



**EXPLORATORY MEETING:
INTEGRATING PUBLIC HEALTH AND
PRIMARY HEALTH CARE SERVICES
IN THE WHO EUROPEAN REGION**

COPENHAGEN, DENMARK, 30-31 AUGUST 2018





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Abstract

With WONCA Europe and the WHO Collaborating Centre for Public Health Education and Training at Imperial College London, United Kingdom, the WHO Regional Office for Europe convened the Exploratory Meeting with international experts from academia and practice and experts from a variety of countries that were keen to take forward the integration of public health services and primary health care. The Meeting was intended to enable the participants to gain: a shared understanding of the variety of activities and policies to integrate public health services and primary health care already in place across the countries of the European Region and of the emerging policy questions about this task at the country level; and clarity on the next steps needed to support countries in moving forward.

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Abbreviation

UNICEF	United Nations Children's Fund
WHO	World Health Organization
WONCA	World Organization of Family Doctors

Abstract

With WONCA Europe and the WHO Collaborating Centre for Public Health Education and Training at Imperial College London, United Kingdom, the WHO Regional Office for Europe convened the Exploratory Meeting with international experts from academia and practice and experts from a variety of countries that were keen to take forward the integration of public health services and primary health care. The Meeting was intended to enable the participants to gain:

- a shared understanding of the variety of activities and policies to integrate public health services and primary health care already in place across the countries of the European Region and of the emerging policy questions about this task at the country level; and
- clarity on the next steps needed to support countries in moving forward.

The participants acted as both experts and learners, working together to capitalize on their experience and expertise and point the way forward. They began by imagining what the successful integration of public health services and primary health care would look like and then identified existing examples in countries, the policy questions emerging from these and concrete next steps needed to further integration in the WHO European Region. The policy questions raised by the participants related particularly to communication, changing the culture and managing change. All agreed on the need for change and realized the need to build systems for health, rather than health (care) systems, as called for by the Sustainable Development Goals.

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Introduction

The predominance of chronic conditions in the burden of disease in the WHO European Region creates increasing and shifting demands on health systems and their public health services, a trend exacerbated by the ageing of the population and the persistence of inequities. This in turn increases the strain on social and long-term care services across the Region. The key to improving public health outcomes is designing integrated, people-centred services embracing a comprehensive approach that promotes health, prevents disease and protects health in primary health care settings. Universal health coverage means access to key health-promoting, disease-preventive, curative and rehabilitative health interventions for everyone at an affordable cost, thereby achieving equity in access and opportunities for health and well-being. As countries work towards universal health coverage, integrating public health services and primary health care is rising high on the agenda of many Member States, because of the cost-effectiveness of promoting health and preventing disease.

In July 2017, staff members of the WHO Regional Office for Europe and relevant WHO collaborating centres discussed their current work on integrating public health services and primary health care. Following up the conclusions reached, the Regional Office – in collaboration with WONCA Europe and the WHO Collaborating Centre for Public Health Education and Training at Imperial College London, United Kingdom – convened the 1.5-day Exploratory Meeting with international experts from academia and practice and experts from a variety of countries who were keen to take forward this agenda as part of their health reforms or had already begun to do so.

The Meeting was intended to enable the participants to gain:

- a shared understanding of the variety of activities and policies to integrate public health services and primary health care already in place across the countries of the European Region;
- a shared understanding of the emerging policy questions about this task at the country level; and
- clarity on the next steps needed to support countries in moving forward (see the programme in Annex 1).

The Director of the Division of Health Systems and Public Health, WHO Regional Office for Europe welcomed the 23 participants from 18 countries. He placed the Exploratory Meeting and its contribution to the integration of public health services and primary health care in the context of WHO's past and current work in the European Region and globally.

This included preparations for celebrating the fortieth anniversary of the Declaration of Alma-Ata at the Global Conference on Primary Health Care in October 2018, co-hosted by the Government of Kazakhstan, WHO and UNICEF. The outcomes of the Conference would feed into the deliberations of the subsequent World Health Assembly and a United Nations high-level meeting on universal health coverage in 2019. Integrating public health services and primary health care is essential to accomplishing the aims of WHO's recently adopted Thirteenth General Programme of Work¹ and the United Nations Sustainable Development Goals.

¹ Thirteenth General Programme of Work 2019–2023. Geneva: World Health Organization; 2018 (<http://www.who.int/about/what-we-do/gpw-thirteen-consultation/en>, accessed 5 October 2018).

The participants were supplied with background materials to assist their work: a glossary of the terms to be used in discussion (such as primary health care, family medicine and community-oriented primary care) prepared by WONCA Europe and a draft literature review of the current models for integrating public health services and primary health care prepared by the WHO Collaborating Centre for Public Health Education and Training at Imperial College London, United Kingdom.

The participants (Annex 2) acted as both experts and learners, working together to capitalize on their experience and expertise and point the way forward. They began by imagining what the successful integration of public health services and primary health care would look like and then identified existing examples in countries, the policy questions emerging from these and, finally, proposed some concrete next steps to operationalize further integration in the Region.



Imagining the future: the vision

Groups of participants devised headlines for news articles in 2030, describing how public health services and primary health care could be integrated. They shared their stories and highlighted examples of major changes in how public health services and primary health care worked differently together within these stories. Many of these stories stressed common factors: information sharing and communication between public health services and primary health care, joint service planning and delivery, changes in the education of service providers and close cooperation with the community.

For example, one group imagined that integrated services would narrow the gap in cardiovascular diseases between the richest and poorest people in society by combining changing laws, collecting and using information and providing appropriate services. This included substantial increasing the reciprocal exchange of information between public health services and primary health care, which would enable them to work with communities to jointly assess health needs and to produce joint plans for prevention and resilience. Community and individual health needs assessments would be informed by the right questions: about soft variables, psychosocial factors and personalized information.

The second example imagined the celebration of the first country in the world to achieve tobacco-free status (a smoking rate under 5%) and opportunities to export the model to other countries. The group thought that such an achievement would require integrated services at the primary health care level that are responsive to public needs and would require public and political support. The major changes in service provision and providers would include creating health centres in communities that would integrate both public health services and primary health care with nursing services and social services that would go on to deal with vulnerable groups; multidisciplinary training for professionals that would include training in integration; and introducing incentives for cooperation and integration that would ensure the sustainability of the model.

Third, a group envisioned creating health-promoting environments for everyone by focusing on the health of children. The required changes would include: establishing a common public health services and primary health care database to identify needs and create ownership of issues in the community, providing continuous professional development opportunities for family doctors to better understand their role at the centre of a health promotion team, translating disease prevention, health promotion and health protection into primary health care services and having family doctors play a strong advocacy and leadership role in the community.

Fourth, a group imagined changes to ensure sexual health and well-being for the whole community. This would mean that community leaders would be active and equal partners in designing all related services in society; the art of hosting would be used to create such partners by holding meaningful conversations between various stakeholders who may differ in language and priorities. Major changes would include setting up a forum for joint decision-making and information-sharing.

Finally, a group envisioned building trust among stakeholders by making everyone more aware of their responsibilities. This would require great vision and participation by service providers, supported by an excellent flow of information. Patients would be informed and empowered, and community leaders would be active partners in designing services for improved health outcomes. Key organizations would take local leadership and invest in the initiative, which would also include patient participation and social accountability.



Mapping existing integration practices

Next, the participants mapped examples of existing integration practices across the European Region, seeking to identify patterns of good practice and the factors that enabled them to be established. The participants cited 33 examples across the Region (and some even beyond), presenting two of them to the group as a whole. These could become the bases for further discussion and development and perhaps for later case studies by WHO.

First, an initiative for interventions for families at risk involved various professionals in the community (such as schoolteachers, doctors and police officers) into a network that supported vulnerable younger people through such means as home visits, to protect them from developing serious health and social problems. Enabling factors included the enthusiastic participation of members of the initiative, excellent communication among the leaders and between them and the members and sufficient time and funding to succeed. The country concerned was trying to expand the initiative to turn it into a standard public health service integrated with primary health care at all levels.

In another country, community health services at the primary health care level tackled children's poor dental health by developing integrated teams accountable for patients. Assessments of schoolchildren showed a social gradient in poor dental health, and some parents said that they could not afford dental care. The teams responded by promoting dental health, involving dentists in discussion and developing new practices in the community and working through schools to identify problems earlier. The key factor was the availability of integrated teams for response, and the model had been taken up throughout the country.

Considering all the examples cited, the participants identified a range of good practices, including: using health information systems and digitization, focusing on specific solutions for specific groups and contexts, multidisciplinary collaboration in both the design and delivery phases and community participation.

They agreed, however, that the enabling factors present helped to determine the development of the good practices (Box 1). These factors included: political will and cooperation at the local and national levels, the presence of efforts driving active health reforms, the meaningful use of technology, the involvement of patients and the availability of funding. The discussion revealed further enabling factors. Participants argued that accountability to the target population at any level is essential to secure better outcomes although costly. Mechanisms are needed for intersectoral and multidisciplinary cooperation. Professionals also need to be motivated for integration, which could perhaps come from supplying them with data on population needs. Visionary leadership is needed to start integration processes, and strong relationships between professionals are needed to sustain them. Decentralization and centralization (for information work, for example) need to be balanced. Finally, the success of an initiative or good practice enables it to be scaled up and formally put into wider practice.

Box 1. Enabling factors supporting the development of good practices for integrating public health services and primary health care as identified by meeting participants

- Political will and cooperation at the local and national levels
 - Presence of efforts driving active health reforms
 - Meaningful use of technology
 - Involving public and patients
 - Availability of funding
 - Accountability to the target population at any level
 - Mechanisms for intersectoral and multidisciplinary cooperation
 - Motivation of professionals, facilitated by the availability of population-level data
 - Visionary leadership to start integration processes and strong relationships between professionals to sustain them
 - Balancing decentralization and centralization (for information work, for example)
 - Evidence of success of a localized initiative or good practice
-

Bridging the gap between the vision and existing efforts for integration

The participants recognized that, despite their diversity in their professional roles, all are addressing remarkably similar challenges and that cooperative preparatory work is needed to enable innovation.

They therefore addressed two questions to bridge the gap between their vision and existing efforts for integrating public health services and primary health care.

- What changes, big or small, would truly make a positive difference in their countries?
- What emerging policy questions need to be addressed to achieve this in practice?

In answering these questions, the participants collated the emerging policy questions under seven headings, indicating their specific interest in each question. Table 1 lists the headings and questions in descending order of interest. By far the most important question identified was: how to change the culture and definition of power from its current orientation towards disease to an orientation towards health and well-being.

Headings

Questions (number of expressions of interest)

Health needs assessment
(14 votes)

How can one change the culture and definition of power from its current orientation towards disease to an orientation towards health and well-being (14)?

Policy and politics (10 votes)

What kind of evidence is needed to convince politicians and stakeholders to initiate change (6)?
How could the hospital sector be reduced (2)? How will those who close hospitals be perceived (1)?
What needs to be done to ensure that priorities on paper are acted on (1)?

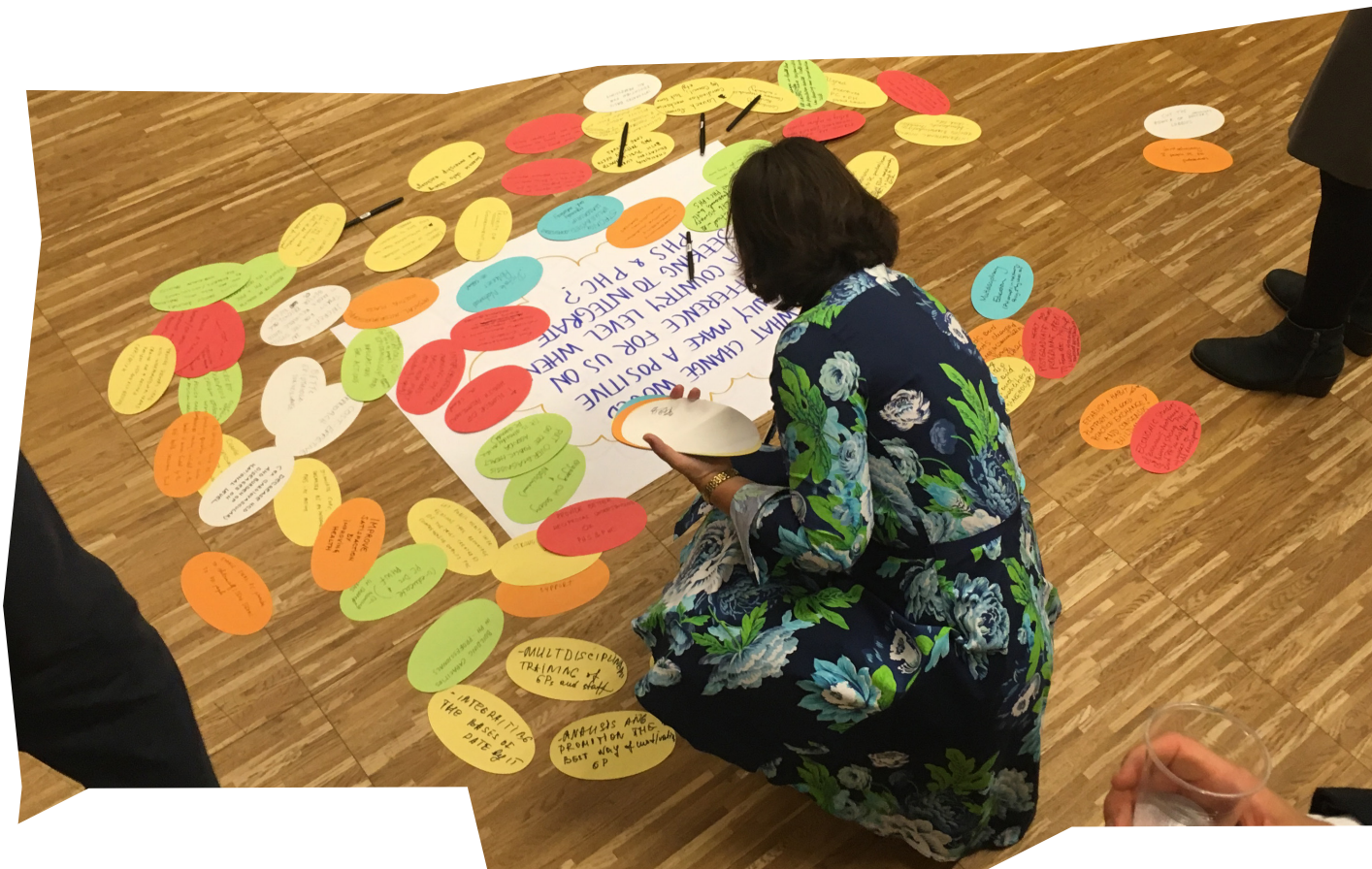
Operationalizing cooperation
(10 votes)

How can one justify or make a case for investing in the integration process? What are models or examples of cooperation mechanisms? What are their pros and cons (3)?
What are the models for integration (2)?
How can one achieve buy-in from different actors (1)?
How can one ensure that the collaboration process yields outcomes (1)?
How can one sustain collaboration (1)?
How can one create the time for collaboration (1)?
How can one prevent or avoid resistance from practitioners (1)?

Engaging and empowering
stakeholders (8 votes)

Who is and should be in charge of the integration agenda and process (8)?

Data and technology (7 votes)	<p>How ethical is disruptive innovation, such as chat bots for primary health care (4)?</p> <p>How can one create privacy laws that allow data sharing (2)?</p> <p>How much data are analysed (1)?</p> <p>Where can one get the resources needed to analyse data and implement e-solutions (0)?</p>
Evidence and economics: best value (6 votes)	<p>What are the financial incentives for partnership and collaboration (4)?</p> <p>How does one translate and disseminate the evidence (2)?</p> <p>What is the cost of integration at the local level or for each health centre (0)?</p> <p>Who funds the research and what is done with the results? Who collects the results and how? Who performs the analysis? (0)</p>
Multiprofessional education (5 votes)	<p>Who leads it (3)?</p> <p>What is the content (1)?</p> <p>How should one monitor progress and adapt programmes (1)?</p> <p>Who is included (0)?</p>



Models for successfully integrating public health services and primary health care

The participants then reviewed six emerging models of public health services and primary health care integration drawn from the drafted literature review prepared by the WHO Collaborating Centre for Public Health Education and Training at Imperial College London, United Kingdom. Trends in health and data on the global burden of disease show the need for health systems to switch from a disease-oriented model to a health-oriented model. In general practice, 4% of the practice population (complex cases) consumes about 50% of the allocated resources, and 80% of the practice population (“healthy” patients) consumes 15% of the resources (in the form of proactive health and well-being support). This shows the opportunity for proactive interventions (disease prevention and health promotion) towards achieving the goals of WHO’s Thirteenth General Programme of Work.

The Collaborating Centre’s research showed that both primary health care and public health services are changing, moving towards becoming increasingly proactive and integrated. Integration requires changing professional behaviour and therefore relies heavily on changing medical education to create a generation of primary health care and public health practitioners with the required competencies (knowledge, skills and attitudes). The literature review identified six models of integration in practice in a range of countries:

1. integrating public health professionals into primary health care;
2. training primary health care staff in public health;
3. public health services and primary health care providers working together;
4. providing comprehensive and proactive benefit packages that include public health services and principles;
5. building public health incentives into primary health care; and
6. placing primary health care services within public health settings (used in exceptional circumstances only).

The participants, using the presented models, shared their insights from their discussion on integrating public health services and primary health care.

- Changes are needed. This is a primary requirement. The availability of diversity of models is an opportunity, not a hindrance.
- These changes depend on the existing health systems. Different solutions are needed for different systems. The discussion showed the strength of public health and changes in primary health care teams.
- The integration process is not easy and requires investment in people. This investment should be aimed at stopping service providers from taking ineffective action; the question is how to identify such action.
- Primary health care should have a strong position in defining health systems and public health priorities alongside secondary care inputs.
- Countries should take a strategic stepwise approach to integration.

- Both clear long-term objectives and clear short-term wins are needed to maintain motivation. Service providers need to receive data showing the success of change, but this requires new types of data.
- In relation to both the glossary and models of integration used at the Exploratory Meeting, characterizing some types of interventions as public health services or primary health care is difficult. The roles and responsibilities of service providers need to be clearly defined. This requires considering the views of all stakeholders.
- Indicators of improvement are not always quantitative. The question is not only what to do but also how to secure greater consensus on this.
- Changing service providers' behaviour and being proactive are important, and this should be applied to all professions. Changing ways of working would be beneficial. Although chronic illnesses will always be important in primary health care, the most striking change in medical education could be increasing the proportion of family doctors working in primary health care up to 40% of the total in future. The education of doctors and related professionals should focus on both populations and patients.
- Public health services and primary health care show trends towards proactive and integrated interventions (prevention and health promotion), illustrating a shift from “illness services” to “health services”.



What it takes to lead change

The policy questions raised by the participants related particularly to communication, changing the culture and managing change. All agreed on the need for change and realized the need to build systems for health, rather than health (care) systems, as called for by the Sustainable Development Goals. Since all change hinges on connections, the participants need to concentrate on making and sustaining connections and focusing them on the most productive changes.

Further discussion identified some issues in leading and managing change to integrate public health services and primary health care and to reform health systems in general. For example, communication and partnerships are essential but hard to build. Moreover, who should lead the integration process? Although stakeholders agree on the need for change, the problem is how to build consensus on what exactly should be done, especially since some stakeholders may lack the necessary alliance-building skills. Change needs to move from the bottom up, but most stakeholders think that others, not they themselves, need to change.

In addition, the evidence for the changes needed already exists but still needs to be accepted by stakeholders and translated into action through policy-making. Evidence could be of different types, and traditional methods, such as randomized controlled trials, cannot be used for all purposes. Other methods should be examined, especially using health systems to build social solidarity through primary health care. Big data, showing that primary health care is the most effective part of the health system (as shown by the public's confidence in it), could contribute to achieving this goal. Tactics that could favourably sway public opinion could include increasingly translating and publishing WHO policy documents in local languages. It was also seen as important to advocate for the "older" values in public debate – such as solidarity and equity, which are under pressure from current social and political forces and to promote change by training the younger service providers.

Having raised these issues, the participants proceeded to share examples from their own work when they attempted to create something new and radically different, to identify common factors that either enabled or impeded their change efforts. Their discussion identified five major positive factors:

1. clarity: clear vision, mutual understanding, sufficient explanation, and clear evidence and research pointing the way;
2. resources: both financial and human resources, accountability for their use (in many forms: hard numbers or positive feedback), patience, persistence and energy to move forward and political will;
3. the quality of relationships: making alliances with subject-matter experts, finding allies with the right strengths and creating relationships with them and welcoming new partners;
4. sustaining momentum: personal investment and persistence, confidence that change can be achieved, celebrating victories together, support from colleagues, using the energy of youth and dedication to and enthusiasm for the work; and

flexibility in coping with emergencies and knowing the health system and what makes it work and thus how to work within it.

The major negative factors were:

1. lack of a supportive platform: the lack of a coalition to support change, support from key opinion leaders, discontinuity of support and a rigid bureaucracy;
2. lack of resources: the lack of time and effort to build relations, the lack of data and intelligence and the lack of financial human and time resources in general;
3. lack of recognition and equity: lack of recognition of the importance of equity in disease prevention (to support service redesign), lack of mutual understanding between change-makers and their opposition and lack of understanding of which stakeholders to involve and what motivates them;
4. the human factor: honesty about the obstacles to be encountered, loneliness and fear, burnout, lack of trust that an initiative will make things better and reform fatigue;
5. lack of a communication strategy: the person who has an idea is not always the best one to take it forward; and
6. corruption.

Both the positive and negative factors need to be acknowledged as part of the process of managing change.



Next steps: identifying practical action

As their last task at the Exploratory Meeting, the participants voiced their thoughts on their practical needs to take the next steps towards integrating public health services and primary health care in their contexts. Seven main ideas emerged, indicating the types of resources participants were keen to see developing either at the national or international level:

1. a marketing campaign to deconstruct the mistaken belief that risk cannot be mediated;
2. training for primary health care practitioners in public health principles and practices;
3. a mobile academy to share information with a focus on integration and digitization;
4. removing remuneration for disease diagnoses;
5. developing health services outside the hospital;
6. national dialogue on the reorientation of the health and financial and payment systems;
and
7. building an alliance or executive platform for integration.

In discussing these, participants raised the question of how to ensure that a national dialogue would actually lead to change that would see the health system focus on disease prevention. One answer noted that the dialogue should include managers, to get them on board as change agents; another answer noted that such a change would require a certain level of public demand for change. The follow-up question that then arises is how to empower the public to express this demand. Another participant noted the need to involve all practitioners throughout the process. Moreover, WHO could support integration by disseminating evidence-informed knowledge and supplying resources for building an alliance or executive platform for integration.

Further, although secondary-care specialists usually define the culture and goals for the health system, primary health care practitioners should have a louder voice in this task. The proposed alliance for integration could speak to this, and WHO guidelines and educational materials could help.

The Global Conference on Primary Health Care, to be held in October 2018 in Astana, Kazakhstan, will issue a declaration to create political momentum. The declaration will call for: empowering people, families and communities to take ownership of their health; addressing the determinants of health through intersectoral action; and ensuring sustainable and strong primary health care and public health functions.

Reviewing their work at the Meeting, the participants agreed that they had:

- improved their understanding of the variety of activities and policies for public health services and primary health care integration already in place across the WHO European Region;
- started to develop a shared understanding of emerging policy questions; and
- made a good start in determining the next steps to take.

In addition, many took the opportunity to establish new or deepen existing professional relationships

as a dedicated, Europe-wide community, which is an essential part of the public health services and primary health care integration process.

Steps to follow up the Exploratory Meeting include: (1) a meeting report to serve both as a summary of the conversation for participants but also for those who were not able to attend the meeting; (2) sharing existing resources, some of which were mentioned by participants during the meeting, that may be useful in promoting the integration agenda in participants' countries; (3) finalizing the draft literature review on models of integration; and (4) further developing the policy questions and potential actions with more Member States involved.

Most importantly, all participants agreed that this interactive conversation should continue, allowing Member States and experts to continually share experiences on effective ways towards integrating public health services and primary health care in pursuit of universal health coverage and the Sustainable Development Goals as a whole.

Annex 1. Programme

Day 1, 30 August

Opening of the meeting:

- Welcome by Hans Kluge, Director, Division of Health Systems and Public Health, WHO Regional Office for Europe
- Welcome by Anna Cichowska Myrup, Programme Manager, Public Health Services, WHO Regional Office for Europe
- Welcome by Pavlos Theodorakis, Senior Adviser, WHO European Centre for Primary Health Care, Almaty, Kazakhstan, WHO Regional Office for Europe

Introduction to the meeting

Glossary presentation by Anna Stavdal, President of WONCA Europe

Imagining the future of public health services and primary health care integration:

- group work: what could successful integration look like?
- feedback from each group

Country sessions – mapping existing integration practice

- group work
- feedback: what patterns are emerging across countries with good integration practice?

Bridging the gap between existing efforts for integration and the vision: collective mind map:

- what are the emerging policy questions in relation to strengthening the integration of public health and primary health services?

Presentation: “Models for successful integration of public health and primary care services”, by Salman Rawaf, Faculty of Medicine, School of Public Health, Imperial College London; and Director, WHO Collaborating Centre for Public Health Education and Training:

- reflection on models from the presentation: what insights from the presentation could support work with integrating public health services and primary health care?

Wrap-up and conclusions, day 1

Day 2, 31 August

Recap of strategic insights from day 1 by Anna Cichowska Myrup and Anna Stavdal

Framing: what does it take to lead change?

Identifying and setting priorities for action for integrating public health and primary health services through group work to identify actions to collectively move forward the integration of public health services and primary health care in the European Region

Closing and next steps

Annex 2. Participants

Willem (Pim) Assendelft, Head, Department of Primary and Community Care, Radboud University Medical Centre, Amsterdam, Netherlands

Vivienne Bennett, Director, Nursing, Public Health England, London, United Kingdom

Elena Boleac, Senior Consultant, Department of Primary Health, Emergency and Community Care Policy, Ministry of Health, Labour and Social Protection, Chisinau, Republic of Moldova

Krunoslav Capak, Director-General, Croatian Institute of Public Health, Zagreb, Croatia

Jan De Maeseener, Professor, Department of General Practice and Primary Health Care, Ghent University, Belgium

Ketevan Goginashvili, Head, Health Policy Division, Health Care Department, Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs, Tbilisi, Georgia

Heli Hätönen, Ministerial Adviser, Ministry of Social Affairs and Health, Helsinki, Finland

Anna Korotkova, Deputy Director, Department of International Issues, Federal Research Institute of Health Organization and Informatics, Moscow, Russian Federation

Margareta Kristensson, Chair, Health Promoting Hospitals and healthcare (HPH) Network

Volodymyr Kurpita, Director, National Public Health Centre, Kyiv, Ukraine

Harris Lygidakis, Honorary Secretary, WONCA Europe; family doctor and PhD student, Luxembourg

Zlate Mehmedovic, General Manager, Public Health Institute Public Health Centre Skopje, former Yugoslav Republic of Macedonia

Peter Novak, Head, Department of Health and Society, Gesundheit Österreich GmbH, Vienna, Austria

Vesna-Kerstin Petric, Head, Division for Health Promotion and Prevention of Noncommunicable Diseases, Ministry of Health, Ljubljana, Slovenia

Salman Rawaf, Director, WHO Collaborating Centre for Public Health Education and Training, Imperial College London, United Kingdom

Anna Stavdal, President, WONCA Europe; Associate Professor, Department of Family Medicine, University of Oslo; and family doctor, Oslo, Norway

Alena Šteflová, Deputy Minister, Ministry of Health, Prague, Czech Republic

Mehmet Ungan, President-Elect, WONCA Europe; Professor, Department of Family Medicine, Ankara University School of Medicine; and family doctor, Ankara, Turkey

Marius Ungureanu, Associate Researcher, Cluj School of Public Health, Cluj-Napoca, Romania

Stamatis Vardaros, Deputy Secretary-General, Ministry of Health, Athens, Greece

Raluca Zoitanu, Executive Board member, WONCA Europe and European Organisation for New and Future General Practitioners/Family Physicians (Vasco da Gama Movement); and family doctor, Bucharest, Romania

World Health Organization

Headquarters

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Jill Farrington, Coordinator, Noncommunicable Diseases Management, Division of Noncommunicable Diseases and Promoting Health through the Life-course

Clayton Hamilton, Technical Officer, Public Health Services, Division of Health Systems and Public Health

Hans Kluge, Director, Division of Health Systems and Public Health

Martin Kraye Von Krauss, Senior Adviser, Public Health Services, Division of Health Systems and Public Health

Anna Cichowska Myrup, Programme Manager, Public Health Services, Division of Health Systems and Public Health

Pavlos Theodorakis, Senior Adviser, WHO European Centre for Primary Health Care, Almaty, Kazakhstan

The WHO Regional Office for Europe

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

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