been able collectively to strengthen the capacity, technical knowledge and governance they need to implement the European policy framework and strategy for the 21st century, Health 2020, and the United Nations 2030 Agenda on Sustainable Development. Part one of the report provides a full overview of the WHO Small Countries Initiative, including its ways of working, the kind of support it provides to the countries, the products it produces, and its vision of the way forward in the coming years. Part 2 consists of the report on the fourth high-level meeting of small countries, which took place in St Julian's, Malta, in June 2017. The report highlights issues of interest to the small countries and provides information about their experiences as part of the Initiative, including challenges and lessons learnt. Part 3 provides a snapshot of WHO technical support provided to small countries and of outcomes related to this support.

Keywords

HEALTHY PEOPLE PROGRAMS
HEALTH PLAN IMPLEMENTATION
HEALTH POLICY
INTERNATIONAL COOPERATION
CONSERVATION OF NATURAL RESOURCES
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CONTENTS

Introduction

The aim of this report is to provide information about the WHO Small Countries Initiative *(1)* and how the countries participating in its network have been able collectively to strengthen the capacity, technical knowledge and governance required to implement the European policy framework and strategy for the 21st century, Health 2020, and the United Nations 2030 Agenda on Sustainable Development *(2,3)*. The report is divided into three parts, providing (i) a full overview of the Initiative *(1)*, how it works, the kind of support it provides, the products it produces, and its vision for the coming years; (ii) the report on the Fourth high-level meeting of the Small Countries held in St Julian's, Malta, on 26–27 June 2017, which highlights issues of interest to, and experiences of, the small countries, including challenges and lessons learnt; and (iii) snapshots of WHO technical support provided to the countries, as well as outcomes of this support.

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Part 1. The WHO Small Countries Initiative

The WHO Regional Office for Europe (the Regional Office) works to strengthen the ability of the Member States to develop national policies on specific health issues, in line with the Health 2020 strategy *(2)* and, as of September 2015, to support the implementation of the United Nations 2030 Agenda towards achievement of the Sustainable Development Goals (SDGs) *(3)*. This work is carried out at different levels of governance through a variety of platforms, an example of which is the WHO Small Countries Initiative coordinated by the WHO European Office for Investment for Health and Development, Venice, Italy, of the WHO Regional Office for Europe, which also acts as the Secretariat of the Initiative *(1)*.

The rationale behind the Small Countries Initiative

As a result of an idea put forward by San Marino, the Small Countries Initiative *(1)* was established in 2013 at an informal meeting held during the sixty-third session of the WHO Regional Committee for Europe in Çeşme Izmir, Turkey. San Marino and the WHO European Office for Investment for Health and Development are co-leading the Initiative *(1)*, which continues to benefit from funds generously provided by San Marino. It has become a platform through which Member States in the WHO European Region with populations of less than 1 million are able to share their experiences in implementing Health 2020 and the 2030 Agenda *(1,3)*. The countries participating in the Initiative are Andorra, Cyprus, Iceland, Luxemburg, Malta, Monaco, Montenegro and San Marino *(1)*.

The Initiative seeks to foster political commitment to, and the development of good practice in, the implementation of Health 2020 in small countries *(1,2)*. Small countries share unique contexts and needs: it is likely that their size and multifaceted vicinities better enable them to navigate the increasingly complex and turbulent global environment. Thanks to their shared sense of purpose, it is easier for small countries to set and implement policy quickly and effectively. It is this strategic agility that makes small countries ideal settings for policy experimentation and innovation. The benefits of their small size can be maximized, especially in the case of implementing broad, multisectoral policies, such as Health 2020 *(2)*, which by their very nature require whole-of-government and whole-of-society approaches.

On the other hand, small countries are sometimes more vulnerable than their larger counterparts. The Initiative *(1)* provides a valuable forum through which these countries are able to share their experiences and find solutions to their challenges, many of which are applicable in larger countries. This makes the case for ensuring that, in setting norms and developing protocols, scientific guidelines and recommendations on policy direction and the experiences of both large and small countries are taken into consideration.

The Initiative provides ministers of the participating countries with the opportunity to meet annually to discuss their health agendas and how to move forward. The meetings focus on issues, such as the life-course approach, intersectoral action for health and resilience, health-information systems (through the Small Countries Health Information Network (SCHIN)) and communication (through a subnetwork of communication officers from the countries participating in the Initiative) *(1)*. Examples of best practice in approaches suggested by Health 2020 *(2)*, and in the practical implementation of WHO policies and strategies in general, are shared through a series of publications featuring case studies from the small countries.

High-level meetings of the small countries are held annually; the latest (fourth) took place in St Julian's, Malta, on 26–27 June 2017 (Part 2 of this publication). At these meetings, statements

have been endorsed, their themes ranging from a generic commitment to the implementation of Health 2020 (the San Marino Manifesto *(4)*) to more specific topics, such as climate change (the Monaco Statement *(5)*) and key concepts of Health 2020 *(2)*, such as the life-course approach (the Andorra Statement *(6)*) and childhood obesity (the Malta Statement (Annex 1)).

The aim of the Small Countries Initiative

The Initiative has four key aims, namely to: (i) document ways of aligning national health policies with Health 2020 and the 2030 Agenda; (ii) develop joint capacity-building events around the key themes of Health 2020 to promote health and reduce health inequities; (iii) create an environment that is supportive of the Health 2020 strategy by enhancing the engagement of the media as an implementation partner; and (iv) create a platform for sharing experiences in, and mutual learning about, Health 2020 implementation *(1–3)*.

Participation in the Initiative *(1)* affords countries the opportunity to share their experiences in implementing Health 2020 *(2)*, and strengthen their technical capacity by accelerating the adoption of innovative approaches (for example, whole-of-government and whole-of-society) to Health 2020 *(2)* implementation, and documenting their processes and outcomes. They also receive tailored technical assistance in Health 2020 *(2)* implementation and, by documenting their experiences, contribute to filling the knowledge gap on health-policy development within the context of small countries in Europe.

The Small Countries Initiative: a policy-making laboratory

The small countries can serve as model sites for the implementation of Health 2020 *(2)* by acting as catalysers and generators of know-how. Their results and achievements, also in terms of governance processes, can – to a varying extent – be used by larger countries. In this spirit, the Regional Office is working closely with the small countries to create a useful platform through which they may share their knowledge and valuable experiences, not only with each other, but also with other Member States. The Initiative *(1)* can be considered a "policy-making laboratory" since, on an annual basis, its work produces measurable outputs and brings about tangible changes in the countries. For example, it organizes meetings on topics put forward by the small countries, raising their levels of knowledge in these areas. In addition, the documented case stories, which are shared with other Member States, can be used as a capacity-building tool.

How the Initiative contributes to implementation of Health 2020 and the United Nations 2030 Agenda for Sustainable Development

Technical assistance to countries

The Regional Office provides technical assistance to the small countries in various ways. Sometimes, this is in the form of direct support, as was the case in aligning the San Marino national health plan with Health 2020 *(2)*. In addition to the WHO European Office for Investment for Health and Development, which acts as the Secretariat of the Small Countries Initiative, other divisions of the Regional Office have provided technical assistance to the small countries, for example, in the use of the life-course and intersectoral approaches for country interventions.

Support in capacity-building has also been provided to the small countries, for example, through the Global Health Diplomacy Course held in Cyprus in 2017. This three-day course,

which was developed by the Graduate Institute Geneva in collaboration with the Regional Office and the WHO European Office for Investment for Health and Development, and coordinated and promoted by the Unit for Strategic Relation with Countries of the Regional Office, was attended by 20 senior-level representatives from various sectors (including those for finance, foreign affairs and education), development corporations, ministries of health and the WHO Regions for Health Network *(7)*. It provided participants from the small countries with an understanding of the key concepts and mechanisms of governance for health within the context of the 2030 Agenda *(3)*. Specific issues addressed were diplomacy challenges related to the resilience and vulnerability of the health workforce, and the best use of global and regional policy documents in addressing national issues, such as the promotion of healthy food. Another example of joint assistance to the small countries is the Small Countries Health Information Network (SCHIN) *(1)* (see "Creation of sub-networks").

The forum provided by the high-level meetings of small countries, which WHO holds on an annual basis, offers ministers from the countries and department directors from the Regional Office the opportunity to discuss topics of relevance and assess needs in terms of technical assistance (see "Annual meetings").

Snapshots of WHO technical assistance provided to the small countries are included in Part 3 of this publication.

Annual meetings

The platform provided by the WHO Small Countries Initiative has played an important role in the implementation of Health 2020 from the outset, and its annual meetings serve as milestones of its progress *(1,2)*.

The first high-level meeting (San Marino, 2014) *(8)* set the scene for the establishment of an innovative knowledge platform through which small countries can share information, develop good practice in the implementation of Health 2020 *(2)*, and foster political commitment. Mindful of the values and principles of Health 2020 *(2)*, the Initiative – in focusing on its strategic

objectives – aims to enhance population health and well-being, reduce health inequity and build more equitable, cohesive and sustainable societies in the context of small-population countries *(1)*. The first meeting also included discussions on how to advance collaboration on the main deliverables of the Initiative *(1,8)*. Experiences shared have shown that being a small country has both advantages, such as strong social cohesion, and disadvantages, such as having to face the same challenges as large countries, but with less capacity.

The second high-level meeting (Andorra, 2015) focused on two of the pillars of Health 2020: intersectoral action for health and the life-course approach *(2,9)*. It aimed to further advance the implementation of Health 2020 in the WHO European Region by exploring intersectoral approaches to improving health outcomes and reducing health inequities. This meeting was truly innovative because it brought together ministers from many different sectors, including those for health, education, environment, finance and energy. Representation from such a variety of sectors showed the whole-of-government approach in action. The Prime Minister of Andorra took part in the opening session, which provided further political support of the Initiative *(1)* and the commitments made at the meeting. The meeting revealed that small countries experience a mix of advantages and challenges related to, for example, intersectoral collaboration, health-systems and health-information-system strengthening, working across the life-course and building resilience *(9)*. This was the first of these meetings in which representatives of small countries outside the WHO European Region participated and provided input.

The third high-level meeting (Monaco, 2016) *(10)* addressed one of the key concepts of Health 2020 *(2)* in the context of small countries, namely, Health in all Policies *(11)*, and made the link with the 2030 Agenda *(3)*, paying special attention to the threat of climate change. It aimed to find common denominators between the European (Health 2020) and global (2030 Agenda) strategic visions for health and sustainable development from the perspective of small countries *(2,3)*.

The fourth high-level meeting (Malta, 2017) addressed one of the four cross-cutting priority areas of Health 2020 *(2)*, namely, building resilient and healthy communities (Part 2 of this publication). This issue is fundamental to the functioning of health systems and a powerful enabler of participatory (whole-of society and whole-of-government) and life-course approaches. Furthermore, the topic of resilience resonates with politicians and common citizens alike.

Publications on different topics of relevance

The Initiative has its own series of featured publications, mostly based on case studies from, and good practice existing in, the small countries in relation to the implementation of Health 2020 and the 2030 Agenda; examples of such practice include taking intersectoral action for health, using the life-course approach, and strengthening resilience *(1–3)*. The publications bring out the essence of the Initiative *(1)*: the participating countries are pioneers in the Region, not only in terms of finding innovative practice and solutions, but also in catalysing change. The publications are briefly described below.

A roadmap to implementing Health 2020 – the experience of San Marino

In 2012, San Marino started the process of creating a new national health plan (2015–2017) that would integrate key components of Health 2020 *(2)*, such as the reduction of health inequity through action to tackle the social determinants of health, and the promotion of intersectoral work by means of whole-of-government and whole-of-society approaches. San Marino chose

to document the process of developing the plan to provide an insight into the experience, which could be of benefit to other countries. The publication, *A roadmap to implementing Health 2020 – the experience of San Marino*, outlines the guiding principles, overarching goals and health objectives of the plan and the stakeholders involved. It also describes the enabling factors and the challenges met both in developing and implementing it *(12)*.

Intersectoral action for health – experiences of small countries in the WHO European Region

Effective intersectoral action is crucial in addressing today's biggest public health challenges. The topic of intersectoral action for health was an important agenda item at the second high-level meeting of the small countries held in Andorra in 2015 *(9)*. Subsequently, the small countries took part in a Region-wide mapping exercise aimed at achieving a better understanding of intersectoral action at the ground level. This involved the collection and analysis of good practice in intersectoral action to address a diverse set of health needs. The results are described in case stories included in the publication, *Intersectoral action for health – experiences of small countries in the WHO European Region*. Topics include: overweight and obesity in children and adolescents; salt reduction in baked products; the promotion of sustainably grown foods and balanced diet; the prevention of child sexual abuse and pornography; and the control of potential outbreaks of highly infectious diseases. The case stories include information about the mechanisms that facilitated intersectoral action, as well as lessons learnt, such as the importance of engaging stakeholders at an early stage, identifying champions and establishing common goals, and engaging other sectors *(13)*.

How small countries are improving health using the life-course approach

The Andorra Statement that emanated from the second high-level meeting of small countries (2015) *(6,9)* called for health-promotion and disease-prevention programmes to invest in the early stages of life because of the high economic, social, developmental and equity returns involved. In 2016, the Regional Office asked the small countries to share their experiences in implementing life-course-related action. Their responses related to: nutrition throughout the life-course; physical activity; the prevention of overweight and obesity; early childhood development; vaccines; supporting parenthood; increasing knowledge about adolescent health; adverse childhood experiences; long-term care; and integrated health care. Most of the countries shared a set of key triggers for taking action with the life-course approach as the guiding principle. The involvement of intersectoral players was also reported as essential for successful action. There was consensus among the eight small countries participating in the Initiative *(1)* that action related to the life-course had helped in the application of a comprehensive approach to health. The case stories also demonstrate how the life-course approach is helping them reach the goals and targets of the 2030 Agenda for Sustainable Development *(3,14)*.

Building resilience: a key pillar of Health 2020 and the Sustainable Development Goals – examples from the WHO Small Countries Initiative

Resilience is one of the least understood pillars of Health 2020 *(2)*. For this reason, the above publication reviews the scientific basis for strengthening it. At the third high-level meeting of small countries (Monaco, 2016), it was agreed to strengthen the resilience of small countries by gaining a better understanding of how decreasing vulnerability results in increased resilience, expanding the adaptive, absorptive and anticipatory capacities of countries, and addressing system-level vulnerabilities before they become individual-level vulnerabilities *(10)*.

This publication addresses all three levels of resilience (individual, community and system). It presents information about the approaches of three countries participating in the Initiative *(1)* (Iceland, Malta and San Marino) to strengthening resilience, describing action taken and lessons learnt *(15)*.

Creation of subnetworks

Part of the Initiative's work has been facilitated by the creation of subnetworks, which have made it possible to delve more deeply into specific topics of interest of, or challenges to, the small countries *(1)*.

SCHIN

Small countries face unique challenges in the collection, analysis, and reporting of health data and information. These concerns were raised at the second high-level meeting of small countries (Andorra, 2015) *(9)*, where the possibility of establishing a health-information network for small countries was welcomed by all participating countries. It was agreed that such a network would address common data challenges, provide better coordination of requests for data from the Regional Office to Member States, support the joint reporting and analysis of indicator-based data, and consider the establishment of a minimum data set for small countries and other activities, as well as membership in the European Health Information Initiative (EHII) *(16)*. Thus, in recognition of the many specific challenges and opportunities that small countries encounter in the governance of their health systems, the Regional Office established SCHIN. This network aims to enable the small countries in the Region to work together to strengthen and improve their health-information systems by sharing their experiences and good practice *(1)*.

SCHIN has held three meetings so far. The first meeting of the network (Valetta, Malta, 3–4 March 2016) brought together nominated focal points for the first time to familiarize them with SCHIN's scope and purpose, discuss and agree on the terms of reference and the modus operandi of the network, identify priority action and agree on a joint action plan, and establish a shared understanding of the roles and responsibilities of each partner throughout the process *(1,17)*.

At the second meeting of SCHIN (Monaco, 12 October 2016), participants discussed new developments and achievements relating to the action points agreed at the first meeting, and updated the joint action plan *(1,17,18)*.

The third meeting of SCHIN (Box 1) was held in St Julian's, Malta, on 27 June 2017 within the context of the fourth high-level meeting of small countries (Part 2 of this publication).

Box. 1. Third meeting of SCHIN, St Julian's, Malta, 27 June 2017

The third meeting of SCHIN built on discussions held at the second meeting *(18)* on the following topics:

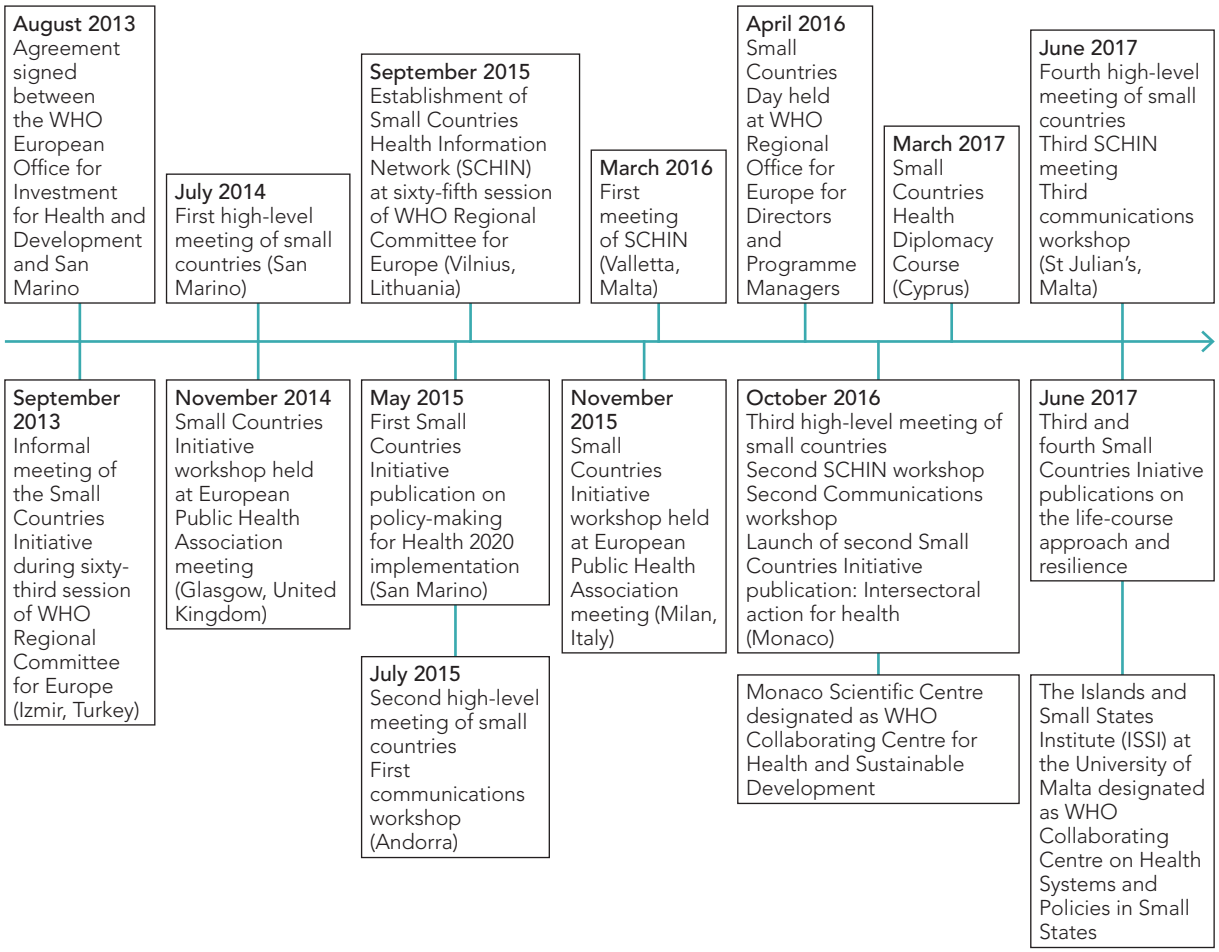
- the application of the rolling averages method and the relevant indicators;
- difficulties in data collection encountered by small countries, including issues related to population denominators and death certification;
- next steps in the development of a core joint set of indicators for health-system performance assessment in small countries, and the criteria for their selection;
- updates regarding the health information system rapid support tool.

Agreement was reached on:

- the most suitable method of reporting, using rolling averages;
- the method of, and next steps towards, defining the joint indicator set;
- an updated action plan for SCHIN *(1)*;
- the priority action points and forthcoming meetings of SCHIN *(1)*;
- the election of Iceland as chair of the network from 2018.

Fig. 1 provides an overview of the milestones of the WHO Small Countries Initiative *(1)*.

Fig. 1. Milestones of the WHO Small Countries Initiative



Support to communications professionals from small countries

One of the four key action areas of the Initiative is the creation of a supportive environment for Health 2020 through better engagement of the media as an implementation partner *(1,2)*. The development of a communications network to enhance the capacity needed for effective communication and exchange of experience has, therefore, been an essential element for discussion at the annual high-level meetings of the Initiative *(1)*.

As part of the fourth high-level meeting of small countries: building resilient and health communities, St Julian's, Malta, 26–27 June 2017 (Part 2 of this publication), WHO organized a capacity-building workshop for communications focal points and journalists from the eight countries participating in the Initiative *(1)*. The workshop built on the positive experiences gained at similar events held at the second and third high-level meetings *(9,10)*, the themes of which were, respectively, health inequalities and Health 2020 and sustainable development.

The aim of the 2017 workshop was to further strengthen the community of journalists and communication staff operating in the small countries and encourage constructive discussion on challenges and opportunities related to communicating about noncommunicable diseases (NCDs) (Box 2).

Using the Malta Statement (Annex 1) and the protection of young people as an entry point, the workshop began with an overview of the key issues, developments and targets driving public health work to address NCDs. Focus was placed on providing the participants with tools and evidence that would help them respond effectively to some of the many arguments posed by industry and misconceptions relating to NCDs. After a presentation on how the Health Promotion and Disease Prevention Directorate in Malta uses social media to respond to public health issues more effectively, and nurture dialogue with the public, discussions covered the inherent advantages of small countries in communicating with key audiences, and the factors influencing the success or failure of public health campaigns. Information about the WHO European Health Information Gateway *(19)* and the Health Behaviour in School-aged Children study *(20)* was also presented.

Box 2. Outcomes of the communications workshop (St Julian's, Malta, 27 June 2017)

The workshop provided journalists and communications focal points from the small countries) with guidance on communicating about NCDs and information about resources available to facilitate such communication. This included:

- a basic overview of the key issues relating to NCDs, the main policy documents, action plans and targets supported by WHO, and "best buys" for policy;
- a tour of the WHO data/information resources available to support communication on NCD-related issues, for example, through the European Health Information Gateway *(19)*;
- an introduction to the HBSC study and examples of policy changes kick-started by findings of the study *(20)*; and
- some of the key arguments communicators may face in addressing NCD-related issues (often raised or backed by industry) and effective ways of responding to them, including use of the Tobacco Control Playbook of arguments *(21)*.

Progress to date

In its four years of existence, the Initiative *(1)* has established a way of working, which has involved:

- building a platform for cooperation and knowledge-sharing under the umbrella of Health 2020 *(2)*;
- facilitating the development of policy statements and commitments on major public health and health-system-development issues relevant to small-population countries and beyond;
- identifying synergies in the implementation of Health 2020 and the 2030 Agenda at the level of small countries *(2,3)*;
- discussing best practice in enhancing access to affordable medicines in small countries;
- collecting and disseminating the experiences of small countries in approaching strategic issues, such as the reduction of health inequity, intersectional action for health and development, life-course intervention towards effective prevention and health promotion, and resilience strengthening.

Assessment of the Initiative

An assessment of the Initiative *(1)* was carried out in mid-2017 with the overall aim of gaining an insight into the key issues of the eight participating countries. This would allow carrying out an evaluation of its impact to date (ways of working, topics covered, etc.), and of exploring suggestions for change in the near future. Despite its short existence, the Initiative *(1)* has developed very quickly and its products are of both political and technical/scientific relevance. It has also allowed small-population countries to speak with one voice on several occasions in both European and global settings, thus lending strength to their participation.

It was agreed that the small countries should continue to:

- work as a group since the Initiative *(1)* allows their voices to be heard in international fora and helps them to maintain a topic-focused agenda;

- produce a synthesis of the knowledge products, which provide concrete examples of policies on, and practice relating to, such issues as intersectional action, child obesity, resilience, and the life-course approach;
- consider conducting research on, and developing know-how specific to, the implementation of Health 2020 and the 2030 Agenda *(2,3)* in small countries, which would provide information about the experiences of similar countries outside the network;
- involve ministers, or other high-level civil servants working in non-health policy sectors.

The possibility of expanding the Initiative *(1)* to include countries outside the WHO European Region was also explored during the assessment. In the past two years, it has raised the attention of small countries in other WHO regions; ministers of health from Mauritius in 2016, and Maldives and Barbados in 2017, participated in the annual high-level meetings of the Initiative *(1)*. They regard the Initiative *(1)* as a platform that enables small countries, on the one hand, to seek WHO technical assistance and, on the other, to share best practice, participate in peer-level discussions at ministerial level, and speak as a unified voice in the most important public health fora.

Overall, the feedback was positive. It was considered that input from countries outside the European Region would be beneficial; however, it was stressed that the focus of the Initiative – in terms of topics and suggested approaches – should remain at the European level.

The way forward

The Secretariat of the Small Countries Initiative *(1)* was asked to consider a number of suggestions regarding ways of working. To this end, an assessment was recently carried out, some of the findings of which are listed below.

- With respect to issuing statements at the high-level meetings of the small countries and monitoring progress, a yearly reporting mechanism would reveal barriers met in dealing with public health issues, and help to assess progress made. It would also allow the creation of literature on the experiences of small countries at the ground level.
- The high-level meetings of the small countries should continue. The presence of high-level people from WHO (for example, the WHO Regional Director for Europe) gives status to the meetings and encourages the participation of ministers. It is important during these meetings to create a moment when, for example, ministers and the Regional Director could exchange ideas.
- Consideration should be given to allotting more time to addressing complex issues, such as participatory processes relating to policy-making and innovation, resilience in small countries, or climate change and its impact, to ensure consistency of effort and analyses. The importance was stressed of maintaining the synergy between Health 2020 and the SDGs *(2,3)* at the country level as an over-arching issue at meetings of the Initiative *(1)*.
- The countries considered the thematic subnetworks (e.g., SCHIN *(1)*) to be very valuable and were in favour of maintaining them.
- There is a need to consolidate the approaches of the small countries in addressing NCDs since, at present, these are fragmented. Information about best practice in this area would be welcome.
- The suggestion was made to revisit other international commitments, such as the *Tallinn Charter. Health systems for health and wealth* (2008) *(20)*, and the outcomes of the Sixth Ministerial Conference on Environment and Health, Ostrava, Czech Republic, 13–15 June 2017, to gain an understanding of how to consolidate them towards achieving the objectives of Health 2020 and the 2030 Agenda *(2,3)*.

- The participating countries felt strongly that the WHO European Office for Health for Development should continue to coordinate and host the Secretariat of the Initiative as they very much appreciated the way in which it was being managed *(1)*.

A full report of the assessment is under preparation.

Part 2. Fourth high-level meeting of the small countries, St Julian's, Malta, 26–27 June 2017

Introduction

The Fourth high-level meeting of the small countries was kindly hosted by the Government of Malta. The theme of the meeting was building resilient and healthy communities, which is one of the four cross-cutting priority areas of the Health 2020 strategy *(2)* and a pillar of the United Nations 2030 Agenda for Sustainable Development *(3)*.

Resilience, a less understood component of Health 2020 *(2)*, was chosen as the theme of the meeting because it is fundamental to the functioning of the health system and to maintaining and improving people's health and well-being. It is also a powerful enabler of participatory (whole-of society and whole-of-government) and life-course approaches. Furthermore, the topic of resilience resonates with politicians and citizens alike. The meeting was attended by representatives of the countries participating in the Small Countries Initiative *(1)*, temporary advisers, invited guests and WHO staff; it also benefitted from the input of two observers from non-European Member States – Barbados and Maldives – who shared their experiences and challenges in relation to this topic.

The aim of the meeting was to:

- provide state-of-the-art knowledge on the various aspects of resilience, and how it relates to health and well-being and systems functioning;
- review effective practice in addressing the vulnerability of small countries from the point of view of the health workforce;
- review practice in strengthening the participation of civil society in the governance and development of health systems in small countries;
- analyse the role of small countries in promoting effective practice in tackling childhood obesity, and building consensus around the outcome statement (Annex 1);
- discuss best practice in enhancing access to affordable medicines in small countries;
- review the progress of SCHIN *(1)*;
- provide an update on EHII *(16)*;
- engage the media as a partner in health and development by building communications capacity in participating countries.

The programme and list of participants are attached as Annexes 2 and 3.

Session 1. Resilience at the individual, community and system levels: a key pillar of health and development

The aim of this session was to provide state-of-the-art knowledge on the various aspects of resilience and how it relates to health and well-being and to systems functioning. One of the four priority areas of Health 2020 is the creation of supportive environments and resilient communities *(2)*. At the global level, resilience is a cross-cutting element of the goals of the United Nations 2030 Agenda for Sustainable Development *(3)*. Within the context of the WHO

Small Countries Initiative *(1)*, discussion on resilience first arose when countries expressed a lack of understanding of its meaning in the context of health and development. For this reason, WHO commissioned a publication to explain the rationale behind strengthening resilience for health and well-being. The publication, *Building resilience: a key pillar of Health 2020 and the Sustainable Development Goals – examples from the WHO Small Countries Initiative* (2017), constitutes an important achievement in facilitating an understanding of the link between resilience and the processes, resources and skills that have a positive effect on health. It includes case stories from Iceland, Malta and San Marino *(15)*.

The relevance of resilience to small countries

The representative of the Islands and Small States Institute, University of Malta, provided background on the topic of resilience and its relevance as a cornerstone of development today. The word "resilience" comes from the Latin, "risalire" (to rise again), suggesting that it is closely connected with the ability to recover, or bounce back. When applied to humans, it is associated with the capacity of individuals, communities or countries to adopt measures to withstand or counteract exposure to actual or potential harm. From the health aspect, resilience is associated with the ability of individuals to cope with and recuperate from unhealthy situations; from the aspect of communities, it reflects the capability to withstand and recover from unfavourable circumstances; and, in the case of governments, it relates to the introduction of policy measures that enable society or sections of society to cope with and recover from harmful situations. Health resilience has been defined as "the ability to react and adapt positively when things go wrong, and suggests that these mostly have to do with the quality of human relationships, and with the quality of public service responses to people's problems" *(23)*. The relevance of resilience to prevention and health promotion is also worth mentioning since its presence at the individual, community and system levels contributes to safeguarding health.

Resilience at the individual level has often been associated with psychology and mental health, relating to the ability to recover from stressful experiences and trauma. Formal and informal social relationships that enable a community to withstand unfavourable situations arising from, for example, income inequality, unemployment, racism and natural disasters are associated with community resilience. Attributes of social relations that are conducive to community resilience, such as trust, understanding and participation in community affairs also play a part. At the national level, policies on health and social welfare can be major contributors to fostering resilience within the society at large. Policies that lead to a better distribution of income, for example, are likely to reduce health-related problems by strengthening the ability of the individual to afford health care. Access to free or affordable health care and medicine is also conducive to resilience at the system level.

Regarding public health, small countries have several inherent constraints or weaknesses, including:

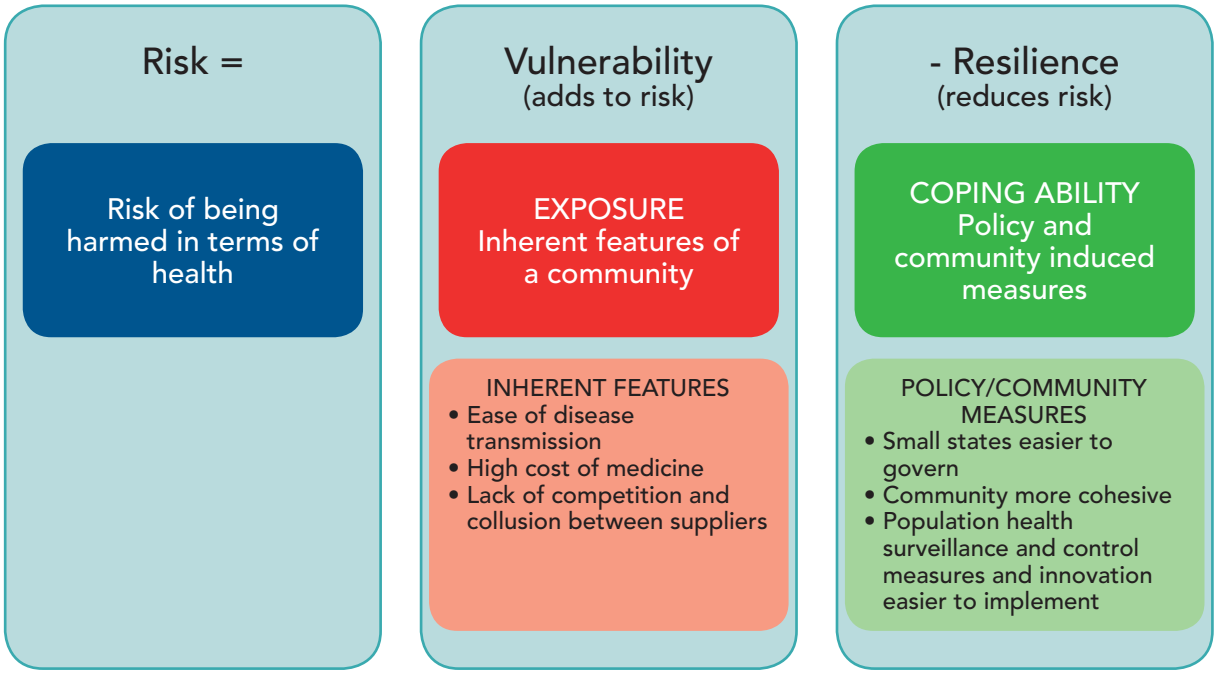
- the small size of their populations;
- limited capacity;
- high medicine and service costs, owing to the limited possibility of benefitting from economy of scale; and
- limited competition possibilities, and collusion among suppliers of medicines.

On the other hand, small countries benefit from:

- small jurisdictions, making it easier for their governments to identify and address shortcomings in health care;
- having a helicopter view of health issues, making the implementation of a Health-in-all-Policies approach *(11)* theoretically more feasible;
- measures put in place to enhance social cohesion, rendering it easier to coordinate and implement health policies;
- easier and more comprehensive population-health surveillance through national registers; and
- a "shorter distance" between research, policy and practice, enabling a more rapid uptake of innovation.

According to the vulnerability/resilience framework, risk of harm = vulnerability – resilience (Fig. 2).

Fig 2. The vulnerability/resilience framework



Source: Building the resilience of small States: a revised framework. A vulnerability and resilience framework for small states (24).

In this context, increased risk (vulnerability) is associated with inherent conditions that expose a system to harm. Reduced risk (resilience) is associated with policy-induced and deliberate measures that lead to the reduction of harm. The most important implication of the framework *(24)* is that, if small countries adopt policies leading to good governance, they can succeed in having strong public health systems despite disadvantages associated with their size.

Country experiences

Iceland and San Marino shared their experiences in resilience building.

Iceland has been working towards increasing the resilience of victims of child abuse, using the Barnahus (children's house) model, the aim of which is to avoid retraumatization and

revictimization of the children concerned *(25)*. The model uses a one-time, single-location approach to collecting evidence. A trained investigation interviewer carries out the investigation in a child-friendly environment. Other individuals involved in the case (such as a judge and social workers) observe the interview from another room. The medical examination does not require undressing, which can retraumatize the victim. Iceland has also developed criteria for giving evidence, depending on the age of the child.

The Barnahus approach *(25)* has proved successful in reducing trauma and speeding up recovery from the negative experience of child abuse. The multifaceted and organized action of the Government, and society as a whole, is an example of community and system resilience; it has been key to improving the overall performance of the system in fighting child abuse and creating resilience in the victims (individual level), which is essential to their healing process and recovery.

Iceland has also embarked on a health-promoting communities programme, involving over 70% of the municipalities in the country. The programme addresses the health determinants, using a comprehensive settings approach, which includes preschools, primary schools, secondary schools, workplaces and settings for older adults.

The **San Marino** approach to building inclusive and resilient communities focuses on addressing the human rights of children with disabilities. In San Marino, justice is central to public health and a core principle in improving public health systems, addressing the health determinants and socioeconomic inequalities, tailoring health programmes to the needs of the most vulnerable, and sharing decision-making with the communities. The National Health Programme 2015–2017 embraces this principle. The health system is in line with the concept of resilience and its implications for health at the three levels (system, community and individual). The life-course approach was adopted to promote the rights of the population with disabilities. On the one hand, solid institutional (system-level) resilience has been strengthened, based on a clear legal framework and the development of implementation and monitoring mechanisms. This can also be said of resilience at the community-level, which is the result of investing in public services, using a people-centered approach, and engaging stakeholders from both formal and informal networks. Individual resilience has been promoted through social cohesion, empowerment and the availability of personalized care. The actors involved form an integrated, supportive and intersectoral infrastructure, and are active at all levels to enhance the well-being of children with disabilities and protect their human rights.

San Marino was one of the first countries to ratify the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (2008) *(26)* and, in recent years, has introduced a number of legislative changes on the human rights of children with disabilities. In 2015, the Government adopted the "Framework Law for assistance, social inclusion and the rights of people with disabilities", based on the principles of CRPD. The National Health Programme 2015–2017 and the related annual programmes of work developed by the Health Authority of the Ministry of Health take the human rights of children with disabilities into account.

In San Marino, intersectoral commissions and working groups have been key in the implementation of legislation and health education in schools. Both have helped constitute an effective interface between bottom-up initiatives and institutional polices, reinforcing resilience at both the system and the community levels. The country benefits from a rich network of voluntary and non-profit associations, which are very active in the promotion of the rights of people with disabilities. These work in partnership with national institutions and the media to create a supportive and inclusive community environment. San Marino also has a wide network of public services responsible for the care of children with disabilities from early childhood through adulthood, as well as people who wish to work and live autonomously.

Meeting health needs is only part of the equation: it is necessary to develop a supportive multilevel infrastructure and strengthen community- and system-level resilience. The country's data-collection system needs to be strengthened and standardized. To this end, work to remove the barriers (cultural, social, physical) that prevent the inclusion of people with disabilities must continue. Longitudinal action, using the life-course perspective of some of the vulnerable moments of life, such as preadolescence, is being explored, and a decree on the introduction of personal assistance for people with disabilities and the promotion of research on assistance technologies, are underway. International networks, such as the WHO Small Countries Initiative *(1)*, are helping San Marino strengthen its resilience by fostering cooperation and the exchange of information about good practice.

Discussion

Enablers and strengths in building resilience were shared by the participating countries. Iceland reported that the huge growth in tourism that the country had seen since the economic crisis (2008–2011) had helped it bounce back. Tourism is now the largest industry in the country. Intersectoral players collaborate on different projects to identify where cuts could be made in streamlining management processes without eliminating important services. Many players have adopted the Lean management process. Iceland is also measuring unhealthy behaviours, such as the involvement of youth in harmful practices (for example, smoking or use of alcohol). Schools, municipalities and sports clubs work together to engage young adults and provide them with alternatives to unhealthy lifestyles.

In Montenegro, work is being carried out to break the cycle of passing on behaviours, such as violence against children and exposure to harmful behaviours, to subsequent generations. Action is being taken to strengthen the capacity of the health system to improve child-rearing skills by introducing positive child-management strategies.

Highlights of session 1

This session showed that the strengths of small countries, such as their small jurisdictions, their policy-makers' helicopter view of health issues, and the short distance between research, policy and practice, make for a more rapid uptake of innovations and contribute to the resilience of their systems. Good governance and a successful economy, which often translate into good health outcomes, also help. Application of the Health-in-All-Policies approach *(11)* is easier in small countries since, on the strength of their size, the number of players involved from different sectors is limited and working relationships are close. The use of the Lean management method in bringing players from different sectors together to identify priorities, without cutting important services, was also found to be valuable. Mechanisms, such as national expert consultations on how to address a given issue and the collection of data, provide the impetus for acting in partnership; this strengthens governance which, in turn, leads to resilience. Finally, the experiences of small countries in strengthening resilience provide examples of action that could be scaled up for use by larger countries.

Session 2. Enhancing access to affordable medicine in small countries

Access to essential medicines is still a challenge in many countries of the WHO European Region, not least those with small populations. Most also have difficulties in introducing new medicines because of high prices and out-of-pocket payments, which can cause a substantial

financial burden on individuals and families. The topic of access to medicines has long been on the global health agenda and, in recent years, action in this area has accelerated. This is evidenced by the number of related resolutions adopted by the World Health Assembly, such as:

- Resolution WHA61.21 (2008) on the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;
- Resolution WHA67.20 (2014) on Regulatory System Strengthening for Medical Products;
- Resolution WHA68.7 (2015) on the Global Action Plan on Antimicrobial Resistance;
- Resolution WHA69.25 (2016) on shortages of medicines and vaccines.

The 2030 Agenda has added impetus to the work being carried out in this area, offering the opportunity for sustained global and regional efforts to ensure equitable access to affordable, quality medical products. The Agenda represents a shift in focus from specific diseases and population targets to a more comprehensive approach to health. Target 3.8, which focuses on the pursuit of universal health coverage in all countries, stresses "access to safe, effective, quality, and affordable essential medicines and vaccines for all" as part of its aim. It provides a clear case for scaling up work on strengthening pharmaceutical systems as part of health-system strengthening, considering the growing need for a wider range of health technologies. It also complements the strategic priorities of the Regional Office for 2015–2020 around health-systems strengthening, in connection with which "equitable access to cost-effective medicines and technology" has been identified as one of the three pillars of action towards "managing change and innovation" to this end *(3,27)*.

Challenges to access to medicines

The main challenges related to access to medicines in Europe are prices, quality, procurement and shortages, and responsible use.

Prices

For some therapeutic areas, even wealthy western European countries struggle to provide access to new medicines due to high prices. Cancer or orphan diseases are particularly impacted by this phenomenon. This "financial toxicity" puts high pressure on governments' public expenditure and raises the question of the sustainability of health systems in the medium term *(28)*. In some countries of the Region, the lack of comprehensive pricing and reimbursement policy creates a situation whereby medicines represent more than half of people's expenditure on health. To resolve this, strategic public procurement could facilitate access and ensure a sustainable supply of new medicines.

Quality

Quality is also an issue of concern due to the weakness of the regulatory systems in many countries and the availability of substandard and falsified medical products on the market. The role of national regulatory authorities is fundamental to ensuring the quality of medicines and medical devices; these entities need to be competent, independent and have strong political backing and the clear authority to enforce established regulations. Shortages of human, technical, financial and other resources inhibit their capacity to perform all core regulatory functions, resulting in the availability of unsafe medicines and medical devices on the market. The regulation of medicines by means of legal, administrative and technical measures will enable governments to ensure their quality, efficacy and safety, as well as the relevance and accuracy of product information.

Procurement

Not all countries make full use of spending and utilization analyses as planning tools to increase procurement efficiency. Procurement responsibilities are often fragmented and needs forecasting is lacking. To increase volume, centralized procurement in the countries is recommended. Greater collaboration among countries, for example, through sharing information about best practice and the provision of assistance to countries, is required.

Responsible use

The responsible use of medicines ensures that the right drug is prescribed to the right patient (appropriate indication), that it is correctly dispensed in the appropriate dosage with appropriate patient information, that it is appropriately administered for the correct duration, that there are no contraindications, and that the cost to society is right. Monitoring drug utilization is the cornerstone of any policy on responsible use. There is a need to strengthen national capacities for collecting good utilization data on a routine basis. To achieve this, countries should ensure that prescribers are adequately trained and that updated printed materials are available. There is considerable interest in structured country collaboration to improve access to medicines in the European Region.

The following are examples of action being taken in the Member States and by WHO regarding access to medicines.

- The five countries of Nordic Collaboration (Denmark, Finland, Iceland, Norway and Sweden) have called for increased cooperation in this area.
- Estonia, Latvia and Lithuania have formed a partnership to collaborate on jointly procuring medicinal products.
- The health ministers of Eastern Europe and Central Asia have adopted a consensus statement on "HIV and TB treatment for all" to strengthen regional cooperation on advancing access to affordable, quality medicines and the delivery of more cost-effective, equitable and sustainable solutions to common challenges *(29)*.
- The issue of access to medicines was included as a key item in the agendas of the EU Presidencies of Malta (January–June 2017) and the Netherlands (January–June 2017), as well as in that of the current Presidency (Estonia (July–December 2017)). (The Austrian Presidency (July–December 2018) will also include medicines as an important area of focus.)
- At a meeting in Valletta, Malta, on 8 May 2017, Cyprus, Greece, Ireland, Italy, Malta, Portugal, Romania and Spain committed to collaborating on negotiating the prices of medicines (Valletta Declaration).

The Regional Office has published a wide range of technical reports on policies and priorities related to the introduction of new highly priced medicines, including the technical briefing held during the sixty-sixth session of the WHO Regional Committee for Europe (2016) *(30)*. On this occasion, the Regional Office organized meetings of technical experts to discuss options for strategic procurement and horizon-scanning, the results of which will feed into a document, which is being prepared for presentation at the sixty-seventh session of the WHO Regional Committee for Europe (2017). The Fair Pricing Forum, organized in Amsterdam, the Netherlands, in May 2017, in collaboration with the Ministry of Health, Welfare and Sport, gathered representatives of more than 200 stakeholders and competent authorities on medicine-pricing policies from across the globe.

The Regional Office seeks to support the Member States in these areas in an effective, integrated and evidence-informed manner, and to promote debate and discussion on important topics

relevant to access to medicines and the wider pharmaceutical sector. Political will and mutual trust among Member States are, however, essential for the success of future collaboration. Sharing best practices will be essential, but specific topics, such as strategic procurement and medicines negotiation, will need special attention. The goal should not only be to achieve fair pricing but also to get industry on board to ensure the availability of new medicines.

Regarding the issue of enhancing access to affordable medicine in small countries, reference was made to Policy Brief 21 of the Maltese EU Presidency, which proposes ways of tackling the issue in a changing environment *(31)*. To ensure that new medicines are available to patients, health systems need to meet the challenge of anticipating and managing the impact of technologies by engaging in horizon-scanning activities, mobilizing capacity to assess the value of new health technologies, and negotiating affordable prices *(32)*. Cross-border collaboration in the field of public procurement is often put forward as a promising strategy to address some of the existing imbalances and challenges of this market.

The SMSHealth.eu 3-year project (September 2015–August 2018), which is co-funded by the Erasmus + Programme, is looking at the gap in the literature related to health policy, particularly European health policy, and the position of small countries on the European integration of health policy. The network consists of three university departments with expertise in small countries and European public health, a public health institute, and an independent non-profit think tank comprising participants from Estonia, Iceland, Malta, the Netherlands and Slovenia. The research is being conducted in a comparative manner across four health-policy issues, namely, access to medicine, cancer, workforce mobility and rare diseases, in four small countries with the aim of enhancing collaboration between research, policy and practice in Europe and beyond *(33)*.

The European Medicines Agency provides Community institutions with scientific advice of the highest possible calibre on all matters relating to medicinal products for human and veterinary use. The Agency's main task is to coordinate the scientific evaluation of the safety, efficacy and quality of medicinal products. The introduction of the EU marketing authorization procedures means that the availability of medicines is reduced immediately after a country accedes. This has raised a number of problems for small countries, including the following.

- Companies decide when and where to offer their products, the result being that the costs for national medicines agencies in small countries are relatively high.
- There is a lack of transparency regarding pricing and reimbursement.
- Generic drugs monopolies mean that only one product of a category attracts interest.
- Small countries have little negotiating power due to their limited markets, which results in problems in the availability of new medicines, for example, those needed for rare diseases.
- Patients start purchasing medicines over the Internet or in neighbouring countries.
- The development of parallel markets results in high import prices and export problems.

Among future issues to be considered are the counterfeit system, temporary registrations and personalized medicine.

Since in EU there is no longer a "one-size-fits-all" approach that works, some countries have already acted. For example, Malta produces medical leaflets in multiple languages and Slovenia has established the temporary registration of medicines. Networking and joint lobbying are valued highly in EU countries. Joint procurement has helped overcome bureaucratic and logistical challenges; however, more transparency is needed regarding

pricing and reimbursement. Creative health-system reforms and more thinking outside the box are called for.

Country experiences

Iceland, Monaco and Montenegro shared their experiences regarding access to affordable medicines.

Iceland has a new medicines policy and an ongoing process of streamlining procedures for the purchase of new medicines. Although access to medicines is one of the cornerstones of the policy, shortages still pose a challenge. In preparing leaflets on medicines, the question of what language to use so that non-Icelandic-speaking migrants will be able to understand them creates a problem. In general, the EU directives in this area are not well suited to smaller markets, and cross-border collaboration could enhance access to affordable medicines.

Monaco has been collaborating with France in the field of access to medicines for 50 years, which has made the link between the two countries in this area very close. A memorandum of understanding, which has been modified over the years, defines France's conditions for issuing authorizations to market medicinal products for human use. It also stipulates the methods to be used in the inspection of pharmaceutical establishments and the supervision and advertising of medicinal products for human use in Monaco. Being in close cooperation with a country with a broader pharmaceutical market has enabled Monaco to deal with all the challenges a small country may encounter regarding the supply and supervision of medicines. The agreement also provides for the sale in Monaco of medicines available in France. On the other hand, Monaco is obliged to accept the prices of medicines agreed between France and the pharmaceutical company in question. The technical assistance of French agencies in monitoring and inspecting medicines in Monaco is also provided for in the agreement. Other advantages of this collaboration include the temporary authorization of innovative drugs for the treatment of very serious or rare diseases, whereby the French authorities can deliver them to Monaco even if they are not yet available in France. In the case of medicine shortages in

Monaco, France has committed to delivering the necessary quantity to meet the most urgent needs. For example, in its emergency response to H1N1 influenza, France provided Monaco with doses of the vaccine.

In **Montenegro**, several measures have been put in place to address the challenges of access to medicines, including new and potentially highly priced medicines. A centralized procurement system was established in response to growing expenditure. Centralized tenders were organized to procure medicines for hospitals and medical prescriptions covered by the compulsory national health insurance. In line with the law on public procurement, a publicly owned drugs wholesaler can issue a public tender to procure medicines on behalf, and at the expense, of public hospitals. This measure was coupled with promoting the use of generics as a part of the solution to manage pharmacological expenditure and improve access to, and the continued supply of, medicines. As a result, the prices of pharmaceuticals were halved during the period 2005–2012. An integrated health-information system was introduced in public pharmacies, the drug agency, and the primary and secondary health-care provider systems as a tool in monitoring, prescribing and dispensing practices. A positive impact was recorded in the first two years of the system in that the quantity of pharmaceuticals prescribed decreased by almost 24%. A national law on procurement in the field of pharmaceuticals has promoted the principles of transparency, and ensured competitive tendering and the equal treatment of suppliers as a way of providing good governance in medicines and openness about the use of public resources.

Discussion

In Cyprus, medicines are expensive and pharmaceutical expenditures very high. Cyprus also faces the problem of procurement shortages, which was exacerbated when the country was hit by the flu pandemic. By signing the Valletta Declaration (2017), Cyprus committed to collaborating (with Greece, Ireland, Italy, Malta, Portugal, Romania and Spain) to ensure better access to new medicines.

Iceland reported that negotiations with a pharmaceutical company had enabled the nationwide treatment of people infected with HIV.

Two small countries from outside the WHO European Region – Barbados and Maldives – also shared their experiences regarding access to medicines.

While Barbados faces the challenge of vaccine procurement, thanks to the involvement of the Pan American Health Organization, 99% of the population is currently vaccinated. Regarding NCDs, Barbados is addressing the need for sound data and information to demonstrate their progress. The country is highly dependent on imported medicines. The Caribbean Regulatory System *(34)*, which is part of the country's public health agency, ensures that products entering the Caribbean countries are safe.

Maldives is fully dependent on tourism and fishing. Although only 200 of their 1200 islands are inhabited, all of them must be provided with medical coverage. As people cannot be forced to move to the larger islands, at least one pharmacy is needed on each inhabited island. Maldives does not produce medicine and, therefore, as is the case in Barbados, relies on imported products and faces challenges related to pricing and quality. In addition, lack of the necessary technology does not allow them to monitor the quality of imported medicines on a continuous basis. Patient affordability is not a problem. Maldives spends about 9% of its GDP on health care and 50% of its workforce of doctors and nurses is comprised of foreign nationals.

Highlights of session 2

This session highlighted the importance of using platforms, such as the WHO Small Countries Initiative *(1)*, to strengthen collaboration on the procurement of medicines. This would increase price transparency, enhance negotiating power, contribute to the containment of costs and lead to greater fairness and improved affordability. Regarding pricing, strategic public procurement could facilitate access to, and ensure sustainable security in the supply of, new medicines. The regulation of medicines by means of legal, administrative and technical measures would enable governments to ensure the quality, efficacy and safety of medicines, as well as the relevance and accuracy of product information. The responsible use of medicines could be achieved through the adequate training of prescribers and the availability of updated printed materials.

There is considerable interest in structured country collaboration to improve access to medicines in the European Region and cross-border collaboration to enhance access to affordable medicines. An examination of regulatory issues, legal frameworks and financial laws that heavily impact the feasibility of cross-border collaboration would be needed to facilitate the process. To complete the picture, it would be important to become more familiar with the experiences of EU Member States that have cooperated voluntarily in joint measures related to the procurement of pandemic vaccines and other medical countermeasures, as well as those of countries in other WHO regions.

Joint strategic public procurement could also facilitate access to, and ensure the sustainable supply of, new medicines. This would require countries to increase their collaboration by sharing information about best practice and their experiences in building negotiating skills. The Valletta Declaration, whereby the countries involved have committed to exchanging information related to the procurement of new medicines, is an example of such collaboration.

Creative health-system reforms and more thinking outside the box are needed in Member States. The optimal balance would consist, on the one hand, of keeping industry on board to benefit from innovations on the one hand and, on the other, the fair pricing of medicines. Since, currently, there is no free flow of medicines in EU, cross-border collaboration would be one way of tackling the shortage of new medicines and issues related to the languages to be used in product leaflets.

It was concluded that the time was right to move forward on the joint procurement of medicines, with WHO support.

Session 3. Strengthening the health workforce in small countries

The needs of health personnel in small countries are varied: some countries may be too small to sustain training institutes for higher-level professionals while others may struggle to support their being trained outside the country and face the uncertainty of whether they will return or not. Often, career structures in small countries are flat with restricted promotion and specialization opportunities. Small countries are also more vulnerable to outflows of staff with resulting migration, or to shifts to other sectors for better financial conditions. In addition to facing the same full range of challenges related to the health workforce as large countries, small countries have the problem of insufficient numbers of management staff and, potentially, limited health-system capacity for strategic planning. For example, managers might find themselves with multiple responsibilities because there are too few policy-making and labour-market specialists in the health system. The resources required to deal with overall planning

and regulation, and to support workforce data systems, are also limited in small countries.

Possible solutions to these challenges could be to:

- adopt a whole-of-government, or whole-of-sector approach to planning human resources for policy-making;
- harness economies of scale and optimize the use of scarce specialist skills;
- collaborate on monitoring trends in migration flow with scope for possible bilateral agreements;
- focus on retention by recruiting and training locally;
- link out-of-country work opportunities with scheduled returns;
- enhance the skills mix by offering advanced, multiskilled roles to nonmedical professionals (for example, nurse practitioners), emphasizing the need for teams (not just individuals);
- improve access to and the productivity of medicines, and expand career structures to help improve retention;
- assess the scope of planned short-term visits of specialist practitioners or medical teams from other countries to encourage workforce mobility; and
- make use of migrating health professionals during temporary visits to their home countries.

WHO has several strategies that could enhance human resources for health. One example is structuring cross-border post-graduate training exchanges by sharing medical schools. The WHO publication, *Global Strategy on Human Resources for Health: Workforce 2030 (35)*, which is aimed at planners and policy-makers in the Member States, is also relevant to stakeholders in the health-workforce area, including public- and private-sector employers, professional associations, education and training institutions, labour unions, bilateral and multilateral development partners, international organizations, and civil society. Grassroots experience in structured cooperation on highly specialized health care to inform macro-level policies could also be utilized when appropriate. The exchange of good practice in cross-border cooperation on health care should be promoted to inspire health-system actors to overcome challenges related to the health workforce for the benefit of patients and health professionals alike. Further support for human resources comes from the High-Level Commission on Health Employment and Economic Growth, which is tasked with proposing action to stimulate the creation of jobs in the health and social sectors as a means of advancing inclusive economic growth with a special focus on the needs of low- and lower middle-income countries *(36)*.

Strengthening the health workforce in Malta

Malta shared its experiences in strengthening the health workforce and presented results from the Small States and Health (SMSHealth) project *(33)*. This project involved a quantitative and qualitative study on the mobility of the health-care workforce. It was conducted in Malta, Estonia, Iceland and Slovenia through face-to-face semistructured interviews with experts on health-care workforce mobility in small countries. The interviews revealed that all small countries had workforce shortages due to a mismatch between the demand and supply of labour, limited financial resources, a lack of specialized training, and the translation of courses into only a few highly specialized professionals. In this context, the possibility of brain drain is always a risk and the key to preventing it is to have specific retention strategies in place. The resilience of health systems in small countries is hampered by factors closely connected to

their small pools of human resources. This fragility can be addressed by improving the overall resilience of the health sector by introducing processes and mechanisms to reduce system-level vulnerability.

Four cases of improving the resilience of the health sector were shared.

1. When the United Kingdom changed the structure of its medical specialty training programme, and upon the accession of Malta to EU, the country was losing more than 35% of its graduates immediately upon qualification. To address this, a Foundation School Programme was set up in Malta, aiming to reverse the brain drain. The Programme now recruits overseas medical graduates and the demand for places exceeds supply.
2. Prior to EU accession, formal systems of specialization were lacking in Malta; many students left to specialize and did not return. To address this lack, a domestic specialization and accreditation system was established (in partnership with other countries). A mechanism was set up whereby training takes place partly in Malta and partly overseas. This has helped retain capacity locally, ensured the necessary exposure to patient numbers/diversity, and maintained the hospital as a teaching and training entity – something which did not exist before. Final accreditation is given upon return to Malta. This hybrid system allows Malta to produce its own medical specialists. Since the United Kingdom has voted to leave the EU, Malta is currently investigating similar partnerships with other countries.
3. Upon Malta's accession to EU, more than 50% of the country's nurses held a qualification that was not recognized. To address this, over a period of around 10 years, more than 800 nurses underwent an upskilling programme, which provided the impetus to professionalize nursing. Nurses in Malta now obtain higher qualifications and are licensed; this has had a positive impact on service delivery and motivation.
4. Case four relates to the development of the new "allied health" profession in Malta, which includes dental hygienists, diagnostic medical sonographers, dietitians, medical technologists, occupational therapists, physical therapists, radiographers, respiratory therapists, and speech-language pathologists, to name a few. Malta received EU funding to build new oncology hospitals, but had no therapeutic radiographers or medical physicists. Two university-level allied-health courses were developed in collaboration with partners based in the United Kingdom, and Malta is now self-sufficient in the provision of training for these professions. As a result, patients who previously had to seek treatment abroad are now treated locally.

The results of these four cases show that the number of physicians per population (including trainees) has risen from below the EU average in 2010 to be on a par with the rest of EU. Maltese nurses have been upskilled, and a new profession (allied health) has been developed. There are still risks due to small shifts in migratory and recruitment patterns, which can have a large impact. Reliance on a single large country can also be a risk, as in the case of Brexit, and a shift from under-capacity to over-capacity can occur very quickly.

Country experiences

Luxembourg is not confronted with a general shortage of physicians nor with their unequal distribution between urban and rural territories as is the case in some other European countries. The challenge for Luxembourg is to maintain a balanced medical workforce; there is no medical faculty in Luxembourg and the country is highly dependent on foreign countries for medical education. In the past, Luxembourg was faced with declining numbers of general practitioners (GPs) because their working conditions were viewed as being more difficult

than those of physicians working in specialist areas, and financial compensation was lower. The maintenance and development of an effective primary-care system became a political priority aimed at motivating young doctors to become GPs. The cost of GP consultations was increased and the Government decided that all medical consultations and other work would be indexed automatically. The concept of the referring physician guiding the patient through the system was established on a legal basis, which promoted the GP role in the country. To reduce congestion in hospital emergency rooms, the Ministry of Health introduced "medical homes" – health-care centres situated near the main hospitals to cater for non-emergency complaints – which are only open during the night between standard working hours. GPs working there may offer to make home visits, in which case they have a car and a driver at their disposal. Since the introduction of the above reforms, the number of GPs has increased by 30% over a period of 11 years.

The health system in Luxembourg remains very attractive to foreign physicians. According to data from 2010, 45% of the physicians in the country were foreign nationals, all of whom benefitted from being able to work in modern health-care infrastructures. There are challenges, however, such as motivating medical students to return to the country on completion of their studies abroad to prevent a shortage of medical doctors, and the need to stimulate collaboration between hospitals and other sectors to avoid duplication of services. The Ministry of Health is promoting stronger cooperation among hospitals

Though **Monaco** has a small resident population, its hospital infrastructure can accommodate more than three times the needs. The country faces the challenge of attracting people to live and work in the country to ensure good health-services coverage. Among the incentives for doing so are state-of-the-art equipment, well-staffed departments, a good social environment with child care, parking space, shuttles to parking lots and the availability of public housing for health professionals from abroad.

Montenegro's strategy on health-sector development (2015) focuses on improving health-care delivery and population health, reducing per capita costs, and enhancing the care experience. Achieving this will require all care providers, including primary health care providers, to strengthen their knowledge and acquire new skills. There is a need for continuing education for providers of primary care to refresh their knowledge and skills in managing chronic care, particularly of the elderly. In addition to being able to provide high-quality, cost-effective health care to patients with chronic conditions, they need to be competent in team work related to chronic care. Preparing a professional workforce that can provide high-quality chronic care within new delivery models will require comprehensive public policies that mobilize aggressive reforms in the education of specialized physicians, nurses, social workers, psychologists, rehabilitation therapists, pharmacists and other health-care professionals.

Discussion

Cyprus has four medical schools, one public and three private. The languages used in the courses are Greek in the public school and English in the private schools. The students in the public school come from Cyprus and Greece whereas those in the private schools come from all over the world (including Cyprus and Greece). According to data for 2015, 30.8% of doctors work in the public sector, which more than 70% of the population is eligible to use, and this results in shortages of medical staff. There are also shortages of doctors specialized in specific fields of expertise. In addition, Cyprus has only a few GPs. To address the gap, specialists in internal medicine have taken on this role. There are four nursing schools, one public and three private, which operate in Greek and Greek/English, respectively. Nurses work mainly in the

public sector. On the other hand, many graduating nurses are currently unemployed. There is a shortage in the private sector.

In **Monaco**, the challenge of convincing youth who study abroad to return to the country is coupled with that of finding enough qualified workers for hospitals. Currently, France has a very good education programme on which Monaco is highly dependent and without which there would be a problem. Twenty years ago, doctors in Monaco were mostly French or Monegasque. Today, there are practitioners from other European countries, such as Italy and Romania, as well as from North Africa. Furthermore, Monaco's small size and the high cost of professional premises are also points for consideration in relation to the expansion of the health workforce. The state provides nationals with housing and professional premises, rented below current market prices, making it possible to lift the financial barrier associated with the return of graduates to Monaco. In agreement with France, French civil servants can be seconded to Monaco for three years as mentors for young people.

San Marino also needs to identify a means of retaining the country's doctors and health-care professionals in the workforce to reverse the trend of their leaving to work elsewhere. To ensure sufficient coverage, it will be important to offer favourable conditions to attract medical professionals from abroad, and to raise awareness of the problem at the government level.

Maldives has no medical school and a shortage of specialists could mean no coverage in a given area (there is one neurosurgeon in the country). Periodically, medical professionals from India pay working visits to the country, but these are only temporary. **Barbados** faces the same challenge regarding shortages of medical staff. Early identification of the specialties needed and the introduction of measures to encourage people to follow studies in the relevant fields are required. Nursing in Barbados has become very specialized: in fact, specialty training is available for every area of care, and it is much needed.

Highlights of session 3

This session revealed that needs and challenges regarding health personnel vary among small countries. Nevertheless, all countries reported shortages in the health workforce and some face the challenge of brain drain. Retention strategies to deal with these situations are required. Possibilities include: motivating medical students to return home on completion of their studies abroad; providing continuing medical or nursing education and opportunities for practitioners or medical teams to spend short-term working visits in other countries through exchange programmes; and introducing incentives to encourage people to enter and stay in the medical profession, such as accreditation mechanisms, opportunities for career growth, and attractive social and working conditions.

Planning human resources was also highlighted as being essential. The early identification of future needs in terms of medical specialties and the introduction of measures to encourage study in the different fields, and taking steps to put the issue of the shortage of medical professionals on the political agenda, were considered important.

Numerous country examples presented during the session showed that the more informed a country is, the more resilient it becomes, making it easier to face challenges that arise.

The way in which health systems evolve, including their use of new technologies, has a bearing on the future work of the country, and it is essential to keep up to date.

Session 4. Leaving no one behind: small countries at the forefront of the whole-of-society approach

Population health is a political choice. The resilience of systems, communities and individuals is dependent on a participatory, whole-of-society approach to challenges, such as inequality. In this connection, some successful examples exist, such as Iceland's Barnahus model of helping victims of child abuse and preventing their retraumatization and revictimization *(25)*. This model calls for a supportive infrastructure and a whole-of-society approach, involving not only the victim and the family, but also different ministries, research centres and NGOs, thus building overall resilience.

Another example is San Marino's approach to addressing the rights of children with disabilities with the aim of strengthening individual, community and institutional resilience. The Ministry of Health, the Ministry of Education, other relevant ministries, NGOs, voluntary associations and national radio and television are all involved. Resilience at the individual, community and system levels is examined in depth in the WHO publication, *Building resilience: a key pillar of Health 2020 and the Sustainable Development Goals – examples from the WHO Small Countries Initiative (2017) (15)*.

Participatory processes are also needed to ensure progress and sustain commitment to modernizing health systems and public health delivery, and developing society. In collaboration with the Member States, WHO collects evidence on, and consolidates knowledge about, ways of increasing performance in this much-needed area to be sure that no one is left behind.

Country experiences

There are many examples of ways in which the small countries apply a whole-of-society approach.

Andorra realized that health campaigns on their own are not enough and that it is often difficult to gauge the results of such efforts. The country has clear examples of success in promoting health and well-being through use of physical activity and its beautiful natural resources in its non-smoking campaign. Historically, Andorra has welcomed refugees, for example, from the Spanish Civil War and the Second World War, who travelled the 30-km route from the south to the north of the country, or vice versa. This route is now called the "Healthy path of human rights of Andorra". Each kilometer is marked by an article from the Universal Declaration of Human Rights *(37)*, and people walking the path are provided with information about the 2030 Agenda *(3)*. At the end of their journey, they receive a certificate of completion. This project coincided with the 70th celebration of the United Nations (2015). Andorra would like to create a network of healthy paths and include it in an app so that it reaches many users. A small fee would be charged for the use of the app and the money collected would go to people in need.

In **Iceland** participation at the local and regional levels is considered not only as a question of stating that a process is ongoing, but also of providing proof that there is openness to involving people and considering their input. The Directorate of Health has been the driving force behind the health-promoting community project, by means of which Iceland is in the process of collecting public health indicator-based data in the municipalities to show how they are doing in terms of health. The municipalities have been active in raising the interest of the public in taking part in the process. Another example of the use of a participatory process in Iceland are the meetings held between the police, migration activists and migrants, which have resulted in reforms in immigrations policies. Iceland's attempts to use participatory processes have been fruitful and the added value of stakeholder involvement has translated into having a real effect on policy. Iceland can vouch for the participatory process as an important tool.

Luxembourg has the tradition of involving everyone concerned in the development of specific policies. This is the case for all sectors. The Ministry of Health uses a participatory process in developing national plans. In general, all working groups in the health domain are organized by the Ministry of Health and the Directorate of Health and their leaders are officially nominated by the Minister of Health. For the last 10 years, the Ministry of Health has organized an annual national conference day. Participation is by invitation only, the press and parliamentary members of the Commission of Health and Social Security being among those who take part. The Ministry of Health chooses one or two topics for each conference. The Minister of Health always takes part in these important occasions at which the Ministry of Health and the Directorate of Health present their projects and solicit the input of the other sectors concerned. The conferences include roundtable discussions in which high-level representatives of the relevant sectors take part.

Improving people's access to health-related information and their capacity to use it effectively helps to empower them. To improve the availability of such information in Luxembourg, ten years ago, the Ministry of Health developed a national health portal for the Internet, featuring health-related information and providing links to other organizations. This is an example of the ways in which Luxembourg has tried to make health-related information available to the population for use in making the appropriate health-related decisions.

San Marino has focused on fostering community participation in health for an inclusive society. San Marino's idea of public health is based on social justice. The country's national health plan (2015–2017) gives a voice to communities and takes into account institutional, community and systems resilience with the aim of leaving no one behind. The development of the national health plan involved a two-year participatory process. San Marino is divided into nine local municipalities called "Castelli" ("Castles") chaired by nine "Captains". The country has one national hospital, one university, industrial and agricultural production, trade unions and a rich history of active associations and civil-society organizations. San Marino used a period of

economic crisis, as an opportunity to involve civil society in the development of the country's national health plan. A parallel capacity-building process has been the "coproduction of health and development in the Republic of San Marino", which has involved social and health professionals, the municipality captains, the municipality councils, intersectoral working groups and civil-society organizations.

Discussion

WHO shared information on how the Organization is facing the challenge of incorporating equity aspects related to the Roma population in public health programmes. Whenever Roma representatives have been included in discussions concerning their health, they have reported that it was the first time they had been asked to talk about their problems, including their lack of access to health-care facilities. Clearly, it would be necessary to build their trust before their participation in an equity-related process could be mutually fruitful.

Highlights of session 4

During this session, it was underlined that citizen participation should not just be symbolic. This will be critical factor in relation to achieving the SDGs *(3)*, for example. Some countries hire educators to facilitate a participatory process. Bridges need to be built across sectors so that decision-making processes involving society become the norm. There may be lack of clarity in small countries about what participatory processes entail and what they can achieve. It would be important to collect and disseminate inspirational examples of such processes.

Session 5. SCHIN: small countries at the forefront

The European Health Information Initiative (EHII) is a multimember WHO network committed to improving the health of the people of the European Region by enhancing the information on which policy is based. EHII's vision is to harmonize health information in the entire European Region and provide solid evidence for policy-makers. This can be achieved by fostering international cooperation on exchanging expertise, building capacity and harmonizing indicators, and collecting and reporting data. EHII works in six key areas: (i) collecting information on health and well-being, with a focus on indicators; (ii) improving access to and the dissemination of health information; (iii) building capacity; (iv) strengthening health information networks; (v) supporting the development of health-information strategies; and (vi) communication and advocacy.

The guiding principles of EHII are: a focus on the development of practical tools; and a focus on the use of innovative approaches and the stimulation of research and development work. It aims to:

- harmonize health information and improve its comparability;
- improve the quality of health information;
- make health information more available, accessible and easier to use;
- support the development of methods and tools;
- support and facilitate the exchange of good practice;
- support the synthesis, dissemination and use of quality evidence for health policies;

- build and sustain expert networks; and
- contribute to capacity-building for public health *(16)*.

To date, EHII has 34 participants, comprising mostly Member States and other entities, such as the European Commission and the Organisation for Economic Co-operation and Development. All activities of the Regional Office in the area of health information fall under the umbrella of, and are overseen by, EHII *(16)*.

In response to the high reporting burden revealed in the countries, the Regional Office has established a gatekeeper function for data collections/surveys (coordinated by the Statistical Policy Group). As of 2016, only surveys approved by the Group may be sent to Member States. In the first half of 2017, 27 surveys were approved; this does not include an unknown number of surveys carried out by WHO headquarters and other agencies. The process will be evaluated at the end of 2017. The Regional Office is also working to align indicators across three policy frameworks, Health 2020, the 2030 Agenda and the NCD Global Monitoring Framework (76% of the Health 2020 and the 2030 Agenda indicators overlap thematically) *(2,3,38)*. The countries are in favour of lowering the burden of reporting, and of developing and implementing a joint monitoring framework; a proposal to this end will be presented at the sixty-seventh session of the WHO Regional Committee for Europe in Budapest, Hungary, on 11–14 September 2017.

The Regional Office's new data portal, the European Health Information Gateway *(19)*, is making great strides in improving access to health information. It includes a new tool, the "Health for All explorer", that allows integrated access to the entire family of Health-for-All databases, thus enabling dynamic searches and comparisons, and making the data reusable and shareable in many forms (social media, graphs, databases). It is now also possible to analyse these data, using a small-countries average against which comparisons can be made. The Regional Office also disseminates health information by means of its public health journal, Public Health Panorama *(39)*, which is aimed at sharing information on good practice and the successful implementation of evidence-informed policies.

Since 2013, WHO has improved capacity-building by means of an annual event entitled, "Autumn school on health information and evidence for policy making", which is followed by an advanced course 8–9 months later.

SCHIN *(1)*, which was established through the initiative of the Minister of Health, Malta, and is currently chaired by Malta, has reached an agreement on reporting on a rolling average of selected indicators. It is in the process of developing a joint indicator list for reporting on health-system performance assessment in relation to Health 2020 implementation *(2)*. Other health-information networks in Europe supported by EHII *(16)* are the Central Asian Republics Information Network, CARINFONET *(40)*, which provides a platform for the joint reporting of health statistics, and the Evidence-informed policy network, EVIPNet Europe *(41)*, which promotes the systematic use of research evidence in policy-making, increases country capacity in developing sound and effective health policies, and institutionalizes knowledge translation (KT) through the establishment of KT country teams. These teams develop their own policy briefs and are trained to hold policy dialogues. The European Burden of Disease Network, in which ten Member States participate so far, is in the process of reviewing the national burden-of-disease manual drafted by the Institute of Health Metrics and Evaluation (USA). The South-eastern Europe Health Network (SEEHN) ministerial summit recently took the decision taken to establish a SEEHN health-information network; the Regional Office is now working with the SEEHN secretariat to move the network forward *(42)*.

Resolution EUR/RC66/A1 on the action plan to strengthen the use of evidence, information

and research for policy-making was adopted at the sixty-sixth session of the WHO Regional Committee for Europe in 2016 *(43)*. The action plan features concrete action for Member States, such as: strengthening health-information systems; harmonizing health indicators and establishing an integrated health-information system for the European Region; establishing and promoting health-research systems to support the setting of public health priorities; increasing country capacities for the development of evidence-informed policies (knowledge translation); and mainstreaming the use of evidence, information and research in the implementation of Health 2020 *(2)* and other major regional policy frameworks.

EHealth Week 2017, which was held in Malta in May, provided the Regional Office with a unique opportunity to demonstrate the importance of eHealth to international public health. The event, which the Regional Office cosponsored for the first time, put the spotlight on the main health-information issues that countries face in reforming their health systems. It also focused on the role of technology in developing integrated models of prevention and care. Finally, it provided key international partners working in the field of eHealth in Europe, including the European Commission, the opportunity to build and strengthen their relationships. The Regional Office's next steps in the area of eHealth and innovation will be to provide a technical briefing on big data at the sixty-seventh session of the Regional Committee for Europe (September 2017), guiding Member States on their use, and to participate in the conference, "Health in the digital society. Digital society for health", which will be held in Tallin, Estonia, on 16–18 October 2017. The conference is being organized by the Estonian Ministry of Social Affairs (as part of Estonia's Presidency of the Council of the European Union), ECHAlliance and HIMSS Europe.

While the health-information challenges of small countries remain at the national level, they have been a driving force in enhancing health information, evidence and monitoring in Europe. The small countries were the trigger for setting up the gatekeeper function at the Regional Office and developing the proposed joint monitoring framework *(44)*.

Country experiences

The small countries have taken an active role in SCHIN *(1)* and EHII *(16)*. They reported on the value of the recently established gatekeeper function.

Andorra reported that its health-information system had undergone many positive changes in the past year, which were catalysed by the existence of SCHIN *(1)*. The system of shared social-security data was updated after a pause of two years. Data on public health expenditure and out-of-pocket private expenditure were now available. Andorra still needs to improve the transmission of data from the data sources, and coordination with other administrative departments. A law on the rights and duties of patients was under parliamentary discussion. The proposed law includes the regulation of access to a shared system of electronic medical records, which would facilitate an understanding of NCD incidence and prevalence in the country. A law relating to the statistics plan for 2017–2020, which includes health statistics, is also under parliamentary discussion. A new unit on health information and statistics is being created to collect and process data and analyse information on health status and the health system. It will also take charge of disseminating information about health, the health system and related policies.

Thanks to SCHIN *(1)*, **Iceland** has already started to work on statistical methods relevant to countries with small populations and ways of reducing the reporting burden and addressing the question of introducing a core set of health indicators relevant to and suitable for the country. Small countries can develop novel ways of calculating progress based on health indicators and

publishing the results should be regarded as a chance to communicate and raise awareness about health risks. Therefore, to ensure optimal impact, it is important to explain the rationale behind each indicator in a language, which users can understand.

The effective translation of knowledge into action is critical in implementing programme and policy changes. This underlines the importance of health indicators to health-promotion efforts at the community level, such as those of the Icelandic health-promoting communities project. It is also important to follow specific examples of how knowledge has been, or is being, translated into action. There is also a need (and the desire) for health information at the local level. In Iceland, the users of health indicators (community-based organizations) need to be able to adapt findings to local circumstances, or themselves produce more local information. For this reason, it is imperative that local communities receive help in making use of the indicators in prioritizing action and motivating local actors.

In **Montenegro**, SCHIN *(1)* provided the impetus to improve the health system at many levels. The country's leading strategy for health-system development through 2020 calls for an integrated health-information system and an eHealth programme with the objective of achieving better management at all levels of the health system by using health information in decision-making processes. Priority activities are planned to further improve the health-statistics and reporting systems, as well as data analysis. Montenegro's reporting needs are growing (as they are in other small countries) and the country is faced with the dilemma of being motivated to improve the national reporting system on the one hand and, on the other, of having limited funds to do so. Health reporting focuses on Health 2020 *(2)*, the NCD global monitoring framework *(38)*, the SDGs *(3)*, and related indicators. Montenegro is also part of SEEHN *(42)* and hosts the Regional Health Development Centre on Non-communicable Diseases, which has established a minimal set of NCD-related indicators. These are in accordance with the afore-mentioned indicators and reporting needs.

In Montenegro, one of the main reasons for establishing the National Council for Coordination and Prevention of NCDs was to take multisectoral action on the prevention and control of NCDs oriented to risk-factor reduction, one of the objectives being to monitor progress towards the goals of the NCD global monitoring framework *(38)*. Montenegro would welcome support in reporting on activities related to the SDGs *(3)* and the forthcoming National Strategy for Sustainable Development (planned for 2018). Use of the existing data and linking information from the different sectors and other sources still constitute a challenge in the country. While eHealth is a national priority, with e-appointments in place, it needs to be expanded to include indicators showing the utilization of eHealth services (e-prescription, e-referral, e-guidelines on prescribing, e-clinical guidelines, an e-medicine list, e-cross-border health care). Montenegro's membership of multiple networks means that the country still receives many requests and there is a need to harmonize these.

San Marino believes that SCHIN *(1)* is a good instrument for supporting harmonization across the small countries. The network facilitates the comparison of common indicators, with a focus on Health 2020 *(2)*, while taking geographic, demographic, social and cultural differences into consideration. It contributes to improving WHO statistics with real data (rather than estimates) from the small countries and could become an interesting laboratory for larger countries and other WHO regions. The network is also useful in encouraging a comparison of data from small countries to see whether their strategies are having an impact on people's well-being *(1)*. San Marino's national health plan includes a monitoring and evaluation system that uses Health 2020 indicators *(2)*. The country is improving the national information system, which is based on an information platform that integrates data flows from hospital, primary-care and social services and collects data on the main determinants of health. The gatekeeper function has been crucial in preventing the burden of multiple requests from, and the duplication of health

information by, international entities. While the gatekeeper function currently focuses on data from countries of the WHO European Region, it is important that it be extended to WHO headquarters since many requests come from other WHO regions.

Discussion

The countries expressed an interest in harmonizing indicator-based data and were keen to have an indicator set that would allow them to compare their progress with their peers and other countries.

Barbados encouraged the Regional Office to share the SCHIN experience *(1)* with countries in other WHO regions, including those falling under the Pan American Health Organization, several of which lack an adequate health-information set-up for informing policy.

Monaco was positive about the work carried out by SCHIN *(1)*, but stressed that in 2017 the country had already received four more survey questionnaires than had been the case in 2016. It is imperative to find the right balance between gathering information and avoiding a reporting burden. This is where collaboration among the regions is crucial.

The WHO Regional Director for Europe agreed that the gatekeeper function required discussion with WHO headquarters; she would bring it up with the new Director-General in due course.

The rationale behind the importance of reporting on progress towards achievement of the SDGs *(3)* needs to be clear, and a way of bringing the efforts of the countries together should be found. The Regional Office has developed a roadmap *(45)* to assist Member States in the implementation of the 2030 Agenda for Sustainable Development *(3)*; this roadmap *(45)* and the proposed joint reporting framework *(44)* will be areas for discussion at the sixty-seventh session of the WHO Regional Committee for Europe in September 2017.

It was agreed that eHealth also needs to be given sufficient attention in the small countries.

Highlights of session 5

SCHIN *(1)* is helping to alleviate the reporting burden and achieve better health-system management in the countries. The network provides small countries with a means of collaborating in a concrete area, and a positive impetus to improve health-system reporting. It can help them take small, yet firm, steps to produce practical joint outputs and prevent reporting burdens from building up in the individual countries. Capacity-building is needed for dealing with different health-information issues oriented towards concrete challenges related to health information in small countries. The establishment of a research platform that could upgrade the level of collaboration among the small countries was mentioned as a desirable possibility.

Session 6. Childhood obesity: impact across the life-course

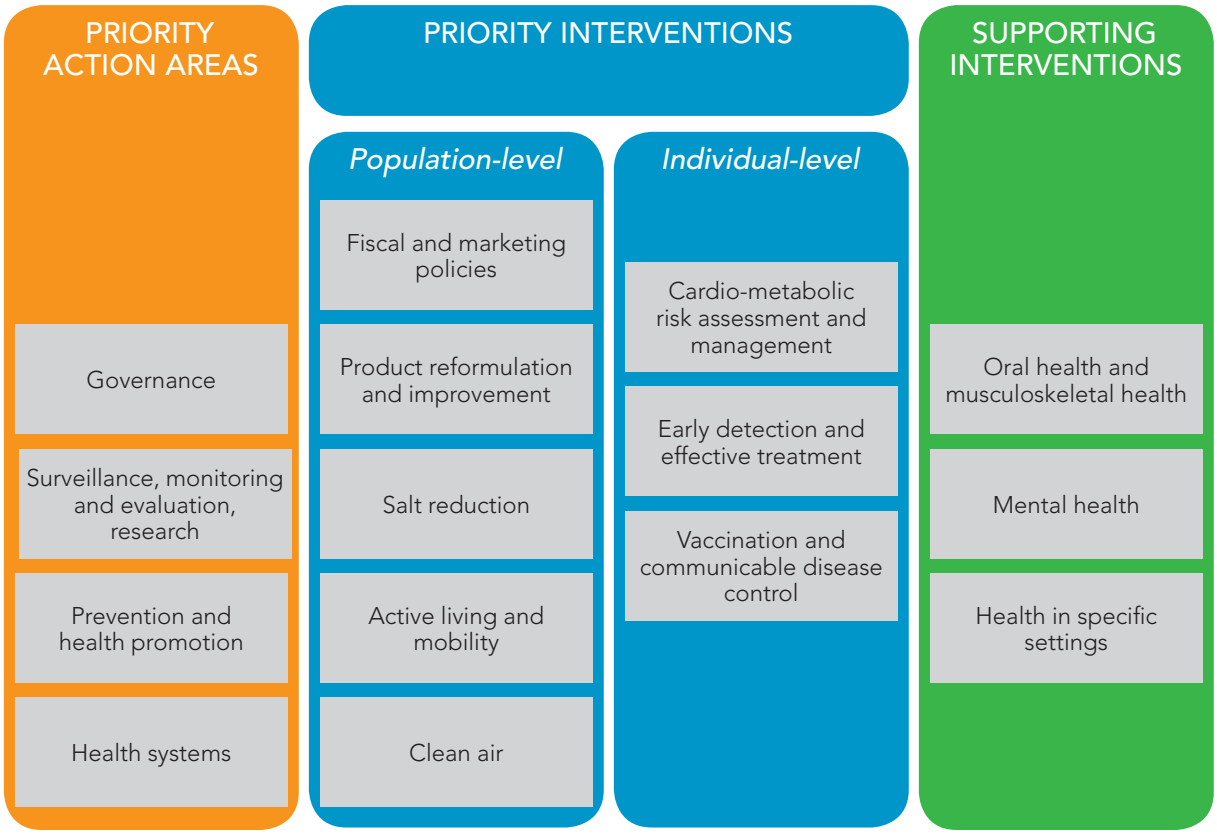
Childhood obesity is a complex issue affected by internal factors (personal behaviours related, for example, to diet, physical activity and genetics) and external factors (food systems, the food industry, agriculture, poverty, access to healthy foods, marketing, urban design and

obesogenic environments), as well as causation and solution networks. Reference was made to the forthcoming WHO Global Conference on Noncommunicable diseases: enhancing policy coherence between different spheres of policy making that have a bearing on attaining SDG target 3.4 on NCDs by 2030, which will be held in Montevideo, Uruguay, on 18–20 October 2017. Contributions to the United Nations Third High-level meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, planned for 2018 in New York, USA, will be prepared during the Conference. The countries were encouraged to identify solutions to childhood obesity that could be put forward at both events.

In Europe, childhood obesity rates are generally very high; in some countries, they are increasing so quickly that the present generation of children will be the first to grow up obese. Often, solutions to a problem are sought by delving deeply into it, whereas they might be found in looking elsewhere. Tackling the rise in obesity rates may require going beyond action related to diet and physical activity.

At its sixty-sixth session (2016), the WHO Regional Committee for Europe launched the *Action plan for the prevention and control of NCDs in the WHO European Region for the period 2016–2025*, the aim of which is to prevent premature death and significantly reduce the disease burden from NCDs through integrated action to improve quality of life and render healthy-life expectancy more equitable within and among Member States *(46)*. Overweight and obesity fall under the "active living and mobility" population-level interventions included in the plan (Fig. 3) *(46)*. The Regional Office and the Member States are collaborating to reduce this burden.

Fig. 3. Overview of action plan for the prevention and control of NCDs in the WHO European Region, 2016–2025



Source: Action plan for the prevention and control of NCDs in the WHO European Region for the period 2016–2025 (46).

The plan also provides a clear focus on what is needed to achieve the nine targets of the *Global Action Plan for the Prevention and Control of NCDs 2013–2020* in the European Region, including halting the rise of diabetes and obesity and achieving a 10% reduction in inactivity and an 80% level in the availability of affordable medicines for treating and curing NCDs *(46,47)*.

Many milestones have been achieved in tackling NCDs. The United Nations Third High-level meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases in 2018 will provide an opportunity to readjust strategies and further increase the impact of policies and interventions. Strong partnerships, such as those established by the WHO Small Countries Initiative *(1)*, are the basis of success and strengthen community-level resilience.

Childhood obesity in the WHO European Region

An overview of the challenge of childhood obesity in Europe shows that more than one in four children are affected and that the levels are rising in some parts of the Region. Data from the 2012–2013 Childhood Obesity Surveillance Initiative (COSI) reveal that, in some countries, about 10%–12% of the children are obese. Forty countries form this initiative, including Cyprus, Malta, Montenegro and San Marino from the group of small countries *(48)*. The prevalence of obesity ranges from very high to severe in many countries. Since overweight and obesity vary by parental level of education (the more highly educated the parents, the less obese the children), the issue of inequality should be considered. Obesity is increasing twice to four times as fast in the eastern part of Europe as in the western part *(49)*.

To tackle problems related to obesity, diet and physical inactivity, Member States have committed to joining efforts in collectively addressing them. The *European Food and Nutrition Action Plan 2015–2020 (50)* and the *Physical Activity Strategy for the WHO European Region 2016–2025 (51)* provide ideal frameworks for action to this end. WHO is supporting the Member States in tackling their priorities in these areas.

Health-system response to overweight and obesity in Europe has been very poor so far; not enough is being done to promote physical activity and improve dietary behaviour. While, on the one hand, a large share of the countries is using the 23 indicators needed for a fully comprehensive physical-activity policy, only eight countries in the EU have made it mandatory

for schools to include two hours physical activity a week in the curricula. On the other hand, due to factors, such as positively rooted food cultures, surveillance measures, governance closer to the people, innovation, and shorter food chains, for example, small countries have the resilience to fight childhood obesity.

Tackling childhood obesity during the Maltese EU Presidency

Childhood obesity was a thematic priority during the Maltese EU Presidency (January–June 2017). Malta took a strategic approach to evaluating the *EU Action Plan on Childhood Obesity 2014–2020*, which aims to halt the rise in childhood obesity in the EU by 2020. The Plan includes the following eight action areas:

1. supporting a healthy start in life;
2. promoting healthier environments, especially in schools and pre-schools;
3. making the healthy option the easier option;
4. restricting marketing and advertising to children;
5. informing and empowering families;
6. encouraging physical activity;
7. monitoring and evaluation;
8. increasing research *(52)*.

The evaluation showed that some action areas were well covered and others not so. Those well covered were: supporting a healthy start in life (area 1); promoting healthier environments (area 2); and encouraging physical activity (area 6). Newly started activities related to reformulation (area 3). More work is needed on labelling and taxation (area 3), restricting advertising and marketing to children (area 4), and informing and empowering families (area 5).

Malta led the process of developing the *EU Council's conclusions on contributing to halting the rise in childhood overweight and obesity*, using an intersectoral approach *(53)*. These conclusions built on the *Council's conclusions on the improvement of food products* prepared during the Netherlands EU presidency (January–June 2016) *(54)*. They highlight the need for governance, early intervention, dietary guidelines for health professionals and the public, and training for health professionals in how to deal with overweight and obesity in the correct way. They also point to the need to integrate national plans and take intersectoral action by improving governance, tackling drivers, maximizing protective factors, introducing legislative measures, and reducing health and social inequalities, emphasizing what can be done better and how. Malta has prepared a guide entitled *Public procurement of food for health. Technical report on the school setting (55)*.

Country experiences

Montenegro participated in the COSI survey for the first time in 2016 *(48)*. According to the preliminary findings of the survey, the prevalence of overweight in 7-year-old children is 19.4%. If these trends are not reversed quickly, projections are gloomy: the present generation of children will live shorter lives than their parents and will have higher rates of heart disease, diabetes and atherosclerosis. Preventing obesity in children can prevent their being obese as adults. Thus, the identification of cost-effective interventions that can be applied throughout

childhood is a clear priority in Montenegro.

With WHO support, the Government of Montenegro established a national council for the prevention and control of NCDs to serve as a platform for ensuring the coherence of multisectoral policy on and action aimed at addressing the key risk factors for NCDs. In addition, the Government has committed to halting the rise of obesity and recognizes that childhood obesity is an urgent national priority. The national food and nutrition action plan 2017–2018 includes a set of policy options and interventions to tackle this growing public health crisis.

In Montenegro, obesity is driven by obesogenic environments. Unhealthy food products, such as fast food with high levels of fat, and sugary, energy-dense drinks, are far too accessible and affordable in the country, and there is an aggressive marketing of them to children. Furthermore, the amount and size of sugary beverages consumed by the overall population has increased significantly. In addition, their availability in schools is putting children at an increased risk not only for obesity but also for diabetes. To reduce the consumption of these drinks, Montenegro plans to use the economic crisis as an opportunity to introduce an increase in excise taxes on sugary beverages. This is an example of a call for all sectors to act together to invest in the prevention of childhood obesity.

In **Luxembourg**, according to the European Health Interview Survey 2014, 15% of adults are obese (based on self-reported weight and height); in children, the prevalence of overweight and obesity is 12% and 5.8%, respectively (based on weight and height measured during school medical examinations). In 2006, Luxembourg developed a 10-year national interministerial strategy and action plan on healthy nutrition and physical activity to improve the situation nationwide, especially regarding children and adolescents. The Ministry of Health is coordinating implementation of the strategy, which also involves the Ministry of Sports, the Ministry of Education, Childhood and Youth and the Ministry of Family and Integration. Relevant action is ongoing, which focuses on the promotion of breastfeeding and the elaboration of actions plans to this end, underprivileged women, healthy eating from the start of life, and quality nutrition throughout childhood. The publication of new national guidelines on the quality of nutrition for children's canteens and day-care centres is foreseen in 2017. The ongoing promotion of healthy nutrition in secondary and residential schools will be reinforced by the introduction of a central catering service.

Luxembourg also participates in the EU school fruit, vegetables and milk scheme, which involves collaboration between the Ministry of Health and the Ministry of Agriculture *(56)*. The agriculture sector is also involved in subsidizing foods in schools, but it is still a challenge to reach underprivileged youth and their families. This issue will take priority in the next action plan on healthy nutrition and physical activity. To increase physical activity in schools, Luxembourg has invested in training courses for teachers and educators involved in sports education.

San Marino's initiatives to tackle childhood overweight and obesity are supported by: (i) strong commitment on the part of the Minister of Health and politicians; (ii) collaboration with the WHO European Office for Investment for Health and Development; and (ii) intersectoral collaboration. One of the strategic goals of the national health plan for 2015–2017 is to reduce overweight and obesity among school children and promote good nutrition as the foundation for a healthy life. The plan strongly recommends working holistically, considering the person at the centre of society, and developing intersectoral action for health.

Collaboration between the health authorities, the health services, the Department of Education of the University of San Marino and the Mental Health Unit of the Hospital of San Marino led to the establishment of the Permanent Observatory on the Condition of Youth and a multidisciplinary and intersectoral working group on youth. The Observatory is engaged in

systematic school surveys, using surveillance systems promoted by WHO to monitor health-risk behaviour and food and tobacco consumption. Working in the communities and with other sectors, the Observatory aims to create a culture whereby San Marino's potential in terms of natural resources and food is used to advantage. Ongoing activities in San Marino include: addressing nutrition in the prenatal and postpartum periods and in pre-schools and primary schools; minimizing food waste and encouraging physical activity among children (in collaboration with food and sport associations); developing personalized assistance plans for children with medical conditions; private-sector involvement in financing the distribution of health-promotion material; and the involvement of an agricultural consortium in the promotion of healthy foods.

In **Iceland**, fruits and vegetables are very expensive, which affects the quality of people's diets. To address this, sugary products are heavily taxed and fruits and vegetables subsidized. The participation of youth in sports is also subsidized, but attrition is a problem; children (especially girls) with foreign backgrounds tend to have low levels of physical activity. The amount of time children spend on the social media has also increased dramatically in recent years. The duration and quality of adolescents' sleep are inadequate, 30% sleeping seven hours or less per night. On the other hand, Iceland has the highest levels of gender equality and inclusion, as well as high-quality preschools (ages 2–5), which create equal opportunities. Iceland also regularly monitors health behaviour in 10–14 year-olds. Forty-four percent of the primary and lower secondary schools and 100% of the higher secondary schools are currently implementing the health-promoting schools approach *(20)*.

In **Monaco**, a survey on children's body mass index, involving all schools in the country, showed that 1% were suffering from obesity. A more accurate survey will be carried out to confirm this low percentage (Monaco is not yet part of COSI *(48)*). A large number of initiatives are in place to promote healthy eating and physical education, following a life-course approach. These include activities to promote breastfeeding (75% of mothers continue to breastfeed upon discharge from hospital) and monitor foods provided at day-care centres to children under three (these centres have a high attendance). In primary schools, 20% of the cafeteria food comes from organic farms, the vending machines are stocked only with healthy snacks, and the school curricula include 2–3 hours of physical activity and one hour of swimming per week. There are now also affordable, state-run sports facilities and clubs throughout the capital. Another long-standing initiative to promote healthy eating is the "week of taste", during which star chefs show children how to transform plain or uncommonly used ingredients into culinary delights. In 2012, Monaco introduced a tax on beverages containing added sugar.

Highlights of session 6.

Addressing the rising tide of childhood obesity was recognized by all the small countries as an urgent national priority. The prevention of childhood obesity also prevents adult obesity, thus, the identification of cost-effective interventions that can be applied throughout childhood is important. These must be intersectoral and multifaceted and should focus not only on behavioural change but also on external factors, such as pressures from aggressive food marketing and the food industry itself, and the influence of the media (for example, in promoting a link between well-being and food). In addition, agriculture and legal measures are needed to limit children's consumption of foods with high-level sugar and fat content. The consumption of fresh, whole and healthy foods should be encouraged, as should physical activity, and both need to be facilitated by governments.

The Malta Statement on ending childhood obesity

The key outcome of the Fourth High-level Meeting of Small Countries was the Malta Statement on ending childhood obesity (Annex 1). Proposed by the host country in consultation with the technical leads in the Regional Office, it was the result of an extensive consultative process, which mobilized considerable interest in, and many comments from, the small countries.

The Statement sums up the work of the small countries that will continue in the coming years, with a focus on:

- health as a fundamental right;
- whole-of-government and whole-of-society approaches;
- the life-course approach;
- early intervention;
- antenatal care and breastfeeding;
- the roles of health and school professionals;
- health-enhancing physical activity;
- urban planning and transport policies;
- labelling and the improvement of food products;
- standards for food provided in schools.

The Statement reflects the agreement of the small countries to join forces in launching comprehensive initiatives to address obesity in children. It calls on their governments to: ensure stronger restrictions on marketing foods high in saturated fat, free sugars and salt to children; promote clear, easily understood labelling; and improve the nutritional composition of food products. These efforts are in line with the *European Food and Nutrition Action Plan 2015–2020 (50)*, the *Physical Activity Strategy for the WHO European Region 2016–2025 (51)* and the recently adopted conclusions of the *EU Council's conclusions to contribute towards halting the rise in childhood overweight and obesity (53)*. The Statement also acknowledges the contribution governments can make to increasing healthy diet and levels of physical activity in the population through changes in the wider environment and the contexts in which people make daily choices regarding food and activity.

Part 3. A snapshot of WHO support to the small countries

This section provides a snapshot of the WHO support provided to small countries in the European Region since the start of the Small Countries Initiative *(1)* in 2013. The range of areas covered is broad and reflects the challenges faced by small countries and ways in which they have been resolved.

Andorra: National Strategy for Nutrition, Sport and Health (ENNES)

Description of action taken

In Andorra, the prevalence of obesity and overweight in people aged 18–75 years is 13% (14.4% in males and 11.5% in females) *(57)*. The Andorran 2004 national nutrition survey revealed unhealthy eating habits among the population, including the consumption of poor-quality breakfasts and the insufficient consumption of fruits and vegetables *(58)*. Certain population groups, such as youth (12–24 years), opt for high-energy food containing saturated fats. Young women (aged 12–24 years) also displayed extremely sedentary behaviour.

To address this, in 2007, Andorra set up the National Strategy for Nutrition, Sport and Health (ENNES) *(59)*, which consists of a set of actions to promote physical activity and healthy nutrition with the aim of preventing overweight, obesity and physical inactivity at all stages of life. The focus is on population groups at higher risk, such as children and adolescents, the elderly, young women of childbearing age and pregnant women. The actions include the publication of various guidelines on nutrition and physical activity (eating healthily and staying active).

ENNES *(59)* has organized several events on topics related to nutrition and physical activity, including: a conference in 2007 on nutrition and public health worldwide; a conference in 2009 on food and women's health; and an event in 2012 looking at what can be done to prevent childhood obesity.

The role of WHO

WHO technical support and guidelines on diet and physical activity, national and international conferences and special national theme days promoting physical activity – such as "Sports Day for All" – were key in the development of ENNES *(59)*.

Outcomes

The implementation of ENNES *(59)* received WHO technical support in the form of guidelines and commitments reached through the WHO Small Countries Initiative *(1)*. The follow-up to the WHO European Ministerial Conference on the Life-course Approach in the Context of Health 2020 (Minsk, Belarus, October 2015) also provided additional impetus to continue ENNES *(59)*.

Given the small size of the country, many of the strategy's initiatives benefitted from high levels of participation among the population. For example, the event entitled "Sports Day for All" has been held every year since 2007. It consists of regular lectures and symposia on healthy eating habits, which target different population groups. Currently, several catering establishments, supermarkets, food and beverage outlets, and cinemas participate in the organization and implementation of the activities.

ENNES reflects Health 2020's whole-of-government and whole-of-society approaches *(2,59)*. In Andorra, the life-course approach has been implemented with the involvement of both

the public and the private sectors. The health and education ministries have implemented planned activities and developed various guidelines in collaboration with the Andorran College of Dietitians. Within the health sector, the departments dealing with epidemiological surveillance, pharmacy, health products, medical facilities, and food and nutrition have also been involved. The education sector received support from the departments dealing with pedagogy, youth and sport. As the development of campaigns and the dissemination of information to the public incur significant economic costs, the support of the private sector, the media, and different associations and companies in the various sectors has also been key.

Cyprus: action against sexual abuse and exploitation of children and child pornography

Description of action taken

Child sexual abuse, a worldwide problem, persists in the WHO European Region. Analyses of community surveys carried out in Europe and around the world have estimated that a prevalence rate for sexual abuse of 9.6% (13.4% in girls and 5.7% in boys) *(60)*. The sexual abuse and exploitation of children and child pornography also constitute an issue of concern for Cyprus. In 2015, the Council of Ministers of Cyprus decided to establish an ad hoc ministerial committee with the participation of the ministers of education, health, justice and labour to coordinate the preparation of a national strategy and comprehensive action plan to protect children and prevent them from sexual abuse and exploitation and child pornography, and to support victims of such abuse.

The role of WHO

The Ministry of Health received guidance from the Regional Office on, and technical support and training relating to, violence and injury prevention *(61)*. The availability of WHO literature and guidelines on how to address this issue played a large role in the development of both the strategy and the action plan in connection with which an intersectoral working group was set up. Four main ministries acted as partners in the development process: the Ministry of Labour, Welfare and Social Insurance, took the lead since social issues fall under its mandate; the Ministry of Health, working in the international arena to reduce violence, made the necessary links with EU and WHO; the Ministry of Justice and Public Order arranged for a specialized police group to be trained in dealing with these issues; and the Ministry of Education and Culture organized seminars for school teachers.

Outcomes

The Ministerial Council approved the national strategy and a comprehensive action plan in March 2016 and a multidisciplinary, interministerial committee was appointed to implement it. Thanks to the guidelines and the technical support and training provided by the Regional Office, which were fundamental in ensuring the scientific soundness and technical feasibility of the strategy and the action plan, referral and management protocols have been developed and the training of professionals working with victims has been initiated.

Iceland: building whole-of-government and whole-of-society resilience

Description of action taken

Building resilience at the individual, community and system levels has become a priority for Iceland. Soon after the financial crisis, the Government of Iceland set up Welfare Watch (2009–2013) to monitor the social and financial consequences of the economic crisis for families and

individuals and to propose measures of support. The Government also made it a priority to defend the rights of those most at risk, including families with young children, people with disabilities, the elderly, people suffering from chronic illnesses, people living in poverty, unemployed people, and people dependent on financial assistance from the local authorities. In 2011, the Prime Minister's Office published *Iceland 2020*, a governmental policy statement relating to the economy and the community. Its guiding principle is "…establishing an integral vision and common objectives to ensure more targeted and effective policy-making and planning within the public sector". In line with Welfare Watch, *Iceland 2020* pays particular attention to groups that risk long-term unemployment in the wake of the financial crisis. It also recognizes the pressing need to make improvements in society that will enable citizens to make informed decisions related to lifestyle, and the importance of evaluating government policies and measures with regard to welfare.

The role of WHO

The whole-of-government and whole-of-society approaches promoted by Health 2020 *(2)* have become the foundation of Iceland's way of working within Welfare Watch and *Iceland 2020.* Iceland bases its health-promotion and primary-prevention work on guidance and recommendations published by EU, WHO and the Nordic Council of Ministers. Furthermore, *Iceland 2020* will reinforce the promotion of health and preventive measures that contribute to improving public health with a special emphasis on alcohol and drug abuse, nutrition, exercise, and sexual and mental health.

Outcomes

The role of the Health 2020 policy framework and its whole-of-government and whole-of-society approaches *(2)* was fundamental in the development of Welfare Watch, and their principles are embedded in its mandate. Both Welfare Watch and *Iceland 2020* have contributed to strengthening individual-, community- and system-level resilience in the country. Welfare Watch has been a role model for the other Nordic countries, so much so that during the Icelandic Presidency of the Nordic Council of Ministers (2014), the Nordic Welfare Watch 2014–2016 was established to strengthen and promote the sustainability of the Nordic welfare system by promoting research and increasing collaboration and the exchange of experience and knowledge among the Nordic countries. In an assessment of Welfare Watch, the large majority (84%) of those interviewed stated that monitoring the social as well as the financial consequences of the economic crisis on Icelandic families and households had been successful *(62)*. In accordance with WHO NCD-related recommendations, the social objectives of *Iceland 2020* focus on health promotion and the prevention of cardiovascular disease, stroke and type 2 diabetes. The vision of the policy is to achieve well-being, health and equality for everyone. In line with Health 2020 *(2)*, it includes a monitoring and evaluation framework, a timeline for implementation, and target indicators.

Luxembourg: promotion of physical activity to reduce overweight and obesity

Description of action taken

According to 2013–2014 Health Behaviour in School-aged Children (HBSC) survey data from Luxembourg, 26% of boys and 14% of girls aged 11 years were overweight or obese *(63)*. Data from the national medical school surveillance system (2014–2015 school year) showed that 14.1% of boys and 14.3% of girls attending primary schools were overweight or obese *(64)*. Following the first National Health Conference in Luxembourg in November 2005, an initiative was taken to develop a national programme to promote healthy nutrition and physical activity. An interdisciplinary body was established to coordinate implementation and evaluate the

initiative. In 2006, Luxembourg created a programme called *Gesond iessen, mei bewegen* (Eat healthily, move more). The aim was to increase awareness among the general population and provide information about the importance of healthy lifestyles for physical, mental and social health, promote balanced nutrition. and increase the quantity and quality of physical activity in the population, including children and adolescents.

The role of WHO

During the 10-year lifespan of *Gesond iessen, mei bewgen* (Eat healthily, move more), WHO data and guidelines, as well as country assessment reports, maintained the momentum of the programme. Luxembourg relied on WHO guidelines for programme development and used the cut-off points defined in the WHO *Global Recommendations on Physical Activity for Health* (2010) as measures of achievement of the recommended levels of physical activity in adolescents and children *(65)*. Other estimates were also used: for example, for 2010, the WHO Global Health Observatory estimated that 22.4% of the adolescent population of Luxembourg (defined in WHO data as ages 11–17 years) met the recommended physical-activity levels for health (boys: 26.6%; girls: 18.2%) *(66)*.

Outcomes

WHO recommendations on physical activity motivated Luxembourg to develop its own national guidelines. These are set out in the national plan on healthy diet and physical activity, which addresses adults, children, adolescents and sedentary groups separately, and provides guidance on the levels and intensity of activity recommended for each category *(67)*. As a result of the programme, *Gesond iessen, mei bewegen* (Eat healthily, move more), the obesity curves were stabilized over a 10-year period (2006–2016). The public is now aware that balanced nutrition and physical activity can lead to a healthier, longer life. The media were involved at various stages of the programme in promoting and disseminating information to the public. The programme led to a shift in the perception of sports, not only as competitive activities but also as non-competitive pursuits, in accordance with the objectives of the European network for the promotion of health-enhancing physical activity (HEPA Europe) *(68)*, thus ensuring equal opportunities to reduce overweight and obesity in the population.

Malta: Healthy Weight for Life Strategy (2012–2020)

Description of action taken

Overweight and obesity across the entire population constitute an increasing problem for Malta. This issue has been a priority since the WHO European Ministerial Conference on Counteracting Obesity in Istanbul, Turkey, in 2006 *(69)*. Malta's obesity strategy, entitled "Healthy weight for life", targets the whole population in addressing overweight and obesity throughout the life-stages. This two-pronged umbrella strategy uses a risk-based approach to tackle obesity in the whole population, targeting people who are obese and those who are overweight in an effort to prevent them from becoming obese. A special focus on schoolchildren is enabled through the Maltese policy, *A whole school approach to a healthy lifestyle: healthy eating and physical activity policy* (2015), which provides schools with an outline of the main aims, along with specific objectives and targets to be achieved. The approach targets the entire school community.

The role of WHO

WHO policies, guidelines and ministerial declarations motivated Malta to tackle obesity in the country. This started in 2006 thanks to the adoption of the *European Charter on counteracting*

obesity (2006) *(69)*; further impetus was provided by *The Minsk Declaration. The Life-course Approach within Context of Health 2020* (2015) adopted at the sixty-sixth session of the WHO Regional Committee for Europe in 2016 *(70)*.

Outcomes

One of the results of following WHO guidance and implementing WHO policies has been the application of the life-course approach to other strategies, including the updated versions of the *Food and Nutrition Policy and Action Plan for Malta (2015–2020)*, which focuses on wider nutrition-related action for obesity and NCDs, and the *National Breastfeeding Policy and Action Plan (2015–2020)*. Another outcome can be seen in the country's overall decrease in total overweight and obesity in adolescents. The WHO Small Countries Initiative *(1)* served as a mechanism through which Malta could document the country's experience in addressing obesity, using the life-course approach, within the context of Health 2020 *(2)*; this is now available to all Member States. WHO policies also influenced Malta's recent EU Presidency (January–June 2017) of which obesity was one of the priority areas. During the Maltese Presidency, a set of guidelines on the procurement of healthy foods for schools and other entities were launched.

The Malta Statement on ending childhood obesity (Annex 1), which was a key outcome of the fourth high-level meeting of small countries (Part 2 of this publication), was proposed by the host country in consultation with the technical leads in the Regional Office. It was the result of an extensive consultative process, which mobilized considerable interest from and comments by the small countries. The Statement represents the agreement of the ministers and delegates of the WHO Member States in the European Region with populations of less than one million to join forces and launch comprehensive initiatives to address obesity in children. They call on governments to ensure stronger restrictions on the marketing to children of foods high in saturated fat, free sugars and salt, promote clear labelling, which is easy to understand, and improve the nutritional composition of food products. These efforts are in line with the *European Food and Nutrition Action Plan 2015–2020*, the *Physical Activity Strategy for the WHO European Region 2016–2025*, and the recently adopted EU *Council conclusions on contributing to halting the rise in childhood overweight and obesity (50,51,53)*.

Monaco: application of WHO International Health Regulations to maritime arrivals

Description of action taken

With the globalization of travel, passing infectious diseases across borders is a real risk. Each year, Monaco, the second smallest and most densely populated country in the world, receives a large number of visitors by ship. To be able to react in a coordinated manner should an infectious disease be detected on board, Monaco decided to develop an alert system. This would ensure that anyone affected would receive appropriate care, health workers would be protected and the spread of disease halted. In this context, the correct application of the International Health Regulations (IHR) *(71)* is critical. In developing the system, the two primary aims were to test disease-management safety on board and ensure that hospital doctors encountering infectious-disease patients (or people who had been exposed to an infectious disease) were familiar with the treatment protocols. The alert system includes guidelines on the procedures to be followed by health workers in caring for affected persons, and on the infrastructure needed to protect all parties involved. The Crisis Unit, the core of the alert system, relies on an intersectoral set of stakeholders and procedures to be followed in the event of such a risk.

The role of WHO

The alert system relies on IHR, which require every ship arriving at a foreign country to submit a Maritime Declaration of Health to the port authority within 24 hours. The aim of IHR is: "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade". Since their entry into force in 2007, the IHR direct and govern particular WHO and States Parties' activities aimed at protecting the global community from public health risks and emergencies that cross international borders *(71)*.

Outcomes

The alert system was tested and proven to be functional and in compliance with IHR. Both the development and the testing processes provided Monaco with valuable lessons. The availability of WHO protocols enabled the country to plan action in line with IHR *(71)*. The initial testing of the system led to several adaptations in ways of working, such as changes in doctors' behaviour and recognition of the need for increased and continuous training.

Montenegro: addressing adverse childhood experiences

Description of action taken

There is strong scientific evidence about the short- and long-term health and social consequences of adverse childhood experiences (ACEs). Montenegro is one of a handful of countries in the WHO European Region that decided to address ACEs with a specific strategic response. Some action related to the protection of children was already being taken in the country, but with no specific focus on ACEs. With WHO support, the country took an

evidence-based approach to tackling the problem by conducting a survey between October and December 2012. The survey revealed the following rates of ACEs: physical abuse – 24%; sexual abuse – 4%; emotional abuse – 30%; emotional neglect – 27%; physical neglect (19%), witnessing violent treatment of the mother – 24%; and alcohol misuse – 12% *(72)*. These data, coupled with subsequent technical consultations with WHO, influenced policy-makers to move forward with the development of a strategic response.

The role of WHO

WHO provided both technical and financial support in connection with the development of the strategy (through the biennial country agreement (BCA) mechanism). The draft was jointly developed by WHO and an intersectoral working group comprising representatives of the health, education, welfare, and justice sectors, the office of the ombudsperson, the police and NGOs. The main sources of international support for the development of the strategy were WHO reports, such as *Implementing child maltreatment prevention programmes: what the experts say (73)*, and *Investing in children: the European child maltreatment prevention action plan 2015–2020 (74)*, and technical consultations with WHO. The strategy was presented during a national policy dialogue at a high-level meeting between the Deputy Prime Minister, various ministers and representatives of United Nations agencies (including the United Nations Children's Fund and WHO) to raise the profile of ACEs and the necessity of their prevention.

Outcomes

Thanks to the involvement of WHO, in April 2017, the Government of Montenegro adopted the National Strategy on Prevention and Protection of Children from Violence *(75)*. WHO technical assistance also resulted in a revision of the curriculum of the medical faculty to allow for the inclusion of child-maltreatment-prevention modules in six subjects taught at the University of Montenegro in time for the start of the 2016–2017 study year. A curriculum for a new optional module for undergraduate medical students on "violence and injury prevention and control" was also developed. This module, which is based on TEACH-VIP- 2 *(61)*, has a multidisciplinary focus on public health strategies related to the prevention of violence and injury. It will also be used by the Medical Faculty in Podgorica, starting with the 2017–2018 study year.

Thanks to this initiative, policy-makers in Montenegro understand the importance of gathering scientific and practical evidence so that action may be based on concrete facts and figures, particularly in resource-limited environments. It also reiterates the importance of working together to reach the highest levels of government and achieve consensus on issues, such as ACEs. This work has had a ripple effect; the current National Action Plan for Children 2013–2017 is based partly on evidence collected through the above-mentioned survey on ACEs (2012), and partly on international evidence.

San Marino: development of the national health plan 2015–2017

Description of action taken

In 2012, San Marino started the process of creating a second national health plan (2015–2017). It would differ from the first plan (2006–2008), in that it would integrate key components of Health 2020 *(2)*, such as the reduction of health inequities through action to tackle the social determinants of health, and the promotion of intersectoral work through whole-of-government and whole-of-society approaches. Triggers for the development of the plan included international health policies and agreements, such as the WHO Small Countries Initiative and Health 2020 *(1,2)*. San Marino was the first of the small countries in the WHO European Region to document its process of aligning a national health plan with Health 2020 *(2)*. The country

undertook an innovative intersectoral process involving all areas of government and society in making a health plan that belongs to the citizens. The process took 20 months. Stakeholders included the ministries for environment and education, local municipalities run by community councils and local citizens, voluntary associations representing health and social welfare issues, and WHO. With WHO support, San Marino took the lead in developing a plan encompassing Health 2020's strategic objectives and priority areas *(2)*, thus acknowledging the need to know more about the distribution of health outcomes in small countries.

The role of WHO

Overall, WHO played both a coordinating role – maintaining active and regular communication, actively participating in meetings and national consultation processes, including initial discussions on a guidance document for development of the national health plan – and a stewardship role, providing capacity-building opportunities and promoting documentation of the process of aligning the national health plan with Health 2020 as part of the Small Countries Initiative *(1,2)*. WHO also provided support in dealing with the most common problems faced by small countries in connection, for example, with data collection, data sets of an insufficient size to be statistically significant, reduced human resources, and preparedness for health emergencies. In connection with the development of the plan, WHO provided policy guidance on aligning it with Health 2020 *(2)*, and on issues specific to technical support, as needed.

WHO also provided official input to the plan as it evolved, such as, highlighting the importance of including a longer-term vision. When San Marino requested detailed feedback to ensure that the guidance document was in line with Health 2020 *(2)*, the relevant WHO staff reviewed the document and their consolidated input and technical feedback was provided to the Health Authority. WHO also helped to develop, and later participated in, a training course aimed at identifying key elements in the health and social-service system that might impede health promotion and the reduction of health inequalities in the country. These elements were analysed and discussed during the training course, where participants shared their experiences relative to these systemic problems and explored possible ways of solving them. This process also helped WHO understand how the integration of Health 2020 *(2)* was taking place.

Outcomes

The main outcome of the support and technical expertise provided by WHO resulted in a fully fledged national health plan. WHO's input was fundamental to ensuring that San Marino was on the right track with a plan to achieve the goals of Health 2020 *(2)*.

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This report was written by Leda Nemer, WHO Consultant, with guidance from Francesco Zambon, Coordinator, Small Countries Initiative. For further information about the Small Countries Initiative, please contact Francesco Zambon at zambonf@who.int, or visit the webpage of the Initiative at http://www.euro.who.int/en/about-us/networks/small-countries-initiative.

Annex 1. The Malta Statement on Ending Childhood Obesity

World Health Organization
REGIONAL OFFICE FOR Europe

THE MALTA STATEMENT ON ENDING CHILDHOOD OBESITY
PROMOTING HEALTHY WEIGHT AND WELL-BEING THROUGHOUT THE LIFE-COURSE
Fourth high-level meeting of the small countries: building resilient and healthy communities
St Julian's, Malta, 26–27 June 2017

We, the ministers and delegates of the WHO Member States in the European Region with populations of less than one million, met in St Julian's, Malta, on 26–27 June 2017 to participate in the fourth high-level meeting of the small countries.

We are concerned with the rise in childhood obesity and its immediate effects on physical development, psychosocial well-being, notably via stigmatization, as well as its potential impact later in life in the form of noncommunicable diseases.

We acknowledge that childhood obesity is an important public health challenge in the 21st century: all countries are affected to different extents, especially the lower socioeconomic groups where children are most vulnerable and inequities in obesity are passed on from generation to generation. We have not been entirely successful in tackling childhood obesity through the approaches used in implementing our national policies, strategies and plans.

We are aware that childhood overweight and obesity already affect more than one in every four children of school age in a vast number of countries, that their prevalence is increasing in many of them, and that some of the highest rates of childhood obesity in the WHO European Region are found in the small countries. In particular, the levels of severely obese children are rising, posing challenges to the physical and mental well-being of those concerned. This trend could hinder the achievement of the Sustainable Development Goals to which we are all committed.

We acknowledge that children's eating habits, access to healthy food and opportunities to be physically active are influenced by their social and economic backgrounds, sociocultural attitudes and gender roles, as well as by the norms and stigma related to weight, and that, if not understood and addressed, these factors may hamper health-promotion efforts. We are aware that gender and appearance stereotypes may drive boys and girls to adopt unhealthy behaviour that may impact their choices and health outcomes throughout their lives. We also recognize that weight stigma and poor body image negatively affect children's well-being, and we are committed to ensuring that health-promotion efforts take stigma prevention into account. Furthermore, we acknowledge that pre-pregnancy, pregnancy and early childhood are critical periods for interventions aimed at reducing obesity and inequities in obesity.

We, the ministers and delegates of the WHO Member States in the European Region with populations of less than one million, consider the development of children and their future, with an equal focus on their social, emotional and physical well-being, to be of paramount importance. We also recognize the specific conditions of, and the additional challenges posed by, childhood obesity in our countries, particularly those relating to the dynamics of the food systems and the need to create healthier environments, which would contribute to increasing levels of physical activity in children. improving the quality and duration of their sleep, and managing their screen time and other forms of sedentary behaviour.

We acknowledge that governments can contribute to ensuring better living conditions for children, including improved diet and levels of physical activity, through changes to the wider environments and contexts in which we live our daily lives. Policies to this end will influence, for example, the ways in which foods are produced and promoted, their availability in different settings, and – in some circumstances – their affordability. Furthermore, altering the environments in which we live, will make it possible to encourage physical activity as part of everyday life, for example, through active transport, increased leisure-time activity and quality physical education in schools.

We believe it is important to act together to:

- help children realize their fundamental right to health, and improve their well-being, while reducing the burden on the health system;
- support whole-of-government and whole-of-society approaches, that can be applied at the individual, community and societal levels to enable an environment, which supports a life-course approach to promoting healthy lifestyle, targeting the socioeconomic determinants of health, gender norms and values, weight stigma and other factors;
- implement interventions targeting early life, particularly among socioeconomically disadvantaged groups, to prevent social and health inequalities later in life;
- encourage antenatal care, breastfeeding education, and the promotion of exclusive breastfeeding until 6 months of age, followed by appropriate complementary feeding;
- increase the skills and competences, and support the roles, of health and school professionals in health education and promotion activities;
- encourage healthy physical-activity habits early in life, by increasing the number of hours allocated to, and improving the provision of, quality physical education in educational settings, including opportunities for physical activity before, during and after formal school hours;
- adopt and promote national guidelines on physical activity for health, using effective communication and motivational tools for children that include challenging gender and appearance stereotypes;
- implement national and subnational urban-planning and transport policies to ensure a supportive infrastructure for safe active transport, and create environments conducive to physical activity, for example, by including green and blue spaces, and preserve the natural environments;
- promote clear and easily understood labelling on the front of food packages, as well as improvements in the nutritional composition of food products for children (through reformulation, reduced calorie content and smaller portion sizes);
- adopt standards for the nutritional quality of foods available in schools.

Our common vision is one where children develop in harmony with an environment that supports their health and well-being, recognizes their diversity as human beings, and helps them realize their potential as future citizens.

We, the ministers and delegates of the WHO Member States in the European Region with populations of less than one million, agree to join forces as a platform to launch comprehensive initiatives to create conditions that foster health and well-being for all children, including preventing and tackling childhood obesity in our countries in line with the Report of the Commission on Ending Childhood Obesity, as well as to share our successes.

The future of our countries lies in the hands of our children. Giving them the possibility to be healthy and happy is in ours. Let us act together to make it happen.


Andorra


Cyprus


Iceland


Luxembourg


Malta


Monaco


Montenegro


San Marino

Annex 2. Programme of the fourth high-level meeting of small countries, St Julian's, Malta, 26–27 June 2017

Monday, 26 June 2017

Opening of the meeting

Charmain Gauci, Superintendent of Public Health, Ministry for Health, Malta

Godfrey Baldacchino, Pro Rector, Chairman, Islands and Small States Institute, University of Malta

Piroska Östlin, Director, Division of Policy and Governance for Health and Well-being. WHO Regional Office for Europe

Session 1. Resilience at the individual, community and system levels: a key pillar of health and development

Chair: Francesco Zambon, Coordinator, Division of Policy and Governance for Health and Well-being, WHO Regional Office for Europe

Presenters

Piroska Östlin, Director, Division of Policy and Governance for Health and Well-being. WHO Regional Office for Europe

Lino Briguglio, Director, Islands and Small States Institute, University of Malta

Contributors

Óttarr Proppé, Minister of Health of Iceland

Franco Santi, Minister of Health and Social Security of San Marino

Structured discussion

Technical leads for the session: Lino Briguglio, Piroska Östlin

Session 2. Enhancing access to affordable medicine in small countries

Chair: Chris Fearne, Minister for Health of Malta

Presenters

Hans Kluge, Director, Division of Health Systems and Public Health, WHO Regional Office for Europe

Helmut Brand, Head of the Department of International Health, Maastricht University

Panel discussion

Alexander Bordero, Director, Department of Health Affairs, Ministry of Health and Social Affairs of Monaco

Óttarr Proppé, Minister of Health of Iceland

Milica Sliljević, Director General, Directorate for Health Economics, Ministry of Health of Montenegro

Structured discussion

Technical leads for the session: Hans Kluge, Natasha Azzopardi Muscat

Session 3. Strengthening the health workforce in small countries

Chair: Hans Kluge, Director, Division of Health Systems and Public Health, WHO Regional Office for Europe

Presenters
James Buchan, Senior Advisor, Human Resources for Health, Division of Health Systems and Public Health, WHO Regional Office for Europe

Natasha Azzopardi Muscat, Consultant, Public Health Medicine, Ministry for Health of Malta

Panel discussion
Robert Goerens, Chief Physician, Health Directorate, Ministry of Health of Luxemburg

Isabelle Rosabrunetto, Vice-Minister, and Director-General, Department of External Relations and Cooperation, Ministry of State of Monaco

Milica Sliljević, Director General, Directorate for Health Economics, Ministry of Health of Montenegro

Structured discussion
(Interventions from the floor:

Maurizia Rolli, Director, Institute of Social Security, San Marino

Alexander Bordero, Director, Department of Health Affairs, Ministry of Health and Social Affairs of Monaco)

Technical leads for the session: Hans Kluge, Natasha Azzopardi Muscat

Session 4. Leaving no one behind: small countries at the forefront of the whole-of-society approach

Chair: Erio Ziglio, Consultant, WHO European Office for Investment for Health and Development, Venice

Presenter
Erio Ziglio

Panel discussion
Carles Álvarez Marfany, Minister of Health of Andorra

Robert Goerens, Chief Physician, Health Directorate, Ministry of Health of Luxemburg

Óttarr Proppé, Minister of Health of Iceland

Franco Santi, Minister of Health and Social Security of San Marino

Structured discussion
Technical leads for the session: Antoinette Calleja, Erio Ziglio

Tuesday, 27 June 2017

Session 5. The Small Countries Health Information Network (SCHIN) – small countries at the forefront

Chair: Neville Calleja, Director, Department of Health Information and Research, Malta

Presenter
Claudia Stein, Director, Division of Information, Evidence, Research and Innovation, WHO Regional Office for Europe

Panel discussion
Neville Calleja, Director, Department for Policy in Health, Health Information and Research, Ministry for Health of Malta

Andrea Gualtieri, Director General, Institute for Social Security, San Marino

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Natasa Terzić, Director, Center for Health System Development, Institute of Public Health, Montenegro

Structured discussion
Technical leads for the session: Neville Calleja, Claudia Stein

Session 6. Childhood obesity: impact across the life-course

Chair: Gauden Galea, Director, Division of Noncommunicable Diseases and Promoting Health through the Life-Course, WHO Regional Office for Europe

Presenters
Joao Breda, Head, WHO European Office for the Prevention and Control of Noncommunicable Diseases, Moscow

Charmaine Gauci, Superintendent of Public Health, Department for Public Health Regulation, Ministry for Health of Malta,

Panel discussion
Chris Fearne, Minister for Health of Malta

Nathalie De Rekeneire, Head, Health Information Department, Luxemburg

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Milica Sliljević, Director General, Directorate for Health Economics, Ministry of Health of Montenegro

Structured discussion
Technical leads for the session: Gauden Galea, Charmaine Gauci

Session 7. The way forward

Chair: Christoph Hamelmann, Head, WHO European Office for Investment for Health and Development, Venice

Formal endorsement of the Malta Statement

Wrap-up and milestones for 2017–2018

Announcement of Fifth High-level Meeting of the Small Countries

Closure of the meeting (Zsuzsanna Jakab)

Third meeting of the SCHIN focal points

Examination of the first results of the action plan

Workshop for communications professionals

Annex 3. Participants in fourth high-level meeting of small countries, St Julian's, Malta, 26–27 June 2017

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The WHO Regional Office for Europe

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

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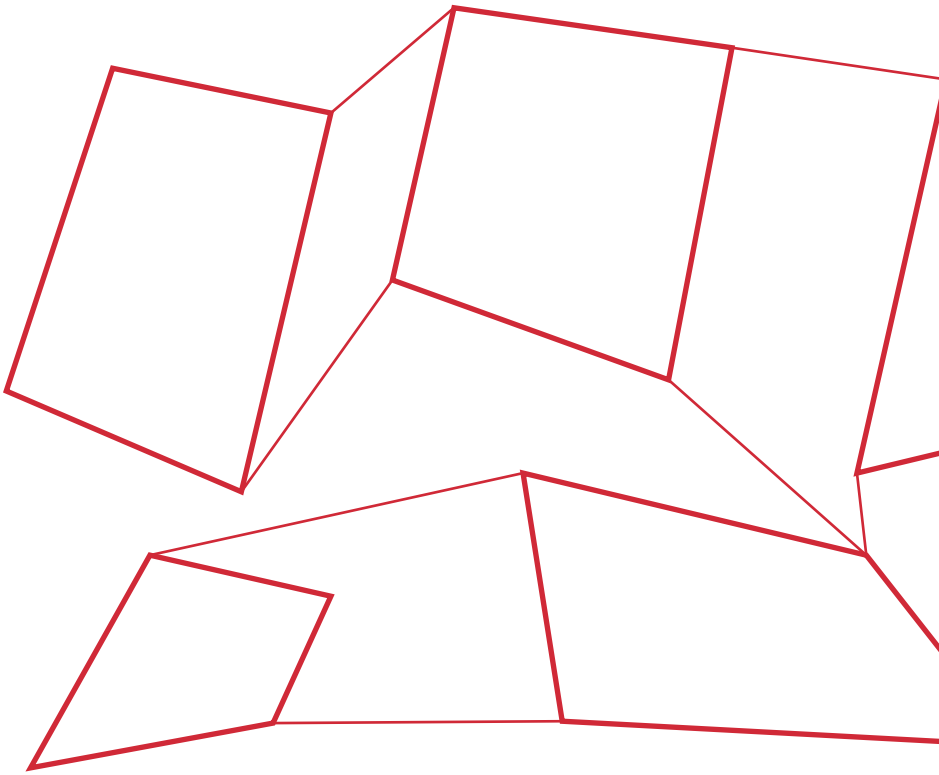
This three-part report provides information on the WHO Small Countries Initiative and how, through participation in its network, countries have been able collectively to strengthen the capacity, technical knowledge and governance they need to implement the European policy framework and strategy for the 21st century, Health 2020, and the United Nations 2030 Agenda on Sustainable Development. Part one of the report provides a full overview of the WHO Small Countries Initiative, including its ways of working, the kind of support it provides to the countries, the products it produces, and its vision of the way forward in the coming years. Part 2 consists of the report on the fourth high-level meeting of small countries, which took place in St Julian's, Malta, in June 2017. The report highlights issues of interest to the small countries and provides information about their experiences as part of the Initiative, including challenges and lessons learnt. Part 3 provides a snapshot of WHO technical support provided to small countries and of outcomes related to this support.



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