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# Regions for Health Network Twenty-first Annual Meeting report

IMPLEMENTING THE HEALTH 2020 VISION  
AT THE REGIONAL LEVEL OF GOVERNANCE

Florence, Tuscany, Italy, 20–22 October 2014





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## Abstract

From 20 to 22 October 2014 the 21st Annual General Meeting of the Regions for Health network (RHN), hosted by the Tuscany Region was held in Florence, Italy.

The main theme of the meeting was whole-of-government and whole-of-society approaches to improve populations' health. The 2014 Meeting had an innovative structure using two main sub events to bring theory and practice in health policy closer together: a capacity building event and the RHN business meeting.

The capacity-building event involved keynote speakers addressing inter sectoral action; co-production of health; investment in health from childhood through the life-course; management of policy change; and the role of advocacy and communication - with the aim to translate into practice and with a regional perspective the European health policy, Health 2020.

The RHN business meeting and workshops provided RHN members with an opportunity to describe and discuss their main activities during the last year, including the revision of the terms of reference of the network and of the knowledge areas, alongside an overview of the functions of the steering group.

**Keywords:** CAPACITY BUILDING, INEQUALITIES, INTERNATIONAL COOPERATION, PUBLIC HEALTH, SOCIAL DETERMINANTS OF HEALTH, SOCIOECONOMIC FACTORS

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## Preface: rationale for the meeting

Health 2020 is the health policy framework supporting action for health and well-being in the WHO European Region. Health 2020 recognizes that real improvements in health and well-being can be achieved if all government stakeholders, at national, regional and local levels, and societies work together to fulfil two linked strategic objectives:

- improving health for all and reducing health inequalities
- improving leadership and participatory governance for health.

Health 2020 gives policy-makers a vision, a strategic path, a set of values and a range of suggestions about what works to improve health, to address health inequalities and to ensure the health of future generations. It identifies strategies for action that are adaptable to the many contextual realities of the European Region.

Health 2020 is the product of an extensive two-year consultation process across the Region and beyond, and was adopted by the 53 Member States of the Region during the 62nd session of the WHO Regional Committee for Europe in September 2012. The Regions for Health Network (RHN) was engaged in the process that led to the adoption of Health 2020 and its own commitment was embodied in the Göteborg Manifesto in November 2012, which states:

*...the members of the Regions for Health Network commit themselves to work together in new ways to increase equity and improve governance for health, in line with the values and principles of Health 2020. We commit ourselves to action across the whole health agenda, with a sharper focus on the environmental, social and economic determinants that can foster or damage health.*

*.....  
Equipped with new vision and focus drawn from Health 2020, we can become an effective and unique cooperation platform for its implementation. In our new phase of development we shall concentrate our efforts on bringing people together to share know-how and tackle hard issues. ... Together we aim to prove that the goals in Health 2020 are right and realistic and that regions can take a strong lead in improving the health of Europeans.*

Fully in line with the Göteborg Manifesto and with the commitment to pursue Health 2020, the programme of the twenty-first Annual Meeting was designed to address a number of key elements of Health 2020 implementation at the regional level of governance that are of crucial importance for making significant steps in improving populations' health equitably and in a sustainable manner.







## A. High-level capacity building

### INTRODUCTION

The Twenty-first Annual Meeting of the Regions for Health Network (RHN) was held in Florence, Tuscany, Italy, on 20–22 October 2014. More than 60 participants from 25 regions and 21 countries took part (see Annex 2).

Dr Francesco Zambon, Policy Development Officer, WHO European Office for Investment for Health and Development, Venice, Italy of the WHO Regional Office for Europe, opened the meeting and welcomed Dr Luigi Marroni, Regional Minister of the Right to Health, Tuscany, Italy.

The Regional Minister greeted all present and welcomed them, saying it was a great honour to host the meeting. The importance of improving cooperation between regions in Italy and beyond in relation to areas such as health care and research and development, and of creating social networks to improve health was emphasized. As was the importance of working toward the cooperation between regions in Italy and beyond in relation to areas such as health care and research and development, and of creating social networks to improve health. He said it was important to work towards implementation of health strategies in Europe, and he looked forward to seeing the results of the meeting. In closing, he invited everyone to enjoy their time in Florence.

Mr Pasquale Morano, Director of the Red Cross, Tuscany Region, Italy, spoke of the aim to achieve by 2020 the highest possible level of well-being for all, which was why he felt it was important to attend and support the meeting. He welcomed RHN members and expressed his hopes for a successful meeting.

Dr Alberto Zanobini, Head of the Office of Research, Innovation and Human Resources in the Tuscan Department of Health and the RHN focal point for Tuscany, was described as the catalyst for the meeting. He said he was proud to welcome everyone. Tuscany had a long tradition of welcoming visitors and also of support for WHO. At a time of global change, perhaps progress could best be made



through social groups, and the RHN could offer the opportunity to share experiences and find new perspectives. He especially thanked the Regional Office for their work in organizing the meeting.

It was indicated that the purpose for the meeting was to implement Health 2020 at the regional level. In September 2012, all 53 Member States of the WHO European Region endorsed Health 2020, which now was high on the political agenda. He said that the regional level within countries was often the engine for change, where progress was made on a human rather than an historic timescale. It was where new ideas could be tested and then, if successful, be scaled up. He quoted from the Göteborg Manifesto, which spoke of regions as “...bridges between national ambitions and local delivery. ...close enough to our citizens to hear what they say and see what they need. ... [with] the capacity to mobilize local resources to protect and promote the rights of all our citizens, particularly those who are poor and vulnerable...”. In the same statement, members had said that “Equipped with new vision and focus drawn from Health 2020, we can become an effective and unique cooperation platform for its implementation.” (1).

The difference in life expectancy between rich and poor was cited – 17 years for men and 12 for women – and the great difference 17 years meant to any of us. The need for action was underlined by the fact that the meeting coincided with the worst financial crisis in history and the Ebola crisis. He cited Dr Margaret Chan, WHO Director-General, who said at the sixty-fourth session of the WHO Regional Committee for Europe in September 2014 of the deaths due to Ebola,

*These deaths are not “collateral damage”. They are all part of the central problem. No fundamental public health infrastructures were in place, and this is what allowed the virus to spiral out of control. This outbreak shows how one of the deadliest pathogens on earth can exploit any weakness in the health infrastructure (2).*

The fundamental cause was that the richest get the best services, the poorest – and often most needy – the worst and least. That the disease had broken out in poor African countries and was spreading was due to international inequalities. We are, he said, all affected at the global level, as everything was connected across the world. It demonstrated that a community medicine approach was essential, recognizing that the health of everyone is linked to everyone else’s. Ebola needed a host, but it also grew off disrupted health systems. Fear was unpleasant but it could now force change, and he hoped the crisis could be used as an opportunity for real progress.

The structure of the meeting was outlined and new elements used in the meeting were described: the use of social media and three commentators to help draw out the themes and lessons in each session. They were Ms Faith Astrid Ivy Kilford Vorting, Communications Officer from the WHO Regional Office for Europe, Mr Luca Carra, Press Coordinator, and Dr Nhan Tran, Manager of the Implementation Research Platform at WHO. He also nominated the rapporteur, Dr Christopher Riley, Strategy Adviser, Department for Health and Social Services in the Welsh Government, United Kingdom.

The programme was adopted (see Annex 1).

# Part 1. Whole-of-government and whole-of-society approaches to improving health and well-being

## SESSION 1. INTERSECTORAL APPROACHES AND ACTIONS TO IMPROVE POPULATIONS' HEALTH

### 1.1 Getting partners together on a common agenda in Wales

The Deputy Minister for Health in Wales, United Kingdom, spoke about Wales, a land with a population of three million, an elected Assembly and its own Government responsible for local government, education, health, housing, industry and social services. Its National Health Service (NHS) is paid for by national taxation, based on planning rather than market mechanisms and free at the point of need for all.



Recent work analysing well-being in Wales had found a third of people had a high sense of well-being, about half middling levels and one in seven a low level. The research suggested that people with low well-being need help with finding employment and managing finances, long-term health problems and relationships. Achieving higher well-being depended on neighbourhood cohesion and safety, information and opportunities for engagement. This showed that policies stretching across government affected people's enjoyment of their lives.

Wales has a Deputy Minister for Tackling Poverty, a cross-government priority with three main objectives: to give people the skills to get into work, to mitigate the effect of poverty on people and to stop poverty in the future. The Deputy Minister focused on six specific areas of work:

- working across health, education and children's services on early years, to ensure the next generation grows up fit, confident and able to take its place in the world and contribute to society;
- improving school attainment to try to bring all children's performance nearer the best;
- helping young people who, having left school are not in education, employment or training;

- working on housing and regeneration;
- reducing the number of workless households; and
- tackling the inverse care law, which says those with the greatest need are the least likely to have access to high-quality health services.

WHO supports a health in all policies (HiAP) approach, but cautioned against relying solely on health ministers to incorporate health into policies across sectors. Wales had used a similar approach to achieve the same objective. It targeted social inequalities, which are at the root of health inequalities, and made different departments work together to tackle them in a focused, well-organized cross-government approach. WHO could use the fact that many of the problems governments face are interconnected and social in their origins, and encourage such approaches. Government's actions on tackling poverty, and promoting sustainable development, well-being and child development should inevitably improve health.

Another example of intersectoral work in Wales was action to tackle domestic abuse, bringing local authorities, the NHS and other key stakeholders, such as the police together with active and committed nongovernmental organizations (NGOs).

The Deputy Minister for Health, Wales recently met Professor Sir Michael Marmot (Professor of Epidemiology and Public Health at University College London, United Kingdom) who advised him, "Don't focus on poverty, focus on inequality." The idea of poverty – if it implies a simple division between the happy rich and suffering poor – is far too crude an approach. The Welsh Government's approach was more sophisticated and combined initiatives particularly aimed at the most deprived communities with programme bending, flexing services to support especially those with greatest needs (3). This was consistent with Professor Marmot's statement of the need for proportional universalism.

Two other initiatives support this idea. The first related to population health planning, grouping local family doctor services into 64 clusters covering Wales. These would become the basic planning and delivery units for the NHS. Each cluster would analyse its local area, looking at the pattern of health problems, the available resources and the assets available in the community. The aim would be to strengthen intersectoral working, as many problems are not medical in nature, and make it easier for people to access non-medical support, for example, debt advice, lay support groups and housing services, and develop their own skills to manage long-term health problems. The aim would also be to open up the NHS, which is sometimes seen as a difficult partner in intersectoral working.

The other initiative is prudent health care, which puts a focus on effective clinical practice and on finding out what patients want and need, and getting them interested and engaged in their own health (4). It encourages them to take a role in decision-making and places greater value on patient outcomes. An NHS based on prudent health care principles should ensure all patients receive the most appropriate, evidence-based treatments to achieve goals agreed with their clinical advisors. This would help strengthen the contribution individuals can make to their own health and well-being.

The Government can help create the environment in which people can live healthy lives and provide a health service, but people also had to play their part. Wales had to work harder to make the Welsh population so-called prudent people, knowledgeable about how to protect their own health and able to put that knowledge into action. That required better information but also better explanation and motivation.

In conclusion, it was mentioned that the Welsh Government aims at using landmark legislation to encourage the whole of government to make a clear and conscious contribution to sustainable development. It would require every major organization to explain how it is supporting defined goals, including better health, and how its decisions support that.

## 1.2 Norway and the Trondheim Declaration

The representative from the Norwegian Directorate of Health reported that Nordic countries have a long history of development of the welfare state, and residents have experienced a high degree of prosperity. They also have a long tradition of health promotion and intersectoral collaboration. The Nordic countries have also a high degree of decentralization of power to regional and local authorities. Yet, despite good health, the countries face a growing challenge in relation to social inequalities in health. Since 1987, the Nordic countries have had Nordic conferences every three years inspired by global public health conferences.

Norway issued in 2013 a white paper on social inequality in Denmark and Norway, and Norway recently completed reviews of social inequality. Norway's 2012 Public Health Act (Act 2011-06-24, no. 29) had as its objective societal development in order to promote public health and reduce health inequalities and was based on the principles of health equity, HiAP, sustainable development, the precautionary principle and participation. The Act applies to municipalities, county authorities and the central Government and established a systematic approach to public health work, linked to mandatory municipality plans out every fourth year. To support this, the Government issued to the 434 municipalities annual data on local health and information on determinants of health, as well as planning guidance.

In Trondheim, Norway in 2014, the 11th Nordic Health Promotion Conference responded to Health 2020 with the Trondheim Declaration (5). This declared that equity in health and well-being is a political choice, with the right to health at the heart of all the countries' actions. Resources and opportunities should be distributed so that people can shape their lives according to their own desires and ambitions. The countries identified four requirements.

1. Address the fundamental causes of health and well-being through universal welfare and action on the social determinants of health; society-oriented efforts to reduce noncommunicable diseases (NCDs) must be based on an understanding of political and commercial driving forces.
2. Demonstrate interactive governance and genuine commitment to implementation, as only real and accountable implementation can give value to policies and plans, seeking mutual benefits and synergies on equal terms through partnerships across sectors, and identifying potential conflicts and negotiating solutions accordingly.
3. Draw on comprehensive evidence and knowledge, recognizing knowledge from many disciplines and sectors, and using various methods and broad participation.
4. Create socially sustainable communities and healthy community development, with local and regional participation and commitment as the backbone of public health with sufficient resources and capacity.

The 747 participants, who were engaged in various roles locally, regionally and nationally in the Nordic countries, agreed on the declaration *in their own personal capacity* and committed themselves to



- spread the message of the Trondheim Declaration to decision-makers;
- take an active role in achieving their shared ambitions;
- contribute to increased Nordic cooperation for equity in health and well-being in the Nordic countries and reduced health inequalities globally; and
- challenge the upcoming Nordic Health Promotion Conferences to follow up the message from the Declaration.

Norway's next steps would be to develop a new white paper (2015), put the Declaration's proposals on every agenda at the level of regions and national partnerships, build a reporting system and develop governance structures.



### 1.3 Discussion

Both presentations, it was noted, raised the need to develop new skills in public health. Participants discussed three questions.

- How to engage other agencies and other government departments and whether legislation helps with that?
- How to ensure progress when politicians changed with elections and whether politicians need education?
- How to reconcile different ambitions of ministers?

To answer the first question, the representative from the Norwegian Health Directorate indicated that the Norwegian Public Health Act of 2012 had been very important, and through its links to planning had made the municipalities and regional planners pay attention. Yet it was still necessary to keep reminding all the levels of Government that the Act applies to all of them.

The Deputy Minister of Health, Wales, said that legislation helped and cited laws making NHS Wales

and social services work better together, and new legislation on sustainable development would make all local bodies work better together through coordinated local planning. Local agencies in Wales were working well together on Flying Start, an early years initiative (6). However, to ensure that joint action is good in practice, performance management is also vital.

For the second question, he thought education was less needed for ministers than for the public; it was essential to raise voting levels. He believed there would always be rivalry between politicians, but it was easier to get unity within government than between interests outside. An issue like improving children's language skills demanded action by both the education service and the NHS and that might be difficult to achieve.

The commentators asked about the role of the media and whether the public could understand complex ideas like proportional universalism and prudent health care.

The representative from the Norwegian Health Directorate replied that politicians did not understand many areas of economics and health, and many did not feel empowered to address these areas.

The Deputy Minister of Health, Wales, agreed that people did not understand the issues; press and public in Wales focused on hospitals while 90% of health activity was in the community. Journalists like conflict and stories about individuals. Politicians should, therefore, change the debate and personalize it to win trust. Clinicians often disagreed and the press liked so-called rogue politicians. Ordinary people needed to be better involved and the media able to see that, with clinicians taking a more prominent role.

## SESSION 2. CO-PRODUCTION OF HEALTH AND WELL-BEING

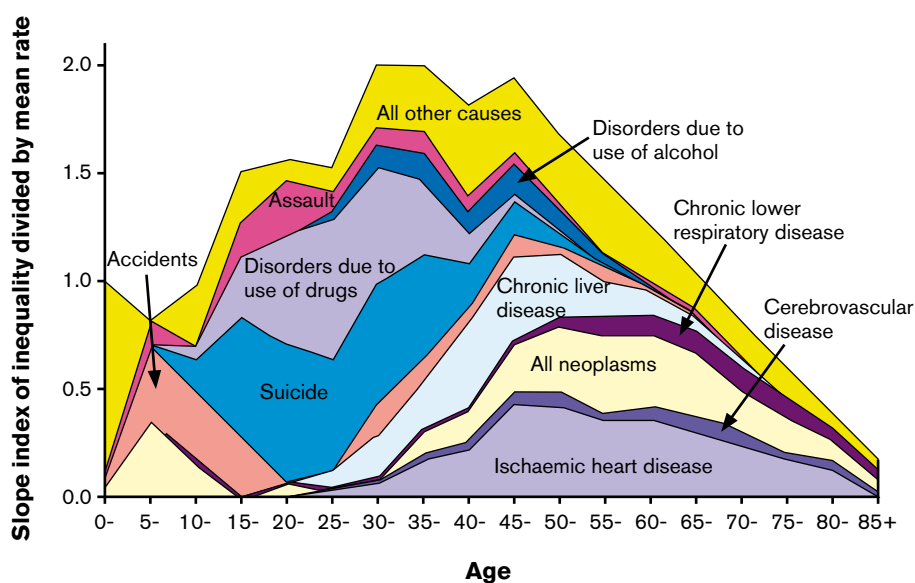
### 2.1 The experience of Scotland on the challenge of health inequalities

The Professor of Global Public Health, University of Strathclyde, Glasgow, United Kingdom, said that, after 15 years practicing surgery, he moved into public health, realizing that Glasgow had the biggest health inequalities in the United Kingdom. He then spent 10 years as Chief Medical Officer in Scotland.

The problem of health inequalities is oversimplified through inadequate analysis; inappropriate thinking is applied to the search for solutions and ineffective procedures are used to try to change behaviour – telling people what to do. The world would be very different and much improved if governments took seriously the wide WHO definition of health. People are misled by so-called silver bullets (where very successful drugs have been able to arrest disease) into thinking there are simple, decisive solutions to wicked problems.

The view that Scotland is naturally unhealthy was disputed. The evidence shows that for decades Scotland's health was as good as any, and that the richest 20% there had health as good as any. If the gap that existed between the rich and poor in the 1950s had remained the same and the poor had increased life expectancy at the same rate as the rich, the average in Scotland would be above the average of its European comparison countries. Data showed that the cause is a heavy burden of deaths among men below the age of 40 years due to drug use, alcohol use, violence and suicide (Fig. 1). This had arisen since the 1970s. The health care system could not fix this. It had social causes – the loss of many, many jobs and with those the money and purpose from people's lives.

Fig.1, Relative inequalities in mortality by cause, Men (2000-2002)



Wellness – a term he preferred to well-being – is characterized by an optimistic outlook, a sense of control and internal locus of control, a sense of purpose and meaning in life, confidence in one’s ability to deal with problems, a supportive network of people and a nurturing family.

The Nordic School of Public Health brought together 25 different psychological theories of “health creation” (7) and referred to two in particular: will to meaning and sense of coherence. Drawing on the work of Aaron Antonovsky (8), wellness results from the interaction of the sense of coherence (seeing the world as structured and predictable, feeling that it is manageable and meaningful, and wanting to engage) – which stable families will develop – and resilience resources (things such as a family, nurture, intelligence, work, material resource, identity, cultural stability, a stable set of answers and optimism), which are the more conventionally understood socioeconomic determinants of health. Fixing one without the other is wasteful and likely to fail, but fixing the sense of coherence is more important because without it, bad things happen. The two interact throughout life with resilience resources helping us when the sense of coherence is tested beyond normal bounds. Both need to be developed, and producing young people with a strong sense of control and aspiration would help build socioeconomic assets in society.

Applying this understanding to policy, a complete change in approach is needed. The basis is that inequality in Scotland is not primarily due to conventional risk factors. Early years experience is important in building resilience and well-being in later life. Conventional methods for preventing illness will not be effective in creating wellness. So transforming health and society in Scotland requires a life-long approach including elements such as the Early Years Collaborative (“make Scotland the best place in the world to grow up”) (9), a focus on raising attainment at school, a reduction in offending and reoffending (“How soon can we close a prison?”), and reduced dependency among older people (“Make 70 the new 40!”).

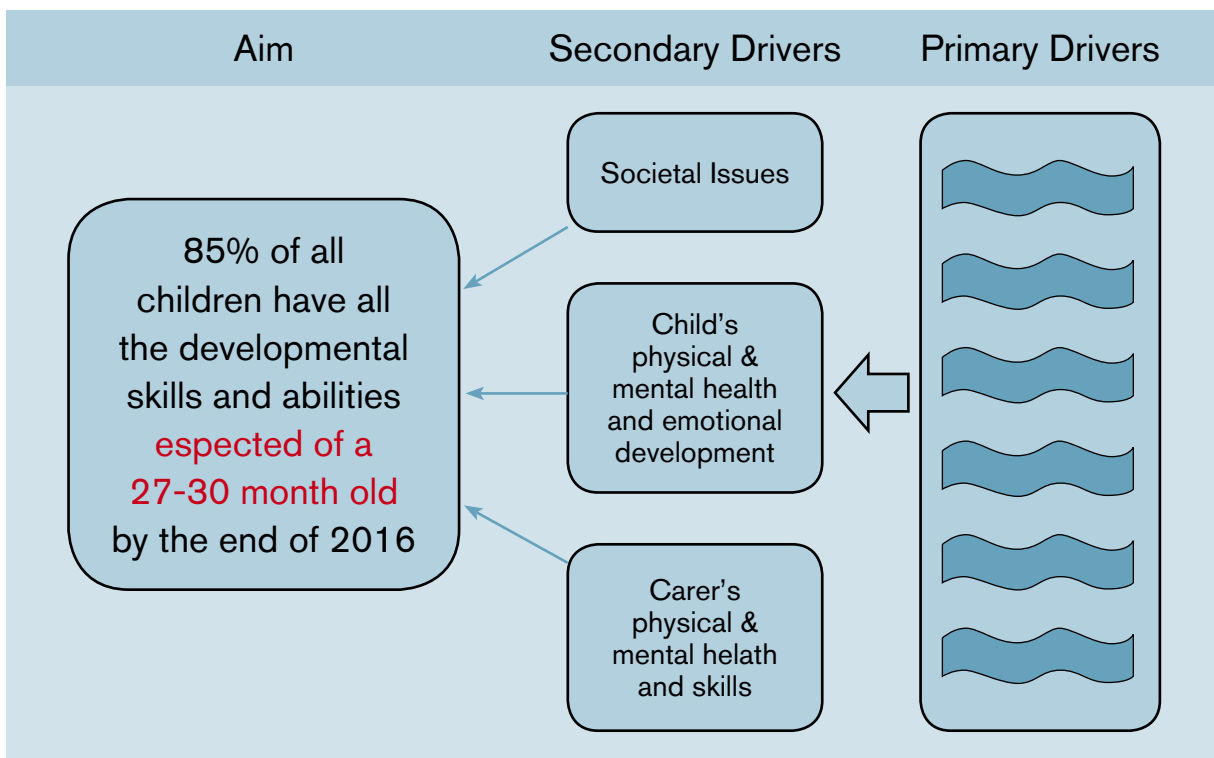
To achieve this required a method. Achieving change in people’s lives in communities cannot be achieved through getting together experts and making decisions that are imposed by others. Creating commitment to a process of change requires those affected to own it. Scotland already had a process of step-by-step quality improvement, which had been tested and used extensively in health care. This had helped it avoid some 10 000 deaths in hospital over a decade.





Applying this method to improving wellness, the approach had been to gather together 800 people from across the country and ask about how to proceed. The decision was for testing change in small groups and scaling up what was successful. The approach is now being tried more widely, for example, in improving children’s chances in their early years. Setting an aim and identifying the drivers of change to achieve that aim could be used to identify what actions might be tested and if successful scaled up (Fig. 2). This approach was used to focus on enhancing a child’s mental and emotional development through encouraging reading to the children by their parents.

Fig. 2, Workstream 2



He concluded by referring to the inspiration he felt from Jimmy Reid, a workers' leader in Glasgow in the 1970s, who expressed with crystal clarity the damaging consequences of alienation (10).

*It is the cry of men who feel themselves the victims of blind economic forces beyond their control. It's the frustration of ordinary people excluded from the processes of decision-making. The feeling of despair and hopelessness that pervades people who feel with justification that they have no real say in shaping or determining their own destinies.*

He noted that in the recent Scottish referendum vote, the areas with lowest life expectancy had been most inclined to vote for independence. A different future would require a very different approach to society.

## 2.2 Moving from concept to practice: tackling inequalities in Västra Götaland

The Chair, Public Health Committee, Region Västra Götaland, Sweden, noted that his region has 1.6 million inhabitants with 49 municipalities. Its major city is Gothenburg, which is a very diverse city. Recent years have seen significant population movements and growing health inequalities.

Because of inaction at the national level, the region decided to take action, setting up a political commission to develop an Action Plan for Health Equity, building on the strong local tradition of collaborative working.

The Regional Council funded the commission in its 2011 budget and commissioned the Regional Executive Board to prepare the Action Plan for Health Equity in Västra Götaland (11). The Public Health Committee was tasked with supporting the commission. The process took two years and involved some political disagreements before it was successfully concluded. Much effort was put into anchoring it in 30 municipalities with diverse stakeholder interests.

To move to implementation, it was decided to use declarations of intention, with municipalities and stakeholders committing themselves to specific actions. Mechanisms were put in place to make it work, including formal structures to legitimize and support long-term cooperation and ensure that health equity would be protected as a policy area at the highest decision-making level and as a permanent political area of responsibility (Fig. 3). This created a regional platform to develop a dialogue between researchers, practitioners and politicians to meet the need for research initiatives, to identify priority areas for research and to establish a system to follow up how measures are implemented, and how health equity is developing, using agreed indicators to assess the health equity impact of the actions.

## 2.3 Discussion

Three questions were discussed.

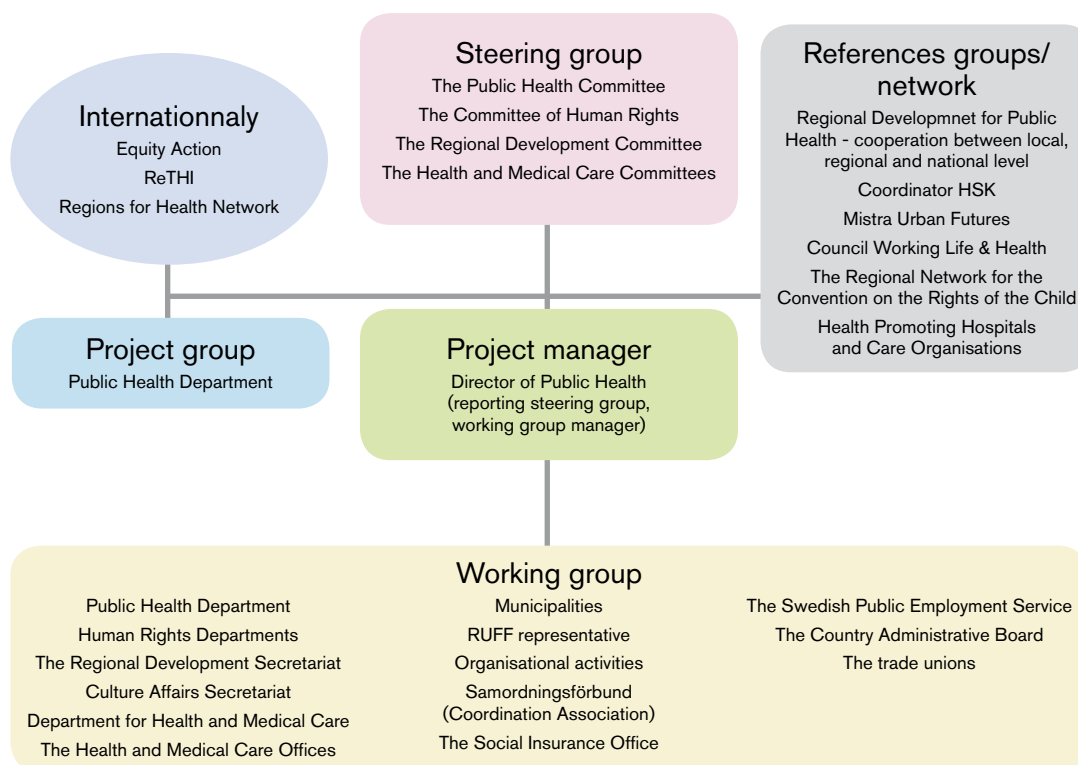
- What example stories are behind the 10 000 deaths avoided in Scotland?
- How is it possible to shift from a culture and information system that focused on interventions – which fuelled medicalization of health – to one that identified the need for more subtle changes across the life-course?
- How could information, especially failures, be better shared?

The Professor of Global Public Health, University of Strathclyde, mentioned reducing preventable

infections and introducing pre-operative safety checks as examples of successful interventions in reducing the number of deaths in Scotland. The local teams themselves led the way. The approach generated convincing evidence. The importance of generating evidence for change, as Region Västra Götaland had done, was emphasized, not least to use in countries where individual champions for improvement were few. Several important elements were mentioned – an understanding that systems are complicated, open-minded politicians, usable science, convincing stories and luck. The need to generate so-called social evidence, as well as clinical evidence, was noted and the need to ensure that evidence was relevant to the problem. Dr Zambon referred to the data collected from each region on issues that mattered to them, which might help generate shared projects and improved learning across the RHN.

At the end of the session, the need for processes that could support the implementation of Health 2020 was indicated as a priority. It was important to support positive change and greater coherence in efforts across the European Region, and he urged those present to consider what they might do to support implementation at the subnational level.

**Fig.3, Organizational structure of the Commission**



HSK: health and medical care  
RUFF: Regional Utveckling För Folkhälsa

Source: reproduced by permission of the publisher from *Together towards Social Sustainability. Action Plan for Health Equity in Region Västra Götaland, Sweden* (11).

### SESSION 3. PANEL DISCUSSION ON PARTICIPATORY APPROACHES TO IMPROVE POPULATIONS' HEALTH

The impact of violence on communities was discussed by the panel. In England and Wales (United Kingdom), which are fairly quiet and peaceful countries, over a million violent incidents are recorded

each year and that number is underreported.

Violent crime is unquestionably a health issue. In a violent area, exercising and socializing in public are not easy, and recruiting health care staff is hard. It places a burden on many services – health care, the education service, the justice system – and of course the community itself. The community certainly wants a say in defining what is the problem and what needs to be done.

### **3.1 Wales – the problem of passivity**

The Deputy Minister of Health, Wales, said that, for many people, health is about what professionals and experts do rather than what they do themselves. Despite the evidence that one's own actions can improve health, people are often unable or unwilling to change. One prompt to change is advice from people like health visitors and doctors and, in Wales (United Kingdom) sometimes, people are required to lose weight or give up smoking before being eligible for a surgical operation. The question is how to capture and apply ways of promoting change.

There is a distrust of evidence. While it is clear that often small emergency departments and maternity centres cannot offer the same quality of services as large, well-staffed and equipped ones, people often prefer small, local services to better ones further away. With services continually needing review and reorganization as evidence and resources change, how to engage people remains a problem.

One opportunity in coproduction and the prudent health care approach was tried in Wales, which engaged patients and the public as partners with the NHS, and encouraged them to work constructively with services on achieving the best outcomes within the available options.

### **3.2 Scotland – the power of stories**

The Professor of Global Public Health, University of Strathclyde, said that stories gave an insight into what prompts change. A common factor that caused change was often when a person at last met someone he or she could fully trust.

He referred to a boy growing up with parents addicted to heroin who by 12 was homeless and by 16 was in jail. There he broke down, overcome by fear that he would be like his father. That was his 'teachable moment'. A prison officer helped him learn to read and write, and after leaving prison he qualified as a football coach. He then had the chance to act in a film, which won a prize, leading to another film with Scarlett Johansson.

A second story related to an elderly lady, who for seven years never left her home. A chance visit connected to a planning project helped create a friendship that took her out of her home and eventually saw her leader of a belly-dancing team!

A third story prompted the thought as to how whole communities lost their way as lively communities lost their purpose under the impact of economic change. The challenge in such communities was how to recreate what had been lost decades before.

The lessons he drew from these examples were: change occurred when people were given permission to change and take control of their lives, and people could through their actions change the lives of others.

### 3.3 United Nations Children’s Fund (UNICEF) – engaging in support of children

The Chief, Programmes and Planning, UNICEF Innocenti Research Centre spoke about a report *Championing Children’s Rights (12)*, produced to celebrate the 20th anniversary of the 1989 United Nations Convention on the Rights of the Child. Many agencies and positions in different countries were created to promote and protect such rights, many at city or regional level. Though they differed in powers and roles, all faced the same challenges: how to remain effective in complex and changing societies, and how to identify issues and build bridges between different levels of government and across society. She too saw the power of stories to illuminate issues and inspire action.

### 3.4 Skåne – health within a regional development strategy

The Director of Public Health, Skåne Region, Sweden, spoke about the development of a regional development strategy in her region. The context was that the region was quite prosperous but had low productivity. As regional health director, she suggested giving health a prominent role and using Health 2020 as a core document. The approach chosen, however, was to review the old strategy, on which the general public was invited to comment. Working with NGOs, municipalities and statutory agencies led to generation of scenarios, websites and meetings and, after two years of dialogue, a new draft document. Health had appeared high on that agenda.

Her advice was to support a process that was truly participatory and be brave and let go, having trust and patience that the right result would emerge, as it did in Skåne Region.

### 3.5 Autonomous Community of Andalusia – a health plan built on a participatory approach

The Professor of Epidemiology and Public Health, Andalusian School of Public Health, Spain, said a participatory approach was used in designing, implementing and assessing the fourth regional health plan IV Andalusian Health Plan (IV AHP) in the Autonomous Community of Andalusia. Commitment to a participatory approach, reflecting the social contract, was one of the key features of IV AHP, along with recognizing health as a right and as a resource, a focus on social determinants, a move towards HiAP, a commitment to reducing inequalities and enhancing public value, support for governance, especially at local level, and exploring the potential of health assets.

The result of a participative process involving citizen representatives, health professionals and academia, among others, IV AHP focuses on six commitments agreed by all departments of the Andalusian Government.

1. Increase citizens’ life expectancy.
2. Protect and promote people’s health from the effects of climate change, globalization and emerging risks affecting environmental factors and food safety.
3. Generate and develop health assets and make them available to the Andalusian society.
4. Reduce social inequalities in health.
5. Provide citizens with a people-centred Andalusian Public Health System with the leadership of health professionals.
6. Promote knowledge management and technology introduction with sustainability criteria in order to improve the population’s health (13).



Participation was considered an asset for health, and a tool for democratic development and for improving the quality of health care. The right to participate in public health policies was included in the Public Health Regulation approved in 2011 and identifying, monitoring and evaluation of tools and procedures for citizen participation in health policies was an important element in the implementation of IV AHP. The participatory approach had its own funding and included a variety of methods.

Participation included involving citizens associations, patient associations and professionals in the evaluation of the previous health plan, and later in informing the technical proposal produced by working groups drawn from academia, professionals and government departments. The final stage was a public hearing open to all, prior to official approval of IV AHP. The participation model was also applied at provincial and local levels.

The process uncovered a number of challenges in this participatory approach, including the need to:

- integrate the different levels of participation and the cultures of different sectors
- apply lessons learnt
- try to achieve equity and reach out to those with greatest needs
- undertake evaluation.



### 3.7 Trento – shifting to participatory approaches in health planning

The representative from the Department of Health and Social Solidarity, Autonomous Province of Trento, Italy, spoke about shifting the focus from health services to health promotion, and from an expert-driven to a more participatory approach. From 1992 to 2012, there was no comprehensive strategic health plan, just annual objectives assigned to local health units. There were annual epidemiological reports, with information on activity- and service-related issues, but little on population health, social determinants of health or the distribution of risk factors/resources in the community. Objectives and goal-setting related exclusively to the health sector.

The decision was made to issue epidemiological reports to highlight the determinants of health and the importance of health promotion and, consequently, to make the case for the HiAP approach in regional health planning, as well as enhance capacity building, joining up epidemiological analysis, prioritization, community participation and public health planning. In addition, work began on drafting a strategic health plan taking into account the main WHO strategic documents, especially Health 2020 and the HiAP concept, using a participatory approach (14).

As a result, the structure of the health report had been radically changed, with a focus on social determinants and population health conditions and risk factors, so that the previous Health Services Status Report had become a Population Health Profile. Great attention was given to the language used to make it very easy to understand. In collaboration with the WHO European Office for Investment for Health and Development, Venice, Italy a training course on public health planning was organized, with four workshops aimed at key decision-makers operating at both regional and health district levels.

A working group to develop the Health Plan 2015 - 2025 included representatives from both the health and social sectors. The first draft had two main strategic objectives: improving health for all and reducing health inequities/improving governance for health, with three main objectives:

- more years of healthy life for everyone (improving well-being and tackling the main health problems applying a life-course approach);
- health-promoting living and working conditions; and
- a person-centred health and social welfare system.

The Health Plan also has two overarching goals to:

- reduce health inequalities
- improve health literacy.

A HiAP commission was established involving all sectors of the regional Government. By the end of the year 2014, an inventory of health-related policies and programmes would be integrated in the Health Plan, with a proposal to establish a HiAP budget, accessible only for joint projects.

To ensure a participatory approach, institutional and social stakeholders were identified and a web-based platform is under development to allow comment on the draft and receive new suggestions, first from technical stakeholders but then from the general public. An initial meeting of stakeholders would be held in November 2014, with additional face-to-face meetings for key stakeholders to collect feedback and new proposals. The aim was that the Government would launch the final version of the Health Plan by summer 2015.

Ongoing issues included some scepticism in the health and social service workforce that all this would happen, as most of the public and professional attention was on short-term political issues and health services re-organization. In addition, there were also some communication issues between different sectors and units within sectors, and uncertainty about how well the participatory process would work, balancing strategic and pragmatic elements to ensure effective change, and producing a draft document that managed to be polished and professional but which people still believed they genuinely could influence.

### 3.8 Discussion

Participants discussed two questions.

- Why was so much focus on health services and not on families – grandparents, children and parents – who needed to be engaged as partners?
- What about the misinformation that comes from some vested interests?

These provoked a range of comments. Being clear about values is vital in having a sure point from which to engage with other interests. All engagement should be on the basis of expecting the unexpected – and that can be hard, especially for politicians. Often individuals are asked to give something up for the public good; that will always be difficult. Open discussion needs to be based on relevant evidence, but that does not eliminate the need ultimately to make a hard choice.

#### SESSION 4. RHN CASE STUDIES ON WHOLE-OF-GOVERNMENT AND WHOLE-OF-SOCIETY APPROACHES IN PRACTICE

The aim of this meeting was identifying how to build capacity to support implementation of Health 2020. Much information was shared but was that increasing capacity? Information might be seen as evidence, but reasons were always available to argue against acting on evidence; it was old, from somewhere else and gave only a partial picture of what should be done. The Minister for Health and Social Services in the Welsh Government had recently noted that improving information for patients is not enough on its own. If they are to become empowered to take a greater interest in their own health and more control, they need also an understanding of why the information matters to them and a reason to act. What is essential to promote change is explanation and motivation, and it would be valuable as people tended to think not just about the information being presented but what that meant in terms of capacity for action.

#### 4.1 Bibione case study on a smoke-free beach

The Mayor of San Michele al Tagliamento (Bibione), Italy, and a WHO consultant presented this case study, which aimed to protect both human health and the environment in Bibione. The study concerned the second most popular beach in Italy, 9 km long, of which 3.5 km was made smoke-free. Approximately 12 000 residents visited during the low season; in 2013, 6 million tourists visited, mainly families (33% Italian and the rest mainly from Austria, Germany and eastern Europe) (15).

While the municipality had been the first in Italy to be certified under the Eco-Management and Audit Scheme (EMAS) (16), a European Union tool to evaluate and improve environmental performance, it faced a major waste problem. Bibione catered for 20 000 smokers a day, smoking 100 000 cigarettes, amounting through the whole summer to 25 million cigarettes. It was estimated in 2012 that for Italian beaches 27% of the waste collected from the Mediterranean Sea comes from cigarette butts, cigars, empty packaging and lighters (17).

The aim of the project was to create a smoking-free zone on Bibione beach to address the challenge of second-hand smoke exposure using whole-of-government and whole-of-society approaches, the first initiative of this kind in Italy. The initiative involved ten steps (Box 1).



### Box 1. Ten steps to create smoke-free beaches in Bibione, Italy

1. Build up scientific evidence for the initiative and the promotional campaign.
2. Get legal support for the initiatives.
3. Identify a champion.
4. Engage and involve stakeholders.
5. Assess interest in the initiative by target audience and stakeholders.
6. Develop and implement the social marketing and promotional campaign.
7. Promote the initiative prior to the campaign launch.
8. Enforce the smoking ban.
9. Assess the impact of the campaign.
10. Expand the initiative in Italy and beyond.

Adapted from: Bibione. Breathe by the sea. The story of a smoke-free beach in Italy (18).

The first step recognized the need for evidence-based strategies to counteract the negative impact of tobacco industry marketing efforts and protect health. From the beginning there was cooperation with the Italian National Cancer Institute in collecting data.

The legal basis was law number 3 of 16 January 2003 (the so-called Sirchia law), which prohibits smoking in all closed public places such as restaurants, offices and bars. The Italian Ministry of Health gives power to local administrations to extend the ban on smoking in areas not covered by the anti-smoking legislation. To ensure a legal framework for the initiative, the local police commander drafted a regulation to ban smoking along the Bibione seashore in specific designated areas. This regulation was approved by the city council in 2012/2013.

The Mayor of San Michele al Tagliamento (Bibione) acted as champion. This important role included promoting the initiative to secure resources, involving and motivating others to support the initiative, and facilitating change at different levels. It also facilitated communications between the communities and organizations that implement the programmes and provided a role model for the adoption of new practices.

A range of stakeholders needed to be drawn in, including community-based organizations, residents, service providers and elected officials at the municipal, regional, state/provincial and federal levels. Those engaged in the local economy were clearly important, as were public bodies, for instance, on health, environment, tourism and culture. The regional or national advocacy organizations and academic, teaching and research institutions also needed to be engaged.

Assessment of interest was through a number of methods including public forums where communities could make their concerns known, face-to-face meetings with key stakeholders, use of demographic data on the profile of the tourists coming to Bibione and surveys of beachgoers to understand if a smoke-free beach would indeed be welcome. This last showed a shifting response. In 2011, 65% of those surveyed favoured a total ban on smoking, and 27% a partial ban. These figures had fallen to 58% and 23% in 2013 as the launch date approached (18).

Promotional actions include development and distribution of posters, advertisements and brochures, display of cigarette butts collected from the beach in transparent plastic containers and distribution of postcards with slogans that could be mailed home from the smoke-free beach; all written materials were

available in Italian, English and German. Initial promotion included a website, ad-hoc conferences, radio and television coverage, and work with WHO. The launch came at the start of the tourist season in May 2014.

The ban on smoking along the Bibione seashore was enforced under the municipal regulation banning smoking in designated non-smoking areas, and the advertised fine for smoking in these areas ranged from 25 to 500€. Local police monitored the non-smoking area on a regular basis.

The impact of the initiative was assessed at the beginning of the season through a questionnaire, at mid-season by surveys on a sample of tourists who received campaign messages and/or questionnaires available at hotels and rented apartments, and at the end of season through online questionnaires.

Next steps included possibly expanding the non-smoking zone in Bibione to the neighbouring beach of Lignano Sabbiadoro, which extends into the neighbouring region.

The analysis of results was still ongoing, but preliminary findings show that the vast majority of beachgoers respected the non-smoking area. Local police officers who constantly monitored the beach throughout the summer have not issued fines for smoking ban violations. Almost 90% of those answering an online questionnaire were aware of the initiative, and more than 50% stated that the anti-smoking campaign would affect their future choice to spend a holiday in Bibione, with 80% thinking that the initiative would improve the quality of their holiday.

The key lessons included:

- believe in your initiative and identify a champion;
- disseminate information using multiple outreach strategies;
- think long-term;
- involve diverse and key stakeholders and gather consensus and ideas;
- know the target audience and identify benefits for all involved;
- monitor and report on progress and identify any obstacles encountered in the initiative; and
- foster coordination and trust-building between the health, environment, economic and tourism sectors and local authorities.

#### **4.2 Another view of the Västra Götaland experience**

From Region Västra Götaland, Sweden, the Senior Public Health Adviser and a member of the Public Health Committee addressed the theoretical grounding of their regional project. The project started by distinguishing the very different worldviews of the politician and the scientist. The politician wants information that is definite, practical and relevant to a chosen ambition, while the scientist is constrained by the available evidence and may not feel bound by the objectives chosen by the politician. The requirement, therefore, is how to manage the complexity that arises when these worlds collide.

The solution depends on identifying the window of opportunity, when what the evidence advises suddenly becomes practicable. Following up on an opportunity requires a clear political commitment from regional, national and local governments as appropriate and constant checks to ensure support

is still there. The relevant stakeholders need to be engaged and a common language found that works across different domains – science, practice and politics. This requires a timeline that allows space for consultation, negotiation, anchoring and decision-making. The John Kingdon work sees three strands being brought together at windows of opportunity – the problem stream, the policy stream and the political stream (19).

In Region Västra Götaland, the new understanding of the role of social determinants coincided with a period when the social contract appeared to be fraying and the costs of inequalities were becoming clearer. In these circumstances, a social entrepreneur can help bring the different actors together to create the window of opportunity. The Västra Götaland work also drew on and exemplified the thinking embodied in actor-network theory, captured by four concepts:

- problematizing – how actors share a common definition of the problem and find it useful to collaborate;
- interessement – how actors are recruited to the network and what makes them want to participate;
- enrolment – the process by which members take on different roles and functions in the network; and
- mobility – the extent to which the members create a common identity, allowing others to represent them (20).

The process of visualization, then, helped draw the different interests together, though growing political differences might make it difficult to maintain the cohesion. Indeed, it was probable that as implementation proceeded there would be a need to revisit some of the stages previously identified to ensure continuing engagement and a shared aspiration and approach.

### 4.3 Discussion

The questions on Bibione included: why did opposition grow, and how did the café owners and other economic interests respond? In reply, the WHO consultant and the Mayor of San Michele al Tagliamento noted that change must always be difficult – and especially cultural change. In response, politics must also be conducted differently, more as a service. There had been very close interaction with the local economic interests and none with the tobacco industry.

In a final comment, the huge importance of leadership in these examples was noted, though the speakers also underlined the importance of being very close to the public and how helpful the support of WHO had been.

## Part 2. Life-course approach to health

### SESSION 5. NURTURING HUMAN CAPITAL ALONG THE LIFE-COURSE

This theme of this session was that health and well-being needed to be moulded and developed over a lifetime.

The representative from the University of Padova, Italy said that supporting healthy development is necessary to enable all people to achieve their full potential. To achieve this required a sound knowledge base, programmes and policy and strategies, and political will. Four ideas gave a foundation to the life-course approach:

- the *timeline*, as today's experiences affect tomorrow's capacity;
- *timing*, as someone's health trajectory is sensitive to different periods, especially the early years;
- the biological, physical and social *environment*; and
- *equity*, in that while genetics and personal choice can explain some differences, health reflects a lot more than those.

#### 5.1 The UNICEF report card series

The Associate Director of Strategic Research, UNICEF Innocenti Research Centre explained the use of UNICEF's report card series and league tables for advocacy. The report card series – *Child well-being in rich countries* tracks progress for children in countries in the Organisation for Economic Co-operation and Development, and the European Union (21). It is a research-based advocacy product that uses data to provoke discussion and raise awareness of an important area of public interest. UNICEF is distinctive in having national committees as key partners in countries, which can raise funds and act as an advocate for the organization locally.

The report card series compare countries through a league table, with each report covering a new theme. While this approach attracts some criticism from researchers, as it might focus attention on the numbers and the controversy rather than the causes, it acts as a stimulus to discussion. Previous reports had generated a great deal of media interest. The 2008 publication was on early childhood services, and aimed to reflect the impact of the economic crisis and process of labour market transformation (22). Based on expert advice on what key element should be included, 10 criteria were selected, with a threshold for each. The resulting card (Sweden scored 10, the United States of America 3) attracted a lot of attention.

The 2010 publication has a league table of inequality in child well-being (23). It went beyond just financial issues to consider also education and health issues, drawing on sources such as the Programme for International Student Assessment education results and the surveys of the Health Behaviour in School-aged Children.

The third league table in 2012 addressed child well-being (24). The approach aimed to establish a way of mapping how well developed children's rights are in practice, using trustworthy sources. It looked at five dimensions:

- material circumstances (monetary deprivation and material deprivation)
- health (health at birth, preventive health and childhood mortality)
- education (participation and achievement)
- behaviours and risks (health behaviours, risk behaviours and exposure to violence)
- housing and environment (housing and environmental safety).

The aim for the 2014 report card was to capture the economic and psychosocial impact of the financial crisis, a difficult challenge because of the variable availability of data sources. A major source was a Gallup poll taken in every country in the world. The report was due to be launched in Rome, Italy in October 2014, under the title *Children of the Recession* (25).

How to establish which indicators, thresholds and indexes to use was also presented. If there was no strong theoretical foundation for selection, the rule was to be pragmatic. This involved looking at the agreed platforms, policies or commitments that countries had signed up to, such as the Convention on the Rights of the Child (26). It also meant avoiding obscure weights in indexes, and being very transparent about what was being used, not least on how the various indicators were combined into a composite ranking.

Ensuring that the ranking was not simplistic, obscuring or misleading was important. It was essential that the tables looked credible and relevant, and that the ranking was presented together with its underlying components, making it meaningful to different audiences and help local advocates support a debate. In terms of data limitations, the use of officially produced statistics was necessary. A compromise always exists between the doable and the desirable. Finding up-to-date statistics was a problem, as was the need for sufficiently large sample sizes to support conclusions about differences and inequalities within populations.

With regards to policy impact, it was vital to present the *right evidence* in the *right format* to the *right audience* at the *critical moment*. Because the issues were complex, a linear approach would not work. There was scope for trial and error, for instinct, for chance and luck in what was selected and presented. Though it was possible to measure media uptake and the level of response, building and presenting evidence on what was really happening to improve meaningful understanding and debate was most important.

## 5.2 Healthy young people in Tuscany

The Head, Office of Research, Innovation and Human Resources, Department of Health, Tuscany, Italy, presented the Healthy Students initiative, Tuscan Region's strategy to promote well-being in schools (27). He linked the initiative to the Health 2020 theme of investing in health through a life-course approach and empowering people. The approach attempted to answer the question: What do wellness and health mean to young people? The answer was summarized in a single encompassing concept – young people being at ease with themselves and others.

The aim was to create a school that promotes health, that is, one that puts in place a structured and systematic education plan that favours health, well-being and the development of the social capital of all students, teaching staff and non-teaching staff. Schools that promote health have been shown to be able to improve the health and well-being of the whole school community and, as part of a broader

social community, are one of the favoured contexts to reduce health inequalities.

The International Union for Health Promotion and Education materials on the Health Promoting School lists six action areas linked to the 1986 Ottawa Charter for Health Promotion:

- healthy school policies
- the school's physical environment
- the school's social environment
- individual health skills and action expertise
- community links
- health services.

Research had found that over 20% of the didactic approach had depended on experts coming from outside the schools. This gave the students too passive a role. A decision was taken to remodel the approach, putting an emphasis on the two approaches favoured by WHO:

- life skills – the abilities necessary for positive and adaptive behaviour that allow individuals to face up to the requirements and challenges of daily life, promoting the self-esteem of students by helping them to realize their physical, psychological and social potential; and
- peer education – the exchange of educational messages and life models among students of the same age participating in the same life experiences.

A decision was taken to move away from informational interventions by experts, short-term projects and pre-packaged top-down projects. Instead, the emphasis would be on incentivizing the participation of the target group, increasing individual competences and capacity to act, working with the school and community, looking after the school's physical and social environment, and taking a global approach. This was the basis for a regional programme to last through 2013 - 2015 aimed at both the health authorities and the schools.

Coordinators and instructors were educated on the new approach, which shifted from a prevention approach to a health promotion approach. The new emphasis was on choice and experiential learning, with active engagement of the students. This drew on the 10 skills identified by WHO as central for the promotion of health and wellness: self-awareness, emotion management, stress management, critical sense, decision-making, problem solving, creativity, effective communication, empathy and skills for interpersonal relationships.

To date, 151 or over 30% of educational institutes in Tuscany Region (Italy) had participated in the programme, and overall 760 teachers were trained and 6080 students engaged through the life skills and peer education methodologies.

### 5.3 Discussion

Four questions were discussed.

- How reliable were the UNICEF report card series since, for example, economic data were skewed

by the extent they reflected estimates of the black economy?

- Were the UNICEF report card rankings aimed at politicians or the public?
- Could the UNICEF report cards be prepared at subnational level?
- What helped the Health Promoting Schools programme and how does it differ from Healthy Schools?

The RHN focal point for Tuscany Region said that success depended on strong, sustained political commitment and the scheme's aim went beyond just schools.

The Associate Director of Strategic Research, UNICEF Innocenti Research Centre said that the score-cards aimed at accuracy, presenting data from safe, internationally recognized sources in a logical framework, but only after being carefully checked. He said the rankings helped everyone join the discussion and look afresh at national policies. He was aware that Italy had an interest in subnational analysis.

## SESSION 6. MAKING CHANGE HAPPEN

### 6.1 Implementing policies and making change happen

The Manager, Implementation Research Platform, WHO said that the Alliance for Health Policy and Systems Research was established in 1999, three years after the WHO Ad-hoc Committee on Health Research identified health policy and systems research as a neglected research topic. It was an independent partnership, funded by the governments of Norway, Sweden and the United Kingdom, hosted by WHO as part of the Health System and Innovation Cluster, and directed and governed by an independent board.

Its overall goal is to promote the generation, dissemination and use of knowledge for enhancing health systems performance through catalytic action, and it has three strategic objectives:

- stimulating the generation and synthesis of knowledge, encompassing evidence, tools and methods;
- facilitating the development of capacity for the generation, dissemination and use of knowledge among researchers, policy-makers and other stakeholders; and
- promoting the dissemination and use of knowledge to improve the performance of health systems.

Since 2000, the Alliance had supported 239 projects in 73 countries and sponsored a number of influential meetings and reports.

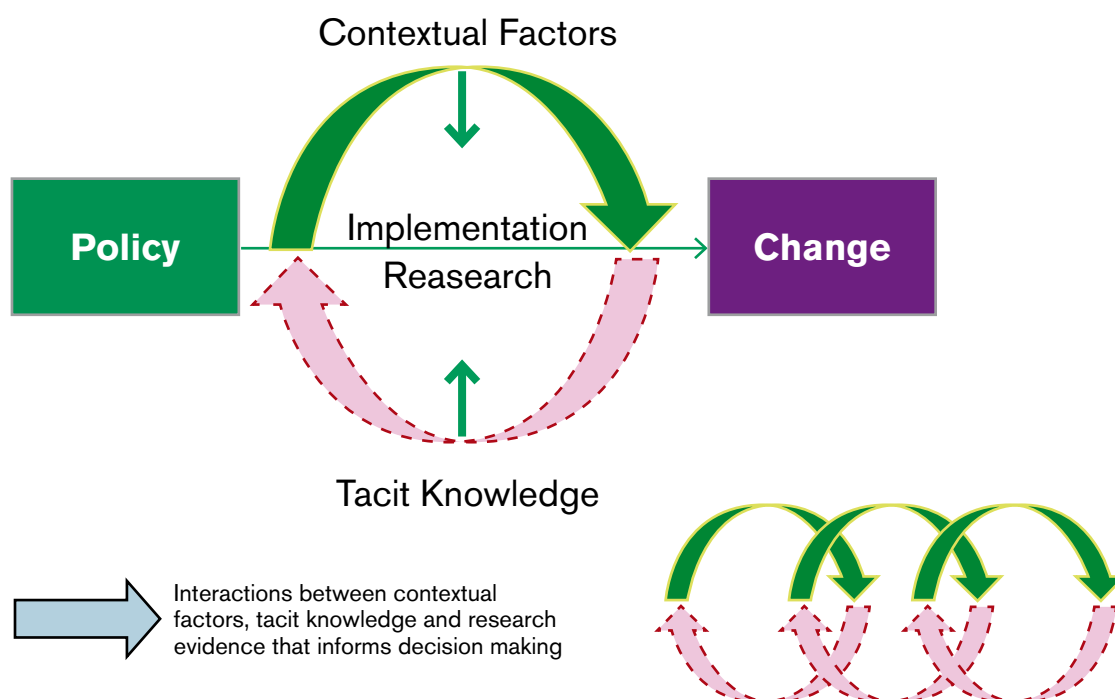
In moving forward, there were two key issues: how to facilitate the implementation of effective health interventions and policies, and how to support the learning capacities of health systems so that research becomes a core function of the system? Examples of systems failure included pregnant women who tested positive for HIV but failed to receive antiretroviral therapy and how thinking failure saw traffic injuries as accidents rather than avoidable events.

From outside the health sphere, a 2010 Economist Intelligence Unit report on *Enabling efficient policy implementation* in government and the private sector (28). The report found that poor implementation is widespread and damaging, implementation tends to be reactive and under resourced, policy

implementation can lead to interests of senior management taking precedence to those of other stakeholders, and people seen as problems rather than solutions. There were many contributory factors.

With regards to the different approaches to implementation – top-down, bottom-up and principal-agent (where the principals who define policy and the agents who implement policy need to arrange how to work together) some assumptions are almost certainly false. Policy-making and implementation are generally **not** highly rational processes, there are generally **not** single solutions to complex problems and implementation failure is generally **not** the result of a so-called know-do-gap. It is an error to try to describe a process omitting the context in which policy implementation occurs (Fig. 4).

Fig.4, Policy implementation and change



He referred to Ignaz Semmelweis who transformed hospital hygiene by applying knowledge derived from observation to everyday practice, even though the underlying causes were hidden from him. Taxi drivers can apply their knowledge of where places are in a very flexible way to match journeys to circumstance and changing conditions. The question was how to institutionalize the process of change, how to strengthen people’s ability to respond and adapt to the changing context.

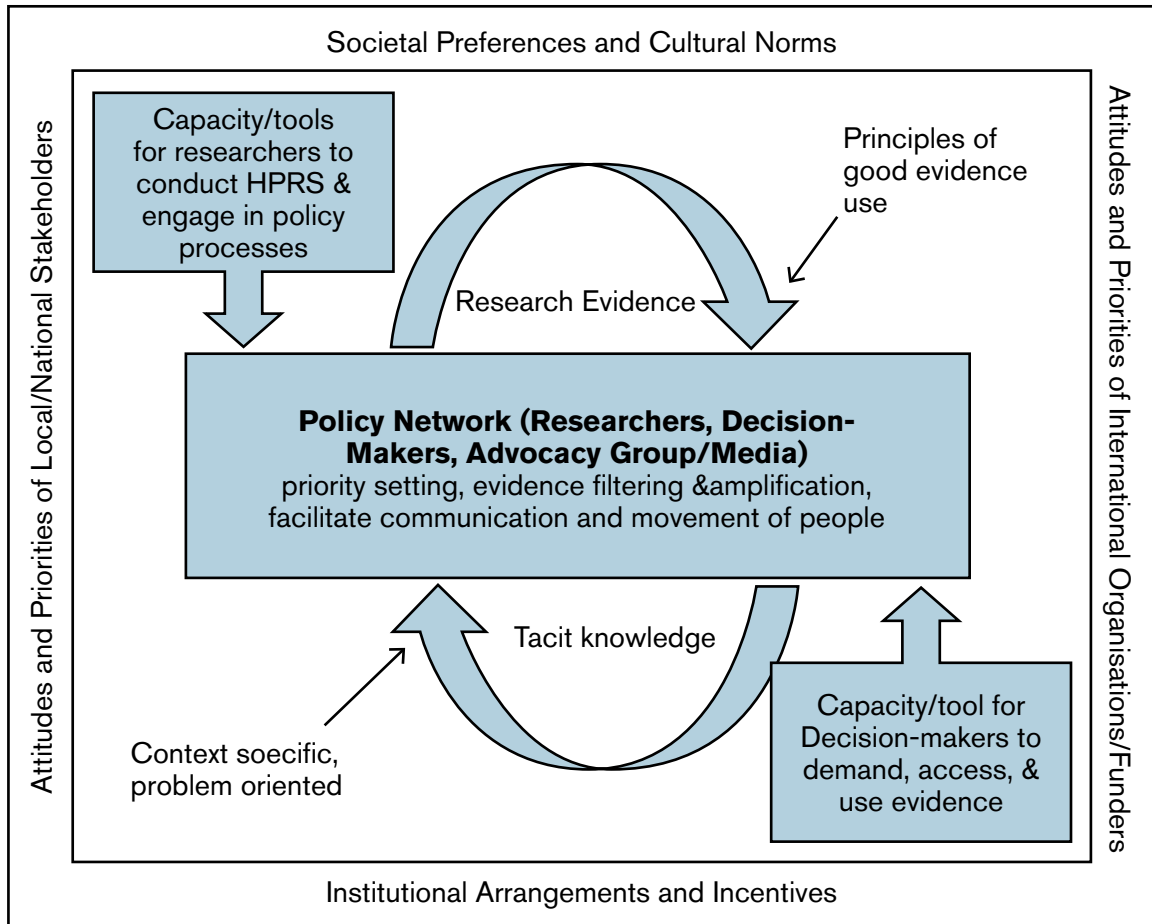
Implementation research should be an important part of the learning process, enabling tacit knowledge to interact with the context. The emerging model he suggested removes the false dichotomy between “knowing” and “doing” and shifts the thinking from “evidence-based” to “evidence-informed”. This, in turn, suggests that the right approach is not to define recommendations but **options**, and to shift from translational research to **transformative** research. Such an approach implies an iterative process drawing in an awareness of the contextual factors and tacit knowledge and allowing for failures as part of the learning process. This would be more consonant with politicians’ views, which value other sorts of knowledge than just science. A learning health system that continually responds to changing contexts will allow practice, science and care to feed into each other.

This sort of thinking is represented in its *Strategy on health policy and systems research: changing the mindset?*, the first ever WHO Strategy on Health Policy and Systems Research issued in 2012 (29).



There is a need to strengthen demand for knowledge generation and embed that and its use in the health system. Fig. 5 shows an early stage framework for embedding knowledge generation into the policy cycle.

Fig.5, Embedding knowledge generation into the policy cycle



The way forward involved three shifts in thinking and behaviour. The first was to realize that change cannot be imposed upon people, though it can be brought about through learning, by framing policies as goals that one works towards rather than a change that is imposed. Second, there is a need to institutionalize iterative learning processes within systems and institutions, with research embedded in systems and implementers fully engaged. Third, this should include learning from failure and ‘negative’ findings, and so incorporate alternative forms of knowledge, drawing in questions about why, how, case studies and tacit knowledge. The result would be a more adaptive and flexible model of research and learning.

## 6.2 Discussion

The Manager, Implementation Research Platform, was asked how to advise RHN to make progress, in light of his presentation, what he heard in the meeting and two questions.

- Since change is always hard, which approach – bottom-up or top-down – is better?
- How different is his view from traditional continuous improvement methods?

The Manager, Implementation Research Platform, replied that incentives in the system block change and value some types of knowledge over others. People do understand the need to change in some circumstances, for example, as part of their own career development. If the system supports change, it will happen, and change as evolution is better than sudden shifts. The literature is clear that to support change, such as human rights enforcement, it must come from the top, and he advocates for the quality improvement approach. In Canada, for example, policy-makers are required to justify their advice with evidence.

## SESSION 7. DEVELOPING NEW SKILLS

In implementation, technical preparation of those engaged is vital as is the capacity to work with others. Only through careful formation and with great support will individuals be able to excel.

This session addressed the key questions on who will lead and deliver the process. Dealing effectively with professionals, the public and society as a whole will need the right people in the right place with the right skills.

### 7.1 Developing public health leaders

A representative from Maastricht University, the Netherlands, discussed developing public health leaders – competencies, collaboration and participation. It was vital to clarify their role and how best to develop them. She agreed with the person who said ‘Today, the need for leaders is too great to leave their emergence to chance’, but also that there is no longer a need for heroes, rather for adaptive leaders coming from within organizations with a wide range of skills. She quoted approvingly a definition from Yukl: “Leadership is the process of influencing others to understand and agree about what needs to be done and how it can be done effectively, and the process of facilitating individual and collective efforts to accomplish the shared objectives” (30).

Key concepts from Health 2020 include participatory governance for health, intersectoral collaboration, citizen engagement, adaptive policies and foresight. Characteristics that leaders need were identified by a group in Sheffield in 2011 and included their being “networker–connectors”, communicators, concerned with developing the profession, and serving individuals and populations. In the modern world, they might be located in one country, working with others in a second and serving a population in a third (31).

A study in Maastricht University (the Netherlands) on behalf of the European Public Health Association on public health leadership in the 21st century identified six themes (32). Besides the importance of the European public health context and benefiting society and improving well-being, these were the inner path of leadership (why and how people work); the essence of leadership, emerging styles of leadership and future leaders’ imperatives.

A number of skills and attributes are attached to each of these. They implied that leaders must act more horizontally, participating actively with a wider range of sectors and actors, able to listen and facilitate the development of others. Future leaders in public health would need to build learning organizations, managing the politics/practice boundary. In illustrating how leaders might develop, the speakers referred to Maxwell’s five levels of leadership:

1. Position – People follow because they have to.
2. Permission – People follow because they want to.
3. Production – People follow because of what you have done for the organization.
4. Person Development – People follow because of what you have done for them personally.
5. Pinnacle – People follow because of who you are and what you represent (33).

The model that emerged from the study came from the real life experiences of public health leaders and did not reflect a particular leadership theory. It represented a more inclusive, less hierarchical style of leadership, working with stakeholder networks to achieve effective public health interventions. Public health should be a calling, not a job, but to be effective those engaged in it must be properly prepared. The new model implied the need for new forms of training in new paradigms.

A previous study had found that public health curricula were very out-of-date. They needed to be updated and expanded, with an emphasis on leadership and working across boundaries. Leaders would need emotional intelligence to enable them to do this and achieve more impact working with and through others. A curriculum based on well-defined competencies delivered through a combination of face-to-face and online methods using problem-based learning, coaching and communities of learners was described.

There is a need for critical public health leadership skills at every level, with interprofessional training of public health leaders; integrative, collaborative mixed-approach learning curricula; and a combination of coaching and personal leadership development plan, using the experience and competencies of contemporary public health leaders and not neglecting the importance for public health of political will.

## **7.2 Building capacity for cross-sectoral investment in health and development**

The Project Manager, Centre for Health and Development in Murska Sobota, said that the Murska Sobota region in northeast Slovenia had the worst social, economic and health indicators in the country, so a pilot initiative to build capacity began in the Murska Sobota region. The first programme in 2001–2006 was to prepare for accession to the European Union. Next was a focus on a health determinants approach in 2007 - 2013, looking at the role of health in regional development. The current focus in 2014 - 2020 was more on well-being and quality of life. Despite these shifts, the sorts of issues discussed had remained fairly consistent. Over time, management and human resource issues had become more important and leadership in particular, had become a prominent issue. Health retained its importance across the chosen themes within the vision for Pomurje: sustainable development, sustainable living, quality of life and development of potential, especially as regards young people.

All groups would like to see their themes high on all agendas. While the mayor of the municipality is by definition intersectoral, higher levels – regional and national –inevitably have administrative segmentation. This argues for a strong bottom-up approach, though there is a danger that projects at that level do not feed into the system as a whole. It is important to facilitate cross- sectoral partnership and interdisciplinary teamwork. Partnership is better than networking because partnership implies a common goal rather than just working together. Evidence on differences in performance can be used as a way of cutting through differences in language. Clarity on exactly what is wrong and needs fixing is better than abstract discussion.

In managing change, public health leaders need to be able to act as facilitators and work across boundaries. They need to have values that prize social development and outcomes not just the benefit of particular groups or financial interests. Knowledge is vital but so are creativity and innovation, and social, emotional and ecological intelligence, to understand and value the ambitions and concerns of others.

A range of ways can support learning from other sectors, such as joint training and workshops, peer learning, mentoring and supervision, learning by doing, methods of open interaction (from influencing through to coproduction), cross- sectoral teams, and formal and non- formal networks and platforms. All this needs to be built into the way people work normally and needs to be sensitive to the pace at which real change is possible.

Communication including effective listening – checking that others understood your message and if you understood them correctly – is essential. Visualization is important both in achieving a common understanding and in clarifying objectives. All this requires building a method for continuous innovation, and because the context for innovation changes all the time, so should the leadership style too.

### 7.3 Discussion

Two questions were discussed.

- Where does leadership come from?
- How does public health leadership differ from any other form of leadership?

Responses included that leadership had changed from simply leading to also doing. Public health leadership differed in needing to include understanding core issues such as inequalities and wicked problems. On the other hand, leaders grow and acquire skills and knowledge, and many skills are transferable. Public health leaders need to create trust and have a reputation for reliability because so much depends on their ability to work with others.



## B. RHN business meeting

### OPENING OF THE MEETING

Dr Zambon welcomed people to the business meeting.

### SESSION 1. SETTING THE AGENDA

He introduced a pre-recorded message from Dr Agis Tsouros, Director, Division of Policy and Governance for Health and Well-being, WHO Regional Office for Europe.

#### 1.1 Aligning know-how areas with Health 2020 and the Göteborg Manifesto

Any health strategy needed the engagement of the subnational levels: regions, cities and communities. In that way, RHN was more relevant than ever, and it was a great success that 25 regions attended the meeting. It was a great opportunity to align itself with Health 2020, which offered a framework and priorities for action. Implementation is now vital, and it would be good to better align the know-how action areas RHN had chosen to Health 2020, so that everyone was working on the same issues. The importance of values and commitment, whatever actions were chosen, were stressed.

The Director, Division of Policy and Governance for Health and Well-being thanked Tuscany for hosting the meeting and for its earlier training courses. He passed on greetings from the WHO Regional Director for Europe.

Dr Zambon indicated his hope that the meeting would change the terms of reference and know-how areas to align them with Health 2020, and reduce the latter in number. He hoped to see RHN align regional plans with Health 2020 and strengthen their capacity to deliver it. He also raised the question of how best to constitute the Steering Group, which the terms of reference said should include the leaders of the know-how projects.

He circulated copies of the terms of reference and asked the participants to consider how best to respond to these points.

#### 1.2 Report from the WHO Regional Committee for Europe

The WHO Regional Committee for Europe. It has for many years invited a RHN representative to attend its annual meeting as an observer; the Strategy Adviser, Department for Health and Social Services in the Welsh Government (United Kingdom), represented RHN at the 64th session in September 2014.

A major decision was the nomination of the Regional Director, Dr Zsuzsanna Jakab, for a second five-year term. The Regional Director gave an excellent report on WHO's work in 2012–2013, focusing particularly on how she restructured the Regional Office to focus on Health 2020, which was strongly supported by the Member States. Dr Chan, WHO Director-General, gave a report with a strong emphasis on the Ebola emergency.

Another important issue on the agenda was the first report on the implementation of Health 2020. WHO's initial tasks had been to promote Health 2020, and realign its own activities in support; it would next look at the role of different sectors in supporting it. Support arrangements are in place for any country that wished to work on Health 2020 with WHO, including agreements about objectives, assistance and implementation. In all, 29 countries reported on their performance to date on Health 2020, with more countries from the former Soviet Union (14), than the Nordics (5) and southern Europe (7); just 3 countries – Austria, Ireland and the Netherlands – were from western/central Europe.

At the Regional Committee meeting, the Head, WHO European Office for Investment for Health and Development, noted that new forms of partnership, exchange and cooperation were developing. He suggested that WHO organize a conference to look at how the different levels of government – national, regional and local – link up to support Health 2020. The Regional Director made clear that if there were to be a conference it would look rather at the role of the different sectors – education, social policy, etc.

Overall, the meeting showed how much WHO does and what considerable resources it can draw on. A long list of initiatives was discussed, each grounded in expert analysis and advice, and with a deliberate attempt to integrate them into the Health 2020 implementation process. It was impressive, though noticeable that the regional level was invisible; representatives from state governments spoke as if they held all initiative.

One side meeting was a technical briefing on the joint efforts of WHO, the European Union, the Organisation for Economic Co-operation and Development, and the Wellcome Trust to construct a common system information system around health. That discussion and the development of a monitoring framework to support implementation of Health 2020 offers RHN a way of collecting information to see how well RHN members are doing in supporting Health 2020 implementation.

Questions arose for the RHN and its Steering Group and Secretariat to consider.

- Are its members individually and collectively sufficiently linked into the Regional Office and all it does?

Are its members individually and collectively doing enough to promote and support Health 2020?

- What do members need to do to raise their profile at regional level?

RHN members might in addition consider whether individually they might:

- more systematically assess the value of WHO publications as they appear;
- more systematically review what they are doing against the Health 2020 approach; and
- use the WHO Health 2020 indicator framework currently in development as a way of monitoring whether each is doing well and how each might learn from others.

In response, Dr Zambon indicated he plans to send a RHN representative to the next Regional Committee meeting in 2015.

## SESSION 2. MIGRATION

The Coordinator for the PHAME project (Public Health Aspects of Migration in Europe) noted the



important role of WHO to share experience and skills, as migration is a major international issue. He said the terminology around migrants is quite confusing and a comprehensive and systematic approach is needed in the WHO European Region.

The 53 countries in the Region have a population of 886 million, including 77 million migrants or 36% of the global total. Six of the 10 countries with the highest level of migrants are in the Region. There are three different challenges. Refugees in the south, people seeking a better life in the north and economic migrants in the east.

The Director, Global Health Center, said that the Center is a multidisciplinary facility coordinating local and international health care initiatives. Its mission is to highlight the connections between health and globalization in terms of equity, human rights, sustainability, diplomacy and international collaborations. It operates in four areas:

- coordinates and promotes research, programmes and education on international health care cooperation;
- sponsors research on health policies and disseminates this knowledge to medical and nursing students and health care workers;
- promotes equity and appropriateness of health care for the immigrant population; and
- works on and provides information on neglected tropical diseases in order to be ready to cope with new diseases and public health threats and emergencies.

Taking the example of Tuscany, she described some of the difficulties facing immigrants. These included a lack of information on what their health rights are, the need to train health workers to work with foreigners and tackle cultural and language barriers, and the need to deal with fragmentation across different services (housing, health, education, social services, etc.). She finished by describing some of the initiatives under way in Tuscany and beyond.

On behalf of Francesco Bongiorno, Political Advisor at the Sicily Health Ministry (Italy) who had been unable to attend, the Coordinator for the PHAME project (Public Health Aspects of Migration in Europe) spoke about the response of Sicily to mass migration from Africa. The island of Lampedusa near the coast of Africa, part of the European Region, played a major role. A service was put in place in October 2013 to collect migrants at sea, and in Sicily additional reception centres were set up. In 2014, a contingency plan agreed with WHO set out how the regional government response would be organized along with the local arrangements, from landings to the migration centres. This ensured that at every level and at each stage the responsibilities were clear and that the system as a whole was properly coordinated.

The Coordinator for the PHAME project was asked questions.

- Why had he made no reference to the RHN study on migration?
- What was the position regarding migrant children?

He said that of 150 000 migrants arising so far in Sicily in 2014, 14 000 were unaccompanied minors. The difference in the situation of legal and illegal migrants was emphasized.

### SESSION 3. RHN CORE BUSINESSES

The meeting broke into four groups to allow more people to offer their views through facilitated discussion. The groups discussed four questions.

- How might members best work with the Regional Office to advance the objectives of the RHN?
- How to best align the know-how areas with Health 2020?
- How to appoint a Steering Group and how should it work?
- What should the workplan include?

The groups discussed all the questions though not to the same extent. Then, the groups presented their views, followed by a general discussion. The questions were not completely independent, and other issues arose such as alignment of the terms of reference with Health 2020. There were a variety of opinions and no immediate unanimity, but a broad consensus and agreement on a way forward. The following reflects what was discussed and aims to reflect the points of agreement and difference.

Consideration of RHN's relation to Health 2020 and the know-how areas touched on the very **purpose** of RHN. There was strong implicit agreement that the purpose was to help regions work successfully for their own populations and to help each other learn and improve their impact. Its aim should be to help increase and share know how on how to implement health policy and transfer information and experience, helping build capacity in the regions. This was seen to require a solid organization (Secretariat, Steering Group, strategic workplan and annual operational plan) with a clear vision and mission. RHN should not limit its impact just to its own members but must be sustainable.

In terms of its objectives, the **terms of reference** were seen as important as a means of ensure the visibility of RHN. The importance of Health 2020 was not in doubt, both because Health 2020 is an important statement and because RHN supports the objectives of WHO. There was a sense that RHN should not tie itself to a single document but have a very broad vision, based perhaps on a commitment to health for all and reduced inequalities. RHN had a strong public commitment to Health 2020 in the Göteborg Manifesto. There was support for a stronger political commitment in the terms of reference.

To work effectively RHN required a number of elements. The **Secretariat** should be the support office connecting regions according to their interest and practice orientation. Each region should have a **focal point** to help with communication and link to local expertise and delivery.

In terms of **ways of working**, there was support for promoting actions such as peer reviews and lobbying, looking at a broader set of interventions than just traditional health approaches and, therefore, for drawing in new people– more politicians and academics, and communications people – who could help disseminate questions and work reports. The role of the WHO communications lead could be expanded.

There was a strong feeling that the **Annual Meeting** should be more interactive. It should be more about how than what, more of a workshop style, with roundtable discussions on key topics, know-how and experience transfer/sharing. It should be a place where members can talk about their challenges. It was suggested that the biannual **conference** could be a showcase of best experience and theoretical papers. There was discussion about who might host the next meeting.



There were many opinions on the **know-how areas**. Some questioned why they existed.<sup>1</sup> One argument was that it was useful to have a written note of the main strategic directions, though others felt a closed list pointlessly excluded useful areas for development. A suggestion was to group them. One point was that Health 2020, together with the Göteborg Manifesto, set the agenda; another point was that analysis of the regional profiles would enable members to see exactly where they had shared interests, rather than using a list from elsewhere. There seemed to be support for keeping the list as a reference set of useful questions but not for allowing it to dominate future work. It could be used to test who was doing what already. It was agreed that a paper would be produced describing options.

It was agreed that a **Steering Group** was needed to work with the Secretariat and to help RHN function and organize meetings, with a clear role and mandate. There appeared to be more support for the view that it consist of elected representatives of the regions, rather than leaders of the know-how areas. There was a suggestion that there be a second level for know-how leads (though one comment was that having a know-how lead was not in the spirit of a network).

It was suggested that it was too soon to move immediately to elections. Therefore, an interim Steering Group was appointed for one year only, consisting of the four leaders of the discussion groups, who coincidentally represented members from the north, east, south and west of Europe. The individuals were Ms Elisabeth Bengtsson (Skåne, Sweden), Ms Tatjana Buzeti (Pomurje, Slovenia), Dr Zanobini (Tuscany, Italy) and Ms Solvejg Wallyn (Flanders, Belgium) and a representative from Wales.

On the **workplan**, it was agreed in principle to have a strategic workplan cover 3–4 years, with an annual plan with more focus and detailed annual actions drawing on the regional profiles, which already stated regions' interests. It would be necessary to measure success. It was agreed that a Steering Group discussion paper would be written.

#### SESSION 4. COMMUNICATION ASPECTS

The WHO Communications Consultant for RHN recalled the communications strategy presented at the Twentieth Annual General meeting in Cardiff, (Wales, United Kingdom), which aimed to communicate better and more frequently through a website, newsletter and social media. All communication channels were in place. The website was visited 5000 times over two years. An email system that sent updates to RHN members was introduced, providing immediate notification of news items accessible by a single mouse-click. Quarterly newsletters, as well as information on RHN publications, were issued to 199 contacts.

Looking ahead, she said that good communications is a strategic issue and requires a plan. It represented a growing area of work, hence the desire to have a discussion in the Annual Meeting. Communications is a means and a goal in itself. She asked how communications could help to increase the cohesion of RHN and support its aims, and whether each region should have a communications focal point.

In discussion, RHN members agreed to support the communications approach.

<sup>1</sup> The answer to this is that the list had been initially proposed by Dr Ziglio and accepted at an earlier meeting as a useful list of areas where evidence could help regions make progress faster in helping improve health at the regional level.

## SESSION 5. THEMATIC WORKSHOP ON SCALING A REGIONAL PROJECT UP/DOWN

The Project Manager of Meuse–Rhine Euroregion spoke about this. This was one of the list of ten project areas agreed at the St Petersburg (Russian Federation) meeting in 2012. The goal for the project had been defined as to strengthen the knowledge of the participants concerning the up/down scaling of projects at any level (regional/national/euregional/European), and to support members of RHN in scaling up/down projects. The aim was to produce a RHN publication with a theoretical basis, some analysis, case studies and practical guidelines for scaling up or down such projects. A questionnaire was circulated and a workshop held at Eupen, Belgium. She hoped to spend some time in the meeting on generating some new material, but limited time made that impossible. She, therefore, proposed to send in the near future the questionnaire inviting further suggestions for inclusion in the project.

### CONCLUSIONS AND CLOSING REMARKS

Dr Zambon summed up the issues to be taken forward over the following months through the secretariat and the Steering Group:

- revised terms of reference
- options for revising the know-how areas
- analysis of the regional profiles
- a letter to all members about the venue for the next annual conference and meeting
- a letter to all members on appointing a formal focal point in each region
- a draft workplan
- ways of improving communication.

He thanked the teams from Tuscany and Venice, who had made the meeting possible and contributed so much to its success.

On behalf of the network, Dr Riley thanked Dr Zambon, who in turn thanked all present and closed the meeting.

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## Annex 1. Programme

### HIGH-LEVEL CAPACITY BUILDING EVENT

Monday, 20 October 2014

#### Part 1: whole-of-government and whole-of-government and whole-of-society approaches to improving health and well-being

<b>Opening</b>	
Welcoming remarks	Luigi Marroni Regional Health Minister, Tuscany, Italy
Welcoming remarks	Pasquale Morano Croce Rossa Italiana, Italy
Welcoming remarks	Alberto Zanobini RHN Focal Point, Tuscany Region, Italy
General introduction to the event	Francesco Zambon WHO Regional Office for Europe

#### Session 1: intersectoral approaches and actions to improve populations' health

Moderators: Francesco Zambon

Most of the major public health challenges, including noncommunicable diseases and inequalities in health, cannot be addressed effectively without intersectoral action and action at the supranational, national and local levels. Health actors need to understand and connect with the perspectives, value systems and agendas of a wide range of national, regional and local actors.

To improve populations' health, we must tackle systemic risks and identify a spectrum of evidence-based interventions and solutions, many involving intersectoral ways of working and a whole-of-government approach.

Keynote speech (30 minutes)	Vaughan Gething Deputy Minister for Health, Wales, United Kingdom
Presentation on Trondheim Declaration (15 minutes)	Monica Fleisje Norwegian Directorate of Health, Norway
Structured discussion (45 minutes)	

#### Session 2: co-production of health and well-being

Moderators: Erio Ziglio

Co-production recognizes that people have assets such as knowledge, skills, characteristics, experience, friends, family, colleagues and communities. These assets can be brought together to support their health and well-being, and can help achieve better health outcomes and improve efficiency.

Keynote speech (30 minutes)	Harry Burns University of Strathclyde, Scotland, United Kingdom
RHN perspective (15 minutes)	Jan Alexandersson Chair, Public Health Committee Västra Götaland, Sweden
Structured discussion (45 minutes)	

### Session 3: panel discussion on participatory approaches to improve populations' health

Moderators: Erio Ziglio & Mark Bellis

Good health benefits all sectors and the whole of society – making it a valuable resource. Good health is essential for economic and social development and a vital concern to the lives of every person, all families and communities. Poor health wastes potential, causes despair and drains resources across all sectors. Enabling people to have control over their health and its determinants strengthens communities and improves lives. Without people's active involvement, many opportunities to promote and protect their health and increase their well-being are lost.

Roundtable among all speakers (5 minutes each)	Vaughan Gething Deputy Minister for Health, Wales, United Kingdom
	Harry Burns University of Strathclyde, Scotland, United Kingdom
	Perna Banati Senior Planning Specialist United Nations Children's Fund
	Elisabeth Bengtsson RHN Focal Point, Skåne, Sweden
	Josefa Ruiz Innovation and Public Health, Andalusia, Spain
	Pirous Fateh-Moghadam Health Observatory, Autonomous Province of Trento, Italy
Structured discussion (30 minutes)	

### Session 4: RHN case studies on whole-of-government and whole-of-society approaches in practice

Moderators: Alberto Fernandez & Chris Riley

The health and well-being of the population are best achieved if the whole of government works together to address the social and individual determinants of health. Whole-of-government activities are multilevel (from local to global) government actions, also increasingly involving groups outside government. This approach requires building trust, common ethics, a cohesive culture and new skills. It stresses the need for better coordination and integration, centred on the overall societal goals for which the government stands.

A whole-of-society approach goes beyond institutions: it influences and mobilizes local and global culture and media, rural and urban communities and all relevant policy sectors, such as the

education system, the transport sector, the environment and even urban design. Whole-of-society approaches are a form of collaborative governance that can complement public policy. By engaging the private sector, civil society, communities and individuals, the whole-of-society approach can strengthen the resilience of communities to withstand threats to their health, security and well-being.

Case study: Bibione (15 minutes)	Pasqualino Codognotto Mayor, San Michele al Tagliamento, Italy
	Flavio Lirussi WHO consultant
Case study: Västra Götaland (15 minutes)	Göran Henriksson RHN Focal Point, Västra Götaland, Sweden
Structured discussion (30 minutes)	

**Tuesday, 21 October 2014**

## **Part 2: life-course approach to health**

### **Session 5: nurturing human capital along the life-course**

Moderators: Francesca Menegazzo & Francesco Zambon

Supporting good health throughout the life-course leads to increasing healthy life expectancy and a longevity dividend, both of which can yield important economic, societal and individual benefits. The demographic transformation underway in countries requires an effective life-course strategy that gives priority to new approaches to promoting health and preventing disease. Improving health and health equity begins with pregnancy and early child development. Healthy children learn better, healthy adults are more productive, and healthy older people can continue to contribute actively to society. Healthy and active ageing is a policy priority and a major research priority.

Keynote speech (30 minutes)	Göran Holmqvist Associate Director of Strategic Research United Nations Children's Fund
RHN perspective (15 minutes)	Alberto Zanobini RHN Focal Point, Tuscany Region, Italy
Structured discussion (45 minutes)	

## **Part 3: making change happen**

### **Session 6: making change happen**

Moderator: Erio Ziglio

Policy implementation remains one of the biggest challenges for organisations and institutions—public and private alike; its failure poses serious threats to the ability of these organizations to carry out their mandates and achieve goals. Despite widespread recognition that implementation needs to be considered in the planning and design of policies, change is innately difficult for people. Various theories for policy implementation are examined in this session along with a framework for learning health systems which has at its core, iterative implementation cycles.

Keynote speech (30 minutes)	Nhan Tran Alliance for Health Policies and Systems Research WHO headquarters
Structured discussion (30 minutes)	

### Session 7: developing new skills

Moderator: Darina Sedlakova

A more flexible, multiskilled and team-oriented workforce is at the heart of a health system fit for the 21st century. This includes: team-based delivery of care; new forms of service delivery (including home care and long-term care); skills in supporting patient empowerment and self-care; and enhanced strategic planning, management, working across sectors and leadership capacity. It implies a new working culture that fosters new forms of cooperation between professionals in public health and health care, as well as between health and social services professionals and health and other sectors.

Keynote speech (30 minutes)	Kasia Czabanowska Maastricht University, The Netherlands
RHN perspective (15 minutes)	Tatjana Buzeti RHN Focal Point, Murska Sobota, Slovenia
Structured discussion (15 minutes)	

### Closure of the high-level capacity-building event

#### RHN BUSINESS MEETINGS

### Opening

#### Session 1: aligning know-how areas with Health 2020 and the Göteborg Manifesto, and report from the Regional Committee

This session focuses on how the know-how areas currently present in the network can be grouped together and made more coherent with Health 2020 and consistent with the Göteborg Manifesto.

Proposed amendments to the terms of reference of RHN and the functions of the know-how area leaders will also be discussed.

Aligning know-how areas with Health 2020 and the Göteborg Manifesto	Agis Tsouros (video) Director, Division of Policy and Governance for Health and Well- being WHO Regional Office for Europe
Report from the Regional Committee	Chris Riley RHN Focal Point, Wales, United Kingdom
Terms of reference Know-how area leaders	Francesco Zambon WHO Regional Office for Europe



	All know-how area leaders and participants
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## Session 2: migration

The session will focus on challenges, which regional and local administrations often face in response to influxes of migrants. An overview of the Public Health Aspects of Migration in Europe (PHAME) project will be provided. The project aims to provide technical assistance to Member States in order to fill potential gaps in health service delivery, including in prevention, diagnostics, monitoring and management of disease, and to provide policy recommendations for enhanced preparedness and response, with special attention to emergency-related influxes of migrants to different European countries.

Setting the scene (20 minutes)	Santino Severoni Coordinator, PHAME project WHO Regional Office for Europe
The experience of Sicily (10 minutes)	Francesco Bongiorno Political Advisor, Sicily Health Ministry, Italy
The role of the Global Health Centre (10 minutes)	Maria José Caldes Centre for Global Health, Tuscany Region, Italy
Structured discussion (20 minutes)	

Wednesday, 22 October 2014

## Session 3: thematic workshop on scaling up/down regional projects

Identifying and disseminating examples of good practice and implementing respective projects and policies at the regional and local levels are important for progress in public health. But how are public health projects transferred successfully from one region to another, from a local project to the regional or even national level, or how is a national programme implemented in a regional/local context? During this session, the results of a survey led by Euregio Meuse Rhine will be presented.

	Brigitte van der Zanden RHN Focal Point, Euregio Meuse Rhine, Belgium
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## Session 4: RHN communication aspects

	Sara Barragan Montes WHO Consultant
	Suzanne Suggs Università della Svizzera italiana, Switzerland

## Session 5: discussion on RHN core businesses

Discussion on: <ul style="list-style-type: none"><li>• RHN challenges</li><li>• RHN assets</li><li>• RHN sustainability</li><li>• feedback on regional profiles received by members</li><li>• presentation of new potential members</li><li>• shared projects</li><li>• RHN workplan for 2015</li><li>• RHN capacity-building events</li></ul>	Francesco Zambon WHO Regional Office for Europe  Chris Riley RHN Focal Point, Wales, United Kingdom  All members
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## Session 6: continuation of discussion and closure of the meeting

The links and synergies with other WHO networks and European players relevant for regional health development will be discussed.

	Francesco Zambon WHO Regional Office for Europe
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From 20 to 22 October 2014 the 21st Annual General Meeting of the Regions for Health network (RHN), hosted by the Tuscany Region was held in Florence, Italy.

The main theme of the meeting was whole-of-government and whole-of-society approaches to improve populations' health. The 2014 Meeting had an innovative structure using two main sub events to bring theory and practice in health policy closer together: a capacity building event and the RHN business meeting.

The capacity-building event involved keynote speakers addressing inter sectoral action; co-production of health; investment in health from childhood through the life-course; management of policy change; and the role of advocacy and communication - with the aim to translate into practice and with a regional perspective the European health policy, Health 2020.

The RHN business meeting and workshops provided RHN members with an opportunity to describe and discuss their main activities during the last year, including the revision of the terms of reference of the network and of the knowledge areas, alongside an overview of the functions of the steering group.

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