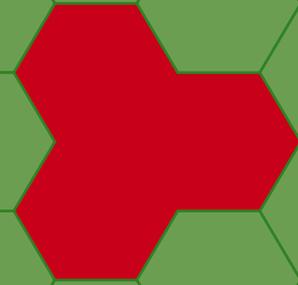




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Regions for Health Network Twenty-second annual meeting report

Improving health and equity across regions and
sectors

Milan, Italy, 14–15 October 2015





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Abstract

From 14 to 15 October 2015, the 22nd annual meeting of the Regions for Health Network (RHN) was held in Milan, Italy. The main theme was improving health and equity across regions and sectors. This year, it was organized as a preconference of the 8th European Public Health Conference, including capacity-building-sessions and the RHN business meeting.

Capacity-building sessions addressed important scientific evidence and practical efforts to improve health and equity: joining forces – citizens and regions for better health; starting people on a healthy life course – evidence, policy and advocacy; and tackling health inequities at subnational level – grounding actions on data. These were put in the context of the WHO European health policy framework, Health 2020, and efforts to translate it into practice at regional level. The RHN business meeting provided its Steering Group and members with an opportunity to describe and discuss their main activities during the previous and coming year, including the revision of the terms of reference, a programme of publications and new ways of extending RHN's effectiveness.

In addition to the meeting, members also had the opportunity to organize and attend three sessions as part of the Conference programme. These are also covered in this publication.

Keywords: HEALTH POLICY, HEALTH PROMOTION, HEALTH EQUITY, PUBLIC HEALTH, INTERNATIONAL COOPERATION, CAPACITY BUILDING, HEALTH INFORMATION SYSTEMS, EUROPE

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Preface: rationale for the meeting

The WHO Regions for Health Network (RHN) works to improve health and well-being through prioritizing equity, developing strategic delivery alliances and fostering good governance. Its members represent 25 regions from 20 countries across the WHO European Region. They work to promote excellence and effectiveness in their regions; share resources and good practice; exchange ideas and experience on structures, processes and skills; work across sectors to build new alliances for health; and openly discuss challenges and possible solutions to bring changes for health gain at the regional and local levels.

The 22nd annual meeting of RHN aimed to take forward the European Health 2020 strategy agenda focusing on effective approaches to achieve better health and well-being, and reduce health inequalities. Participants explored a series of key issues across the session topics, namely:

- **background policies and evidence** (i.e. link to Health 2020 or national programmes, projects and good practices across the European Region; existing/needed research evidence and monitoring systems/health data at regional level; etc.);
- **practical approaches and driving change** (i.e. specific and practical examples such as urban/transport planning, environmental matters, new legislation/regulation, education and training initiatives, etc.);
- **participatory approaches and work across sectors** (i.e. implementing/examples of whole-of-government and whole-of-society approaches; multiagency programmes and projects, including organizations across the public sector, as well as the private sector and nongovernmental organizations/communities; etc.); and
- **collaborative and European funding opportunities** (i.e. European Union (EU) and other income, which is instrumental and supports public health in a climate of austerity; relevant EU funding programmes and streams; possible cross-regional collaboration and joint funding applications; etc.).

The meeting was held immediately preceding the 8th European Public Health Conference, and members also attended three sessions organized as part of the Conference programme, which are also covered here:

- **joining forces: citizens and regions for better health**
- **scaling up (pilot) projects successfully** – lessons from theories and experiences
- **quality health information systems** in small European countries and regions.

Part 1. The RHN annual meeting

The twenty-second annual meeting of RHN was held on 14-15 October 2015 in Milan, Italy (see programme in Annex 1). The meeting was held immediately preceding the 8th European Public Health Conference where RHN organized and presented three sessions (see Annex 2). More than 70 participants from 25 regions and 20 countries took part in the meeting (see Annex 3).

Dr Francesco Zambon, Policy Development Officer at the WHO European Office for Investment for Health and Development, Venice, Italy of the WHO Regional Office for Europe, and Solveig Wallyn, Policy Officer, Flemish Agency Care and Health, Flemish Ministry of Welfare, Public Health and Family Affairs, opened the meeting and welcomed all present. Dr Zambon mentioned, in particular, potential members from Albania, Estonia and Turkmenistan; representatives of five countries in the WHO European small countries initiative (1); two national coordinators from Healthy Cities; and a representative of EuroHealthNet. The rapporteur was Dr Christopher Riley, former Strategy Adviser, Department for Health and Social Services in the Welsh Government, United Kingdom.

He also thanked the representatives from Wales (United Kingdom), Flanders (Belgium), Skåne (Sweden), Pomurje (Slovenia) and Autonomous Province of Trento (Italy) who as members of the Steering Group helped organize the meeting, as well as his WHO colleagues in Copenhagen (Denmark) and in Venice (Italy).

Milan was chosen as the venue for the meeting to coincide with the 8th European Public Health Conference and with the closing days of the World Expo 2015. The Expo site was organized around a central thoroughfare rather like the *decumanus*, the main road that ran east-west through a Roman city, acting as the backbone for the town plan. Similarly, the new WHO European health policy framework Health (2) acted as the backbone for health policy in the WHO European Region. It provided strategic direction, gave a mandate for action and acted as a common denominator for every part of the Region. Most importantly, it offered an opportunity for all to act separately and together around a shared purpose.

Over the previous year, the RHN's Steering Group had convened monthly to develop the meeting and address issues. The attention of those present was drawn to the recently issued document entitled *Taking a participatory approach to development and better health: examples from the RHN* (3), which was discussed during the meeting and Conference. Thanks were due to Region Skåne, which led the work on its publication, and to other contributors.

Dr Piroska Östlin, Acting Director of the Division of Policy and Governance for Health and Well-being at the Regional Office offered best wishes from Dr Zsuzsanna Jakab, WHO Regional Director for Europe. Health 2020, adopted in 2013 by the 53 countries of the Region, called for a policy change that would be vital to success in achieving health for all and reducing inequality. The Regional Director sees strengthening all the networks, RHN, the South-eastern Europe Health Network, the small countries initiative, Healthy Cities, health-promoting schools and hospitals, and all the others as a means to support Health 2020.

The health sector should reach out and work with other sectors, and adopt an approach that engaged the whole of government – all the ministries at all levels – and the whole of society – including citizens, nongovernmental organizations and the private sector. In this task, regions would have an important role, both at the subnational and nation levels.

Organizations at the regional level have the benefits of close proximity to citizens, able to hear their voices, assess their needs and provide remedies. They also worked with the national level on implementation and could inspire the national level by example. WHO sees regions as champions for Health 2020. The meeting provided a platform to meet and exchange ideas and solutions.



Session 1. Joining forces: citizens and regions for better health

1.1 INTRODUCTION

The whole-of-government and whole-of-society nature of Health 2020 required broad participation across sectors to build policy coherence, bring together levels of governance, support understanding of the opinions and needs of others, and promote solidarity, especially with the aim of ensuring vulnerable groups are not neglected. Experience in trying to improve health policy for the Roma had demonstrated that their involvement was vital to progress. In that context, the report of the work led by Region Skåne was helpful and innovative, and included valuable case studies, and its lessons deserved to be studied in this session.

1.2 PARTICIPATORY APPROACHES – GENERAL REMARKS FROM A POLITICAL SCIENCE PERSPECTIVE

Using a theoretical background, political deliberation can be defined as “argumentative negotiation with an orientation on consensus and public welfare”, which is distinguished from political struggle, a decisionistic model and a technocratic model (4). Habermas had identified these last two as giving decision-making powers to political leaders alone or to those with scientific authority, adding a third pragmatic model where government, citizens and science collaborated in the decision-making process (4).

Participation increasingly extends decision-making beyond politicians to include their colleagues and parties, different levels of administration, organized interests such as corporations or professional groups, broader civil society and citizens. This is against a background where the state is losing authority (e.g. through globalization, growing public scepticism), traditional political parties and organized interests are challenged by new ways of organizing and expressing opinions, and scientists are no longer seen as offering certainty.

Participation offers the hope of extending democracy, but can perhaps make accountability more obscure and undermine formal processes. Its benefits could include drawing on more and better advice and information, leading to greater consensus and better, more sustainable solutions, and perhaps greater motivation and activation. But it generates its own challenges in relation to the reality of the commitments to action it creates and the sheer complexity of engaging large numbers of very different groups.

The nature of participatory engagement will differ, for example, in relation to agenda setting, policy formulation and evaluation, and the balance between components such as communication, coordination, cooperation and self-commitment will vary. It will also need to respond to local variations in political structures, culture and the nature of the health system.

1.3 KEY MESSAGES FROM THE SKÅNE REPORT

The Regional Office published *Taking a participatory approach to development and better health: examples from the RHN* (3). A representative of Region Skåne introduced the report and presented it as a follow up activity to a presentation given at the twenty-first RHN annual meeting in Florence, Italy (5). Regions in Sweden were required to prepare a regional strategy, and the Skåne report documented how they had done that. It also included case studies from other regions. The group sessions that followed each considered a key message identified in developing the Skåne strategy (Box 1).

Box 1. Six key messages from the Skåne report were discussed in group sessions.

- “Find a common purpose for stakeholders. Emphasize the potential of the common good or the common issue when working as a connected whole, and enable people to see beyond their boundaries.”
- “Focus on the process rather than the product. Creating ownership and involvement from all stakeholders is much harder than producing a policy product. Identify the common driving force as to why everyone is doing this, and determine the new behaviour and norms everyone wants.”
- “Trust the process. Be a sounding board that moves in between stakeholders like a free agent (or a broker or convener), and guide the process by being receptive and flowing with rather than controlling it. Trust that stakeholders will jointly make the best informed decisions for the Region.”
- “Create ownership of the process through leadership and ambassadors, and engagement with networks and alliances that will ultimately drive the process and maintain its momentum.”
- “Involve and empower other sectors (not only health) by engaging the whole of the public sector, as well as communities and industries to share purpose, objectives and benefits.”
- “Joint mobilization requires leadership characterized by courage, a willingness to take risks and, at the same time, an openness to invite all stakeholder views and initiatives in order to challenge prevailing ideas and adapt to new circumstances.” (3).

1.4 FEEDBACK FROM GROUP DISCUSSIONS

1.4.1 Find a common purpose for stakeholders

The group discussed the finding in the context of a short presentation on new legislation in Wales, which among other things committed public bodies to work towards achieving goals that included improving the health of future generations (see subsection 3.3.2). A twelve-month period of public engagement, a national conversation asking people about “the Wales we want” (6), had been part of the process, helping to prepare and influence the legislation, which would require those bodies to encourage participation when they prepared local plans and when preparing plans to achieve the goals. The group explored what had helped make this approach possible, and identified strong leadership by the government and cultural determinants as important factors.

1.4.2 Focus on the process rather than the product

The group agreed this was a valid idea. Engaging people in discussing issues that concern them will often benefit health even if health is not their immediate concern. The Healthy Cities model has been a good way of doing this, and health impact assessments also help people have ownership of issues that affect their health. Strengthening links between the regional and local levels and ensuring that those who lead a decision-making process are capable of drawing out different types of knowledge are both important. Politicians will most likely want to see a product, so identifying good news that emerges from the process is key. That also suggests the importance of making links with the formal media and considering how best to use social media.

1.4.3 Trust the process

The group was given a brief report on the Skåne process. Those with a health background had been concerned about how to ensure that health was recognized as an important issue in a very open process

and how to ensure sustainability. Involving social groups in a way that was meaningful was vital. Lead agencies need to be able to flow with the process and not try to control it, accepting that clashes will occur and consensus will be difficult. The benefit of this type of process is the opportunity to generate new ideas and make new connections. Ensuring that all participants have equal influence in the process is hard, so ground rules will be needed. Politicians may be reluctant to lose power and share privileged information, and getting people to see beyond their own established position may be a challenge.

1.4.4 Create ownership of the process

The group discussed how the idea of ownership would apply in different situations. Issues within government and across public agencies were very different compared with those within a community. In the former, the problem might be a clash between officials who were willing to collaborate and politicians who wanted exclusive control; the issue is about who has ownership. In a community, the issue might be a lack of ownership; one possible response might be to provide transparent information that provokes a feeling that some action must be taken. There are real differences in language and culture between areas and countries and in formal responsibilities and access to resources. It is also important to ensure ownership is not just tokenistic involvement of a few, to ensure the most vulnerable and marginalized groups are given a sense of ownership, and to avoid a slide into victim-blaming when changes do not happen quickly.

1.4.5 Involve and empower sectors other than the health sector

The group discussed how involving others at an early stage of planning and open-minded planning meetings enables people to feel engaged in the process and engages their trust. Listening and using a common language is essential, so people feel connected to each other rather than remaining in professional silos. Groups have languages as countries have currencies, and a so-called language currency conversion is needed, especially at national level to make it easier to share ideas and agree upon concrete actions. The private sector is very different in its basic motivation from public agencies, but efforts should be made to engage it.

1.4.6 Joint mobilization requires leadership

The group identified political leadership as vital, because progress might be impossible without it; though the point was also made that educated, technical people might be reluctant to acknowledge political leaders. Bringing together a group of leaders is sensible and more sustainable than relying on a single leader who might leave and destabilize the process. Leaders must be able to make a convincing case and link to social movements. Good participation processes help protect and maintain the process if a leader leaves.

1.5 CONCLUSIONS

Commenting on the session, the rapporteur noted that participatory approaches are not a simple solution but introduce a different set of challenges. A more open process is much more complex with many more players and interests to bring together. The discussions made clear that no one approach will make this work, but that each region would need to find an approach that sensitively matched its

own ambitions and culture. RHN provides a valuable service in helping to bring together a selection of examples of how this has been tried and in making them available, so regions can choose what might work for them.

Three lessons were identified.

- Participation is vital to success in linking different actors and activating citizens.
- Skills and lessons can be learned.
- No simple solutions exist and that each area must design its own approach.



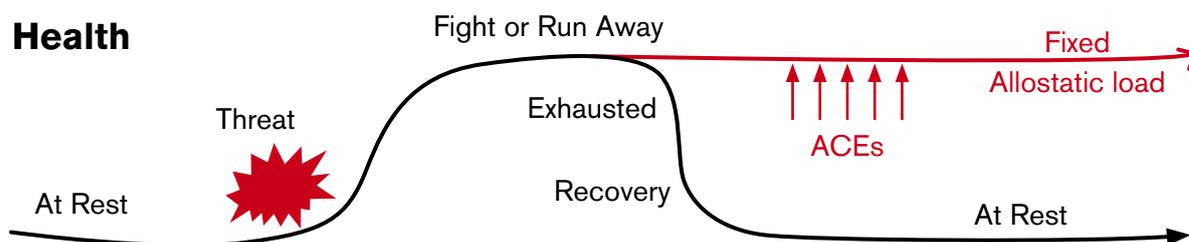
Session 2. Starting people on a healthy life course – evidence, policy and advocacy

2.1 CHILDHOOD ADVERSITY AND ITS IMPACT ON HEALTH ACROSS THE LIFE COURSE

Interest has been growing in why childhood experiences matter for childhood health and throughout life. Work in the United States of America (7) suggests that adverse childhood experiences (ACEs) can lead successively to disrupted nervous, hormonal and immune development; social, emotional and learning problems; adoption of health-harming behaviours and crime; noncommunicable diseases; disability; low productivity; and ultimately early death.

Early childhood development is critical, with evidence that a baby's brain grows from 25% to 80% of adult size in the first two years. As development continues, the child learns empathy, trust and how to engage with a community. A child learns that threats can be met by fighting or running away, and then comes recovery and a return to normal state (Fig. 1). But chronic stress through constantly facing ACEs means the child does not return to a normal state but is constantly stressed. Over time, even normal situations can be interpreted as threatening, and the child reaches a state where a pattern of disturbed behaviour is set. At school, this may be marked by the child being anxious, disengaged and a poor learner (8).

Fig.1. How ACEs cause long-term stress



Problems may be more common than believed. A survey of 10 000 students aged 18–25 years in parts of eastern Europe found that 18.6% of them suffered physical abuse (9). Even after controlling for poverty, findings show that compared with no ACEs, those with more than four experiences were:

- three times more likely to be a current smoker or to have had sex before the age of 16 years;
- six times more likely to have used drugs;
- 10 times more likely to be problem drinkers; and
- 49 times more likely to have ever attempted suicide.

A somewhat similar survey in Wales of people aged 18–70 years found a similar pattern, with also an increased likelihood of being involved in violence or imprisoned. Estimates show that problems resulting from such exposure could be significantly reduced if those having suffered ACEs had not. Data suggest that tackling these issues can dramatically reduce long-term harm (Table 1).

Table 1. Potential benefits from eliminating ACEs

Issue	Decrease in behaviour suggested by	
	Eastern European data (%)	Welsh data (%)
Smoking	-22	-24
Early sex	-21	-31
Drug use	-36	-66
Problem drinking	-51	-35
Suicide	-83	NA
Violence	NA	-60

NA: not available

Source: adapted and reproduced by permission from Public Health Wales (10).

In addition, data from England suggest that, while some 50% of people who had no ACEs reached age 70 with no diagnosed major diseases, the figure was as low as 20% for those who had faced four (11).

Interest in addressing these issues has been growing, with violence against children included in the new Sustainable Development Goals (12), Health 2020 (2) and various WHO reports, and on the agenda of the World Health Assembly. Approximately 9.6% of children in Europe are estimated to be suffering sexual abuse and 22.9% physical abuse (13).

A number of ways of preventing ACEs have now been identified including home nurse visits to support parental skills; parental programmes to develop skills, knowledge and confidence; preschool enrichment; and training for doctors in screening parents. These have all been shown to reduce child maltreatment and have other benefits (14).

Building resilience is a way of helping people cope with ACEs, and avoid damaging behavioural and physiological changes in response to chronic stress. This can happen where people feel they can overcome hardship and guide their own destiny, are grounded in cultural traditions (feeling connected), are equipped to manage their behaviour and emotions, and have one or more stable, caring child-adult relationship. Evidence shows the value of the latter; rates of people who are problem drinkers, users of hard drugs or ex-prisoners are around twice as high among those who as children felt they did not have access to an adult they trusted and with whom they could talk about their problems compared with those who did (15).

Good schooling can also help. An example from Washington State Family Policy Council showed that ACEs were the best predictor of health, attendance and behaviour, educational success (more than income) and academic failure (after special education needs). The school in that case shifted from punishment in dealing with problem behaviour to support, helping children develop attachments, resiliency and skills and control their emotional experience. Fights and suspensions fell dramatically and graduation rates improved (16).

Recognizing that ACEs can provide the underlying reasons for accessing health care later in life, a number of studies are under way in the United States of America, including use of a routine self-completed ACEs survey pre-examination and use of relevant questions during examination. These have led to significant decreases in the following year in visits to general practices (down 35%) and emergency departments (down 11%) (17).

Alcohol misuse is also a factor, implicated in child sexual abuse and fatal child abuse, intimate partner violence, parental separation, incarceration and suicide. The European Region has the world's highest alcohol consumption (18).

It is evident that a good start in life will reduce noncommunicable disease and harm across the health, social, education and criminal justice sectors and throughout the life course and cut health inequalities. Existing knowledge emphasizes the value of good parenting, good schooling and alcohol control. Further research and progress will depend on acting on what is already known and on promoting a unified research agenda bringing together neurology, epigenetics, public health and other areas.

2.2 EVIDENCE FROM THE HEALTH BEHAVIOUR IN SCHOOL-AGED CHILDREN (HBSC) STUDY 2014 ON WHY SLOVAKIAN CHILDREN DO NOT LIKE SCHOOL

Results of the HBSC study (19) indicate a high prevalence of children from eastern Europe who do not like school. A supportive school environment is an asset for health-enhancing behaviours, health and life satisfaction, while a non-supportive school environment may constitute a risk.

The HBSC study provides an opportunity to explore a wide range of health-related behaviour taking place in school. It began in 1994 and gathers data from young people in over 40 countries in Europe and North America about their health and well-being

The HBSC survey is conducted every four years at the same time in all countries, using a common standardized survey questionnaire and survey method. The data are collected on nationally representative samples of 11-, 13- and 15-year-olds in each country. It monitors social context, as well as health and behaviour and offers information on how health is influenced by social circumstances and developmental processes that can help focus policy on social and economic determinants of health.

Slovakia has data on 9200 adolescents aged 11–15 years from the 2014 data collection, which illuminates some of the problems facing children. Three were highlighted.

Bullying affects 10% of children and 46% of those experiencing it did not report it. The main reason for bullying was weight (figure, overweight or underweight – 18%), followed by race or colour of skin (7%), problems in the family (money, sickness or other factors – 6%) and religion (4%).

Screen-based activities were also investigated. Results show that 65% of children watch television more than three hours a day; 65% of boys and 35% of girls play personal computer (PC) games more than two hours a day, and more than 50% of children work on their PC more than two hours a day. The consequences are health complaints including headache, backache and irritability, with excessive work on a PC related to more health problems than watching television.

High consumption of soft drinks and energy drinks also causes problems. The study found that 25% consumed soft drinks daily and 20% regularly consumed energy drinks. The consequences of high consumption include health complaints, poor self-rated health, negative school experiences, aggressive behaviour such as bullying and fighting, and substance use (smoking and drunkenness).

The study is important, because it has a large and representative sample of adolescents and uses validated measures of adolescent health and of social and developmental context. Its cross-sectional design means that inferences regarding cause and effect are not possible. While based on self-reporting, which can be inaccurate or influenced by social desirability, previous research has shown it to be valid.

2.3 THE ALL WALES HEALTHY CHILD PROGRAMME

A gap opens up between the abilities of poor and prosperous children as early as two or three years of age. Giving every child the best start in life is crucial to reducing health inequalities across the life course. Action is needed to address the social gradient in children's access to positive early experiences. Later interventions, although important, are considerably less effective where good early foundations are lacking. Early action can bring cost effective benefits, not only by improving health outcomes and educational attainment, but also by reducing the knock-on costs of expensive health, social care, criminal justice and welfare support.

Poorer health behaviours in pregnancy, such as poor nutrition, smoking, drinking and substance abuse, can result in low birth weight, which is linked to poorer subsequent outcomes for the child. Breastfeeding has a positive impact on later health outcomes, but is less prevalent in more disadvantaged socioeconomic groups. Stress and mental health issues can make it harder for parents to bond with their children and to be positive. To reduce inequalities in children's health, well-being and achievement, the focus needs to be on all children, as well as offering the most vulnerable children and families additional support. Identifying children with high risk and low protective factors is necessary to ensure that these families receive more help.

Acting on this, the Welsh Government reviewed its various programmes to ensure that they work collectively to build resilience and especially support those who face the highest risk and have low levels of protective factors. The All Wales Healthy Child Programme will be a Wales-wide, standardized, cross-sectoral approach aiming at tackling the determinants of poverty and providing essential support. The aim is a universal service for all children and their families in Wales during the important first 1000 days, while also identifying and supporting families in need of additional support. Every contact should be regarded as an opportunity to engage parents and carers in taking steps to put children on the best life course.

The approach aims at a standardization of good practice, offering a prudent, systematic, evidence-based approach to health surveillance and screening. It places a major emphasis on parenting support and public health priorities. In some areas, introduction of the programme will cut the number of contacts between families and professionals; in others, the number of contacts will stay the same. The principle of proportionate universalism, essential services for all with more for those with greater needs, will also apply to those aged 3–7 years.

In the longer term, the vision is for an early years workforce, developed so that maternity services and health visiting will work closely with all other children services such as schools and mental health in order to deliver the range of preventative and early intervention services for different levels of risk and need.

Three elements will make the Welsh approach unique. The family resilience tool, currently under development, will ensure that all families are assessed in the same way at key contact times. An acuity tool will enable local health boards in Wales to take into account optimum caseloads linked to levels of deprivation and health inequalities. A single all-Wales record will be used to monitor and record all contacts, using common coding.

2.4 FLANDERS CHILD AND FAMILY POLICY FOR DIVERSITY

Kind en Gezin (Child and Family) (20) is a Flemish agency that works actively in the public health, welfare and family policy area. The agency focuses on preventive treatment and guidance of young

children aged 0–3 years geared to good outcomes in the future. The agency works to enable children to achieve their full developmental potential, physically, mentally, emotionally and socially, with respect for diversity and children’s rights. This principle holds for all the different areas in which it works.

The agency has a formal definition of underprivileged: a condition in which people are limited in their opportunities to participate adequately in high-level social activities such as education, housing, health and employment. Since 1995, an on-going method of registering this situation has been based on six criteria: income, level of education of the parents, development of the children, conditions of employment, housing and health. In 2014, 11.3% of children in Flanders, Belgium were identified as affected by three problems of this sort and deemed at higher risk of going into poverty.

The policy approach has five strands: a vision based on proportionate universalism; a range of different strategies; a range of different methodologies and instruments; training competences; and monitoring.

Two strategies relevant to the diversity policy are the family supporter and the house of the child. The family supporter is an expert by experience, with personal knowledge of issues by having faced social exclusion through poverty and/or migration. This fits the person for the task of connecting with socially vulnerable families, with other service providers and with the organization, to give children as many opportunities as possible and to support parents in achieving their family aims. They help the family understand what options are available and relevant and help interpret their wishes to services. Their challenges include setting their own boundaries, balancing between different tasks, maintaining communication with other service providers and training.

The house of the child is a family centre, operating as a network that integrates and coordinates a broad range of services providing family support. It is primarily for children aged 0–3 years but can help people up to age 24 if needed. In January 2015, 120 of these houses (Huizen van het Kind) covered 172 of 308 municipalities, all functioning as networks, and some have a physical building as a community resource. They work with current and future parents, children and young people, developing goals, setting minimum requirements and tailoring services to local conditions. The challenges include getting the right mix of services; ensuring they are coherent, integrated and of high quality and reflect the principle of proportionate universalism; and supporting user participation.

Supporting communication with users is important, and the agency uses a tool called Child in Pictures. This uses illustrations to explain key messages on topics such as care, nutrition, development, childcare and education to people with mental disabilities, people who are functionally illiterate, non-native speakers and others. Again, the prime beneficiaries are intended to be those aged 0–3. Careful attention has been given to reviewing how this is used to ensure that it supports families in the most effective way.

2.5 A PUBLIC HEALTH CAMPAIGN AND ROLE OF THE MEDIA – VACCINATION AGAINST HUMAN PAPILLOMAVIRUS (HPV) INFECTION

Health literacy matters greatly in terms of individuals finding and using information, support and help in taking control over their own health; in improvements in general population health outcomes; and in cost–benefit terms. People with lower health literacy use health facilities more, have lower drug compliance, pay less attention to disease prevention and generate higher health expenses. The media are often part of the problem.

Vaccination against HPV infection was recommended for several years in Croatia, but not funded by health insurance, so parents had to pay if they wanted it. The City of Zagreb was one of the first to offer

vaccination free of charge, and vaccination was available for those aged 13–14 years. In spite of the efforts and activities of doctors and nurses, vaccination coverage was very low, and the vaccination rate fell from 25% to 10% over a period of seven years.

A number of public health agencies (the Andrija Štampar School of Public Health, the Croatian Institute of Public Health and the Croatian League Against Cancer) joined forces to work with a daily newspaper, a popular radio station and two web portals aimed at young people, to improve the vaccination rate.

They organized a three-phase approach. The first, in December, aimed at raising awareness of the issues among the general population. The second phase, in January, built on this with particular attention paid to parents and on a campaign for action. The third brought in the young people themselves with four debates organized in secondary schools in Zagreb.

The campaign was a great success with young people pleased by their involvement in the process, and professionals were satisfied with the many positive reactions. At the end of the school year, the vaccination rate in Zagreb had doubled, and the Ministry of Health had agreed to fund these vaccinations in the future. As a result, the recommended vaccination against HPV infection became available from 2015/2016 for girls and boys aged 15 years old, free of charge, and on a voluntary basis.

The role of the media was important in opening up the discussion and creating a positive atmosphere in which discussions could take place, supported by consistent messages from professionals and role models. The approach allowed active involvement of the target groups and good interactive engagement.

2.6 CHILDHOOD HEALTH INEQUALITIES – EVIDENCE FROM THE DRIVERS PROJECT, 2012–2015

EuroHealthNet has set out its commitment to action to reduce health inequalities in and between countries, and acted as coordinating partner for the Determinants to Reduce health Inequity Via Early childhood, Realising fair employment, and Social protection (DRIVERS) project 2012–2015 (21), funded by the EU's 7th Framework Programme. That substantiated the evidence that ordinary or targeted services cannot compensate for the social gradient (the fact that the lower the social status, the worse health is likely to be), so structural actions are needed.

EuroHealthNet is concerned that child poverty is not adequately recognized in the work of the European Commission. It is working with the EU Alliance for Investing in Children to urge the Commission to implement the 2013 recommendation on investing in children: breaking the cycle of disadvantage (22) and to get the support of members of the European Parliament for action, including child poverty indicators in the social pillar.

2.7 DISCUSSION AND EXPERIENCES FROM OTHER REGIONS

One issue was whether support for children and families helped empower the community as well as families. In Wales, an assessment would look at both families and communities. The Flanders family centres are community-oriented and support neighbourhood networking.

A participant asked why vaccination had not initially been funded in Croatia. The reasons included cost, and concerns to protect children against early sexualization and to support personal responsibility and about adverse effects.

The relationship between poverty, poor communities and health was raised. Professor Mark Bellis, Director of Policy, Research and Development for Public Health Wales and Chair of the WHO Collaborating Centre for Violence Prevention at the Centre for Public Health, Liverpool John Moores University (United Kingdom), noted the need to distinguish between direct impact of poverty on health and what happens in poor communities that harms health. Even though poverty is hard to eliminate, action to deal with other issues must be pursued. The new All Wales Healthy Child Programme would be much more comprehensive in identifying people facing problems. Flanders was continually reviewing whether it was reaching all who needed help. Kaunas, Lithuania noted the importance of looking at changes across the life course and how people's needs at different ages meant that the agencies who could best help with health issues changed with the age of the population they served.

Three lessons were discussed.

- Early years have a powerful impact on later life.
- A wealth of evidence and data on which to base policy and services exists.
- A great deal of practical lessons can be learned from those who have already taken action and from those leading new approaches.



Session 3. RHN business meeting

3.1 TERMS OF REFERENCE AND MEMBERSHIP LETTER

New Terms of Reference were written to replace the Membership Agreement, which needed updating. After a process of consultation and authorization lasting two years, it was approved by WHO legal advisers in May 2015. The Terms of Reference were ready to be placed on the RHN website (23) and the Secretariat would send out a copy of it.

Some members had asked for a document certifying RHN membership. Discussions with WHO legal advisers had resulted in a proposal that each member write a formal letter to WHO expressing its wish to be a member, signed at the highest appropriate level, and that WHO reply with a formal response signed by the relevant Director or WHO focal point. The proposal for the Steering Group to agree on the wording of the letter by the end of December 2015 was accepted.

3.2 FINANCIAL SITUATION

Section 3 of the Terms of Reference, echoing the Göteborg Manifesto, commits members to working “in line with the values and principles of Health 2020” (24). This is important, because it opens the way for WHO to work with regions and for them to have common approaches. Sections 7–8, which acknowledge the role of regions in and beyond the health sector and the importance of RHN in supporting regions, provides a basis for engaging with politicians and other agencies in support of RHN’s objectives, and Section 11 sets out an agenda of actions.

Section 18 sets out the rules for paying fees, which, as Sections 21–22 suggest, support the Secretariat and RHN activities (publications, communication activities, meetings, etc.). However, the fee requirement is not extended to exclude members and specifically allow for a year’s grace if a member provides justification for not paying for one year.

All income from membership fees is used to support RHN, and WHO provides additional funding, for example, to support attendance of non-members at RHN meetings. A report on the annual budget would be presented as usual to the Steering Group by the end of November 2015.

Currently, 15 of the 25 recorded members have paid membership fees. Membership letters (see subsection 3.1) would help clarify membership status and provide an administrative record.

Kaunas asked about the possibility of meetings between regions, noting that the European Hospital and Healthcare Federation supports exchanges of that nature. Kaunas also suggested inviting mayors to the annual meeting. Dr Zambon thought that there would be more time to try different approaches at the 2016 annual meeting. Representatives of Flanders visited Wales in 2015 to follow up issues from the twenty-first annual meeting.

3.3 FORTHCOMING PUBLICATIONS

The purpose of preparing publications is to identify and make available best practices to members and beyond, and they were proving popular. WHO publicized them through its website (23) and the 7 RHN newsletters it issued. The Skåne report (3) was published in 2105, with three more planned for 2016.

3.3.1 Scaling up regional projects: Euregio Meuse-Rhine

This publication would be issued in early 2016. It would include case studies from Austria, Belgium, Israel, the Netherlands and Sweden. Additional material could still be included, and those present could attend the workshop on the matter (see section 6).

3.3.2 Sustainable development and health in Europe: Wales

The publication would bring together the United Nations Sustainable Development Goals (12), Health 2020 (2) and the EU growth and sustainable development agenda, identifying the implications for health and well-being and inequalities. An example of the first of its kind sustainable development legislation would be presented (the Well-being of Future Generations (Wales) Act 2015 (25)), as well as other regional case studies.

The purpose would be to provide relevant information, practical examples and to enhance understanding for national and regional implementation of the Sustainable Development Goals in Europe. The publication would suggest a coherent framework and possible pathways/approaches, linking sustainable development with population health and well-being across global, European, national and regional contexts and putting the Sustainable Development Goals into practice.

Wales, together with RHN, would lead the work over the period September 2015–September 2016.

3.3.3 Whole-of-government, whole-of-society and regional planning: Trento

The publication would address the health and development plan for Trento through to 2025. The health plan could be an example of regional implementation of Health 2020 in terms of its contents and method, and might be interesting for other regions, hence its planned publication in the RHN series. RHN members and the Regional Office's WHO European Office for Investment for Health and Development had been involved from the start, and had given very useful and valuable advice and support.

A participatory approach was chosen using a range of approaches such as an internet platform, face-to-face meetings, assemblies, world cafe and open space technology. In successive waves, experts and then citizens were engaged, with about 1200 comments, opinions and proposals received, two thirds of which were integrated in the draft health plan. The participatory approach was new for the province and untried, and the process used and its achievements might be useful for other regions.

The publication would document how the plan was developed, but in particular how to encourage people to understand that health is about a broad social agenda, not just about health services or the health sector, and how people can work together to serve a common purpose.

3.4 PROPOSAL ON A HUB AGREEMENT WITH RHN

Norway has 19 regions and 428 municipalities. The WHO Healthy Cities Network is a network of cities, regions and national networks that engages local governments in health and societal development. Its primary goal is to put health high on the social, economic and political agendas. It includes nearly 100 cities and 30 national networks across the Region with more than 1400 affiliated cities and towns.

Sunne kommuner (healthy communities or healthy municipalities) is the Norwegian national network with 26 members of all sizes (21 municipalities and five regions), spread across the country. It puts a high priority on a Health in All policies approach and action to address the social determinants of health and reduce or eradicate inequalities in health, working closely with politicians and decision-makers in a formal way, both at member and national levels. It organizes the biggest public health conference in Norway.

It is constantly looking for collaboration and partnership opportunities, and has noted RHN's new phase of development. Following discussions involving the steering bodies in RHN and *Sunne kommuner*, participants agreed that *Sunne kommuner* would have the status of a national network for RHN, enabling all interested Norwegian regions to join RHN in the same way a city joins the Healthy Cities Network. That would not prevent regions in Norway from joining RHN directly.

The benefits to *Sunne kommuner* would be to strengthen the regions' profile and its links to WHO, and to increase its profile and attractiveness. The benefits to RHN would be to strengthen its position and presence in Norway and test a new model of working.

Participants agreed this could be a model for other countries too, which reminded RHN members of the need to try to promote the benefits of RHN to other regions in their own countries. The opportunity to work with *Sunne kommuner* as a way of strengthening links to the Healthy Cities Network in other regions was also noted.

3.5 ØSTFOLD COUNTY PROPOSAL ON PARTNERSHIP AMONG UNIVERSITIES IN RHN REGIONS

Too little is known about what to do in practice to apply knowledge on reducing social inequalities in health in the very different contexts that exist at local level across Europe. Many initiatives are not rigorously and independently evaluated. To address this knowledge gap, Østfold County Council, Norway proposed a new idea involving universities.

With others, Østfold had worked in a two-year project with the Institute of Health Equity at University College London (UCL) in London (United Kingdom) and the WHO European Healthy Cities Network aimed at supporting local action to address health inequities. Taking into account lessons learnt from the UCL project, it proposed linking universities with as many regions as possible that will act as a driving force locally/regionally to reduce social inequalities and promote equity. The aims would be to link universities and regions, collect and disseminate good practice, and understand better what works best where. This proposed network of universities could share skills and experience and exchange staff.

Other benefits would include strengthening the ability of institutions to educate students on Health 2020, supporting future joint research projects and development strategies, promoting knowledge exchanges, raising university profiles, helping recruitment and linking the best institutions with others.

For its part, Østfold is considering a three-month placement for an official with UCL and is looking to strengthen international university links as bridges between practitioners, politicians and researchers. It is also examining how masters' theses might be better designed to address practical issues and generate population health benefits. The proposal was to prepare a concept note and determine the best way ahead.

Several regions indicated interest in the Østfold proposal. Kaunas noted that the efforts to support the development of health promoting universities in Europe. The Steering Group will take the proposal forward.

3.6 COMMUNICATION ACTIVITIES

Communication consultants at the WHO European Office for Investment for Health and Development are publicizing the work of RHN and the small countries initiative, using RHN's website (23) and newsletter, social media and links with the press. An article was recently published in a leading Italian newspaper. The RHN website is widely read, and the newsletter appears regularly, with an increase in subscribers from under 200 to nearly 700 in a year.

Characteristics of the media that members needed to understand and respond to include their short-term perspective linked to the political cycle, and general lack of interest in long-term societal processes. Disease prevention and health promotion are not seen as newsworthy. The media focuses more on emergencies, on events rather than processes and on negative rather than positive news. Journalists may lack specific skills in public health and on data interpretation.

This can be countered by providing capacity-building opportunities for journalists, covering issues such as health inequities, non-health components of health problems and health intelligence, and creating a media network. Therefore, a meeting with local journalists was organized in Andorra on Health 2020 and health inequalities, and the WHO European Office for Investment for Health and Development is willing to do the same in other regions.

RHN is also present on Twitter (@WHO_Europe_RHN), with some 870 followers and continuous engagement. The goals are dissemination of information, with 3–4 news items tweeted a day drawn from a variety of sources, and story-telling to explain what is happening in different countries. The WHO European Office for Investment for Health and Development can help provide Twitter support for events organized by RHN members if requested.

3.7 REPORT FROM THE WHO REGIONAL COMMITTEE FOR EUROPE

The WHO Regional Committee for Europe has for many years invited a RHN representative to attend its annual meeting as an observer; Elisabeth Bengtsson, Director of Public Health from Region Skåne, Sweden represented RHN as an observer at the 65th session in Vilnius, Lithuania in September 2105. The meeting was attended by ministers and high-level officials from the 53 Member States in the Region and by other interested parties such as networks and nongovernmental organizations.

Health 2020 was very high on the agenda, with a great deal of discussion of the role of sectors outside health, including the role of the education ministry and the finance ministry. *The European health report 2015* (26) was discussed with priorities for health system strengthening in the European Region 2015–2020

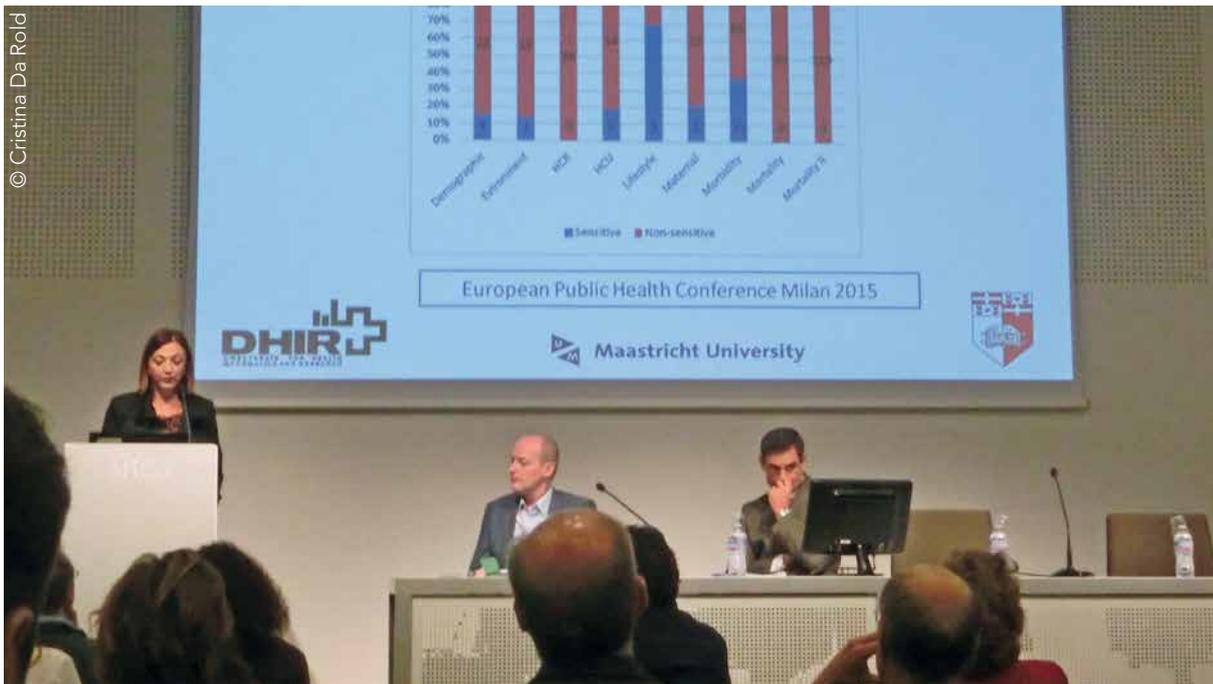
Physical activity was also given great importance, in view of its role in obesity and mental health and a new WHO European Region physical activity strategy 2016–2025 (27) was discussed. Europe is the region with the highest smoking rates and hence the new roadmap of actions to strengthen the implementation of the WHO Framework Convention on Tobacco Control in Europe 2015–2025 (28) also received great attention.

Her Royal Highness Crown Princess Mary of Denmark, Patron of the Regional Office, spoke passionately about health issues from personal experience. WHO Director General, Dr Margaret Chan, said she was proud of the efforts made in Europe. The WHO Regional Director for Europe emphasized the importance of Health 2020 as a platform for progress.

The point was made many times that Health 2020 requires action at regional and local levels, and that sometimes real collaboration is easier at those levels. It would be very positive if the observer representing RHN at the 66th session could make a brief statement in support of that position.

3.8 THE TWENTY-THIRD ANNUAL MEETING

The Steering Group had agreed that Kaunas would host the next annual meeting, to take place on 22–23 September 2016. The co-chairs thanked Kaunas.



Session 4. Tackling health inequities at subnational level: grounding actions on data

4.1 DATA PROFILING AND SOCIAL MARKETING CAMPAIGNS SUPPORTING HEALTH EQUITY AND POVERTY REDUCTION STRATEGIES

Saskatoon Health Region in Saskatchewan, Canada has a more than Can\$1 billion budget, 15 000 employees and comprehensive health services for the population plus a provincial referral centre for most tertiary care. The problems and scale are similar to many a European region.

The Public Health Agency of Canada says that population health necessarily includes targeting material and social inequalities and the benefits “therefore, extend beyond improved population health outcomes to include a sustainable and integrated health system, increased national growth and productivity, and strengthened social cohesion and citizen engagement” (29).

Achieving this requires a shift from producing large reports in traditional format, which are largely unread, to shorter, more frequent reports including recommendations for action and discussions with the target audience to fine tune the format and content, and to assist in understanding and ownership. Technology gives the opportunity to offer simple infographics backed up by one-page documents with hypertext links to detailed tables and summary recommendations (31).

In Saskatoon, much use is made of visualization – infographics and maps. A matrix is used to identify trends that require most attention, based on analysing disparity rates (rates recorded for different neighbourhoods ranked by income quintile). This coupled with the move from full reports issued every four years to regularly updated data and regularly published mini reports, with periodic recommendations and presentations to policy-makers and the media, has resulted in greater understanding and better uptake by the media, the government board and decision-makers.

Saskatoon Health Region’s Public Health Observatory has been gradually built up over 15 years to include 12–14 staff including epidemiologists, a geographic information system analyst, a policy analyst, research assistants, a knowledge transfer specialist and a database analyst, with university partnerships and cross-appointments for population health intervention research. “Bringing knowledge into action” (30) is an explicit objective.

Social marketing activities include social media (Twitter, blogs, YouTube videos, websites), advocacy, letter writing to politicians and presentations to the policy committee of government. Providing usable data to advocacy groups strengthens their ability to promote action, for instance, on poverty, which is estimated to cost the province Can\$ 3.8 billion but could be alleviated for Can\$ 1 billion (32).

Results in the health sector include equity audits and improvement cycles that are addressing inequalities. Equity is embedded in the health system performance management framework, and a health equity index measures progress with targets each year. Equity is also present in improvement and Lean activities and in planning and primary care development. Broad results include help in moulding the priorities of the Saskatoon Regional Intersectoral Committee, which supports action in areas such as homelessness, poverty, Aboriginal employment and early childhood development, and changes in public awareness and investment policies.

4.2 THE ROLE OF UNIVERSITIES AND RESEARCH INSTITUTES IN CREATING REGIONAL PROFILES ON HEALTH INEQUALITIES

Regions need a strong evidence base to tackle inequalities in health. Usually health inequalities on national and regional levels in Lithuania are measured through the Health Information Centre of the Hygiene Institute of the Ministry of Health in Lithuania. Annual reports include standardized mortality rates for the 60 municipalities and the country. Other universities and research institutes also have an important role.

Research studies include the HBSC study of schoolchildren (see subsection 2.2); the Finbalt Heart Monitor, which surveys health behaviour among adults (20–64 years, every two years since 1994) in Estonia, Finland, Latvia and Lithuania; the national registers of cancer and diabetes; a myocardial infarction and stroke register in Kaunas; and research programmes with evaluation of noncommunicable disease risk profiles (Countrywide Integrated Noncommunicable Diseases Intervention, the Heredity and Phenotype Intervention Heart Study, the Kaunas-Rotterdam Intervention Study, the WHO monitoring trends and determinants in cardiovascular disease project, etc.).

The Finbalt Health Monitor includes a Lithuanian national random sample of about 3000 people. It shows that in the period 1994–2010, overweight and obesity rose only among Lithuanian men aged 20–64 years and not among women. The proportion of people eating fresh vegetables daily rose in the period 1996–2010. While the proportion of men drinking whole milk fell between 1994 and 2010, there are marked differences depending on the place of residence, with the highest consumption in villages, lowest in cities, and middling in towns (33). While data collection may be good, interpretation of results is sometimes poor, because presentation of the data is poor.

The discussion identified potential pitfalls in having poor data and poor data interpretation and in making judgments on small data sets.

4.3 USING KNOWLEDGE FROM RESEARCH TO INFLUENCE NATIONAL STRATEGY ON ROMA HEALTH

The 400 000 Roma who reside in Slovakia form the largest percentage of Roma in any European country (8%). About half live in 500 disadvantaged and segregated settlements. They have low educational attainment, high unemployment and poverty, and very poor living conditions, especially those living in settlements. The results for those affected are low socioeconomic status and poorer health, though other Roma are well integrated and relatively healthy.

In 2011, the community-based HepaMeta participatory research study on hepatitis B/C and metabolic syndrome was conducted in two regions in Slovakia (34). It aimed to explore differences in health and health-related behaviour between the population living in Roma settlements and the majority population, and to assess the contribution of selected socioeconomic characteristics and living conditions to health and health-related behaviour within the population living in Roma settlements.

The study found many differences in health conditions between Roma and non-Roma including the settlements having worse education, unemployment and living conditions; poorer health; poorer eating habits; higher smoking levels; less physical activity; and more cardiovascular disease risk factors. However, among Roma respondents, health and health-related behaviour were not found to be associated with socioeconomic status. This implied differences had some other basis, and health literacy level was suggested as a cause (34). As a result, the national strategy on Roma health added an aim on monitoring and promoting health literacy in Roma settlements.

The Department of Health Psychology, Faculty of Medicine at the P. J. Safarik University was invited to comment on the existing strategy in the light of the new evidence. They suggested reformulating the goals and measurable outcomes, and expanding its scope. They proposed monitoring the health status of people from marginalized Roma communities, their living conditions, access to health care and health literacy, and the interventions aimed at attaining health goals. They recommended analysis of health differences between these communities and the general/non-Roma population and of data from existing databases (national registers), as well as a survey of health differences, determinants and interventions. They proposed creating a portfolio of health indicators and a map of health risks to reflect the results from these analyses, and a health mediation programme. This enabled the strategy to be better focused. In addition, Roma are to be involved in future strategy development.

4.4 ASSESSING PREVENTION ACTIVITIES FOR AT-RISK ALCOHOL CONSUMPTION

Alcohol-related harm is a public health priority, contributing to mortality in many different ways, with Europe highest in suffering alcohol-attributed mortality (6.5% of its total mortality). Consumption is a little lower in Switzerland than in Europe generally, and Ticino has a higher abstention rate than the rest of Switzerland. Harmful drinking is on the rise among young people and women in many Organisation for Economic Co-operation and Development (OECD) countries, partly due to alcohol becoming more available, more affordable and more effectively advertised, according to a new OECD report (35).

Ticino has lower levels of at risk drinking than other parts of Switzerland though chronic drinking is slightly higher. A notable fact is that medium high-risk drinking has fallen for men in Ticino but is higher among women over the age of 50. The cantonal alcohol action plan 2015–2018 aims to address this, with a vision of harm-free alcohol consumption. A mixed set of approaches are used to address the problems, and a notable innovation aimed at reaching the women in the over-50 target group is to use folk drama, a popular entertainment in the canton. This has been piloted and identified as an option for wider use.

4.5 HEALTH RELATED INTEGRATION, PARTICIPATION AND SOCIAL MOBILITY: THE ØSTFOLD COUNTY HEALTH PROFILE 2011

Østfold County Council in Norway conducted a health profile through self-administered questionnaires in all its municipalities to support their development and targeting of public health initiatives and interventions, with a special focus on health inequalities to identify those groups lagging behind.

The profile was part of an EU-funded project (HEPROGRESS (36))¹ conducted in parallel in Norway and Latvia, and involving Finnish partners as well. In Latvia, long term activity limitations were few among the young but increased through age showing a social gradient. In Norway, the gradient was already present among the young but overall did not increase with age. Evidence showed that poor health among young people in Norway harmed their education and career prospects. This is potentially an important and troubling finding.

¹ The Reducing health related social and gender inequalities and barriers to social and economic participation – Evidence based local policies, interventions and empowerment planning (HEPROGRESS) project is managed by the Directorate-General for Employment, Social Affairs and Equal Opportunities of the European Commission.

During planning, some favoured including migrants or non-Norwegian ethnic groups in the profile, but this was not done for two primarily methodological reasons. First, because of language and cultural differences, a separate questionnaire would be needed for each specific group translated and adapted to meet their needs and probably with different information strategies. Second, because of their relatively small numbers in the population, a separate specific sampling frame would be needed to secure statistical efficiency of ethnic specific analyses. This would have been too complicated and expensive.

Statistical data only make sense when compared to a relevant reference group or benchmark. To secure valid interpretations of figures, migrant workers, for example, should be compared both to the population of their home country and to the population of the host country. This can reduce cultural bias (arising because people understanding the questions in different ways related to their background) and selection bias (arising because the migrant population may not be representative of the larger population).

A proposed response to these two problems, allowing quantification and adjustment, is to conduct the profile in a *triangular mode*, using a profile of the migrant population, a profile of the host population, and a profile of the population of origin developed and conducted simultaneously and coordinated in a common project.

Østfold suggested joining others to discuss the idea of a triangulated migrant survey in different languages and to possibly develop a common project and seek funding. The contact point is Knut-Johan Rognlien at Østfold County Council who may be reached by email at: knurog@ostfoldfk.no.

Eurostat has already collected relevant health data and other data from surveys, which could be used in this triangular approach, from its member states and other European states that work together with it. During informal talks after the presentation in subsection 3.5, it was proposed to further develop the use a triangular survey as a task for the proposed partnership among universities in RHN regions.

4.6 CONCLUSION AND KEY MESSAGES

The last two sessions of the annual meeting represented the two aspects of RHN – the business meeting considering developing better ways of working together and the presentations on inequalities offering concrete examples of exciting practice.

In this phase, RHN was becoming more professional, and provided a forum for sharing problems, experience and evidence. There was great creativity in thinking how best to do that, with members becoming a network of champions for change. The recent emphasis on publications offered a valuable new approach, enabling regions to raise their profile both at home and through WHO and providing evidence and inspiration to others with similar challenges. RHN offered its members evidence of what can be achieved and reassurance that effective action is possible.

Part 2. Additional sessions at the 8th European Public Health Conference

Session 5. Joining forces: citizens and regions for better health

Following the meeting, RHN organized and presented three sessions at the 8th European Public Health Conference (see Annex 2).

5.1 INTRODUCTION

This session presented the importance of participatory approaches for the implementation of the WHO policy framework for Europe, Health 2020 (see subsection 1.1). After a theoretical review (see subsection 1.2), the presentations reflected the six key messages (Box 1) that emerged from the Skåne report, *Taking a participatory approach to development and better health: examples from the RHN* (3).

5.2 DEVELOPMENT AND BETTER HEALTH IN SKÅNE – TRUST AND INVOLVEMENT

This session presented the Skåne report that WHO recently published based on work in Region Skåne and other European regions. The publication was produced in a participatory manner, with many contributors. Two lessons emerged from the work in Region Skåne.

The first was to **trust the process** of working with others. One can never start a major social initiative in a vacuum. A lot of history exists in the background, with a lot of other activity and processes going on. The convenor of any major social project should, therefore, be willing to allow others to find their own way into discussions, accepting that new participants may not understand all that is discussed.

The second was to **involve and empower other sectors**. Others should be included if the aim is to engage wide elements of society, even though this will not be easy. But the benefits will outweigh the problems.

The initiative in Skåne was the Skåne Regional Development Strategy – *The Open Skåne 2030* (37). Traditionally such strategies had focused on business and infrastructure, but this time the decision was to have a more open, social approach. Those with a health interest had wondered whether they might be marginalized, but the process allowed many voices to be heard and the case for health was made from many sides.

It was a large participatory process, starting with political dialogues lasting more than 18 months, a series of 35 seminars with 1300 participants from 2013 to 2015, and citizen dialogues including focus groups and secondary school scenarios. The Skåne panel included 4000 citizens. Statutory agencies took part in consultation rounds.

The outcome was five prioritized positions for the region. Skåne shall:

- offer optimism and quality of life
- be a strong, sustainable growth engine

- benefit from its polycentric urban structure
- develop the welfare services of tomorrow
- be globally attractive (37).

Region Skåne's Public Health and Social Sustainability Unit produced an action plan linked to the strategy, and identified priority areas where sustainability, public health and other sectors' interests coincide. These are public health reporting, employment and skills, diversity, growth and health, culture and health, participation and influence, social sustainability in physical planning, environment and health, and health promotion in health care.

The challenge now was to ensure that the benefits derived from the participatory approach were sustained into the future.

5.3 SUSTAINABLE DEVELOPMENT AND HEALTH IN WALES – FINDING A COMMON PURPOSE

This session presented the creation of a piece of sustainable development legislation in Wales, the Well-being of Future Generations (Wales) Act 2015. That placed a legal duty on the Welsh Government and 43 public bodies to act individually and together to maximize well-being in Wales. It bound them to a legally-binding common purpose – a better quality of life for future generations – and to new sustainable ways of working. Guidance was in development to support its implementation and to help make sustainable development the central organizing principle for the public service.

The process of finding a common purpose and creating ownership started with a national conversation on the theme of “The Wales we want” (6). This aimed to involve groups and individuals across the country: schools, women's groups, universities, businesses, etc. and targeted cultural sporting events and youth groups. It used a variety of media, including the internet, postcards and young people as champions. Emerging messages were monitored and fed through to ministers and their officials.

Seven goals emerged, shaped by people across Wales: a prosperous Wales; a resilient Wales; a healthier Wales; a more equal Wales; a Wales of cohesive communities; a Wales of vibrant culture and thriving Welsh language; and a globally responsible Wales (25).

Each of the public bodies must set objectives for meeting its goals, reflected in local plans and based on engagement with the local community. The new way of working requires all listed public services to adopt a long-term approach, to consider prevention and to apply to their work the principles of integration, collaboration and involvement.

The Act requires Welsh ministers to publish a Future Trends report within twelve months following a National Assembly election, in order to understand the challenges faced by the country. Support, monitoring and accountability structures, based on the goals and principles, are also built into the legislation. The session ended with a quotation from Nikil Seth, Director, Division for Sustainable Development, Department of Economic and Social Affairs, United Nations, “what Wales is doing today the world will do tomorrow” (38).

5.4 HEALTH STRATEGY DEVELOPMENT IN THE AUTONOMOUS PROVINCE OF TRENTO – LEADERSHIP AND KEEPING FOCUSED

The Autonomous Province of Trento's health plan 2015–2025 represents two firsts: the first strategic health plan in the region and the first time a participatory approach has been applied. That approach meant that the current version of the plan was very different from the first draft produced a year earlier.

Up to two years ago, apart from the annual objectives assigned to the Local Health Unit, no comprehensive strategic health plan had been developed in the region in 20 years. Annual epidemiological reports were rich in data on services but thin on underlying causes. A few experts set objectives and goals that were exclusively related to the health sector.

The first steps were to change the health report to focus on social determinants, population health conditions and risk factors, making the language simpler and more accessible for all. It also highlighted the importance of health promotion and the case for a Health in All Policies approach in planning. A training course on public health planning was organized in collaboration with the Regional Office's WHO European Office for Investment for Health and Development in Venice, Italy.

Clear political leadership, with a newly elected health councillor, supported the strategic and participatory approach, and technical, high-level leadership and local support enhanced the participatory approach. Having a broad cadre of leaders is vital, not least because of sceptics.

Doubts existed as to whether the participatory approach would work, but the availability of the first draft showed that it could work, and support and reassurance from other RHN members was very helpful. Despite the loss of the political lead, the process kept on course, with a wide variety of means and methods and support from WHO, and the process has proved to be successful.

5.5 HEALTH POLICY AND STRATEGY IN THE AUTONOMOUS COMMUNITY OF ANDALUSIA – COMMON PURPOSE

The Autonomous Community of Andalusia has to develop a health plan every four or five years, and even before Health 2020, was considering basing its plan on the Health in All Policies approach, the social determinants of health and equity issues.

During the development of the plan, 28 social and administrative authorities participated in working groups; 77 representatives of social and administrative actors and authorities were invited to a workshop, and 33 bodies and organizations were requested to submit a report. Local participation took place in over 100 municipalities.

The lessons in terms of the theme, finding a common purpose, were that health equity in all policies is a powerful idea that is well accepted and acknowledged by other sectors. This enabled the process to survive four significant political changes. Timing was an issue, and existing well-established systems such as budgeting could be used creatively. In addition, health impact assessment is mandatory in the region, and community participation is a required element. Collaborating with local authorities in designing and implementing health plans can bring people together around community health needs and assets. The approach must differ across sectors according to their culture, and more needs to be done to ensure vulnerable communities are fully involved.

5.6 DISCUSSION AND EXPERIENCES FROM OTHER REGIONS

The presenters agreed that the messages from the Skåne report had been applicable in all the regions discussed and had proved to be very relevant despite differences in culture and tradition across the regions. Transfer learning in one region to another was possible; for instance, the lesson that putting representatives of narrow interest groups together enabled them to find common interests and constructive proposals.

The discussion raised certain points.

- A lack of theoretical understanding of participation exists, for example, looking at the difference between countries with national health systems and insurance systems and between choice-based and prescriptive systems. Also lacking is the importance of differing levels of trust in government on participation and its differing impact across groups. It was suggested that theory was being generated through evaluating practical examples.
- There is a shortage of documented examples showing that policies based on participatory approaches prove more resilient in the face of political changes.
- A pragmatic approach to manage the involvement of potentially aggressive groups in discussions on sensitive or controversial matters, such as Roma health or immigration, might be to exclude groups who are by nature exclusionary and closed.
- To address the potential problem that extensive participatory approaches might generate an excessive number of issues requiring attention, the most important point is to be transparent and accountable in selecting which should receive priority consideration.

Session 6: Scaling up (pilot) projects successfully – lessons from theories and experiences

6.1 INTRODUCTION

This session was organized on behalf of euPrevent, Maastricht University in the Netherlands, RHN and the European Public Health Association section on public health practice and policy.

The topic was chosen, because of the importance of spreading good practice, so as to make the best use of scarce resources. Certain questions were continually posed. Can something that works well in one place work in another and, if so, what factors need to be taken into account? What influences the successful transfer of practice from national to regional or local level or vice versa?

6.2 EFFECTIVE SCALING UP – RECOMMENDATIONS FROM LITERATURE

This session looked at how regions can increase “the impact of successfully applied policies, programs and projects ... in order to reach a larger number of beneficiaries” (39). The goal was to contribute to a RHN publication that is useful for those who want to do this, and certain questions should be answered. Which theories, frameworks, concepts, tools etc. are helpful? Who (practitioners, policy-makers, researchers) needs what?

A literature search identified a guide produced by a group in Australia (40) and a systematic review (41), which disclosed that the scientific debate is relative new, though the number of publications is growing. The focus is often on low and middle income countries. Publications differ in terms of definitions, focus and their underlying models/ frameworks.

A useful working definition is “deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and programme development on a lasting basis.” (42).

Distinguishing between expansion and replication and the problems of each is possible. Expansion from small to large scale carries a number of challenges, as the task moves out from a small group of well-motivated and informed participants to a larger group with more mixed understanding and motivation and different or mixed values (43).

Replication involves moving from an environment with actors, capacities, tasks and motivation to another potentially quite different, raising many questions about differences in knowledge, understanding and culture.

The Australian guide identifies four stages in transfer: assessing scalability, developing a scaling up plan, preparing for scaling up and scaling up, each of which has defined components. It is very logical but may not reflect usual practice in the field. Other tools are also available (44).

It is claimed that the possibility to create space for growth exists, which might increase the overall ability of the system to absorb transfers. This would involve looking at a number of areas including fiscal space (including changes in costs per unit), political space (visibility and resistance against scaling up), policy space (the regulatory and legal framework), organizational space (willingness, ability), cultural

space (culturally sensitive services), partnership space and learning space (a learning-by-doing culture, adaptation, flexibility, openness).

Points raised in discussion included:

- the fact that it is easier to mandate changes from the centre as it has national political authority behind it, but scaling up may be more difficult;
- the importance of leadership and of the presence or absence of an organization with a clear mission to support change;
- the need to consider the likely influence on implementation of local and national culture;
- timescale as an issue, with a formal measured process being less likely when transfer is forced or rushed; and
- the similarities to the points already made to issues in the literature on project management and dissemination of innovation.

6.3 THE SCALING-UP SURVEY: AN EMPIRICAL CHECK OF THEORETICAL ASSUMPTIONS

A questionnaire (Box 2) was used to investigate issues around upscaling among RHN members, based on a similar design to those used in other cases by the North Rhine Westphalia Centre for Health.

Box 2. General project information of RHN questionnaire

The questionnaire requested information on:

- a project's transfer to or adoption from another region
- target groups
- project description: main subject(s), motive, needs assessment, objectives/outcomes
- project conditions
- project evaluation
- extent upscaling project elements including project modifications
- promoting/hindering factors

Out of 23 responses, seven were scaled down and 16 scaled up to a higher level or wider (e.g. from regional to national level), with 14 implemented at regional level.

The survey was small and drawn from a single network, with a bias towards local/regional projects and to successfully implemented projects. The majority of the reported projects were implemented at the regional/local level. The target groups were health professionals and specific population groups, and covered a large range of public health issues.

The 13 identified promoting factors in the questionnaire were reported as very promoting for the projects, noted as such by 45–100% of respondents. The most important were personal commitment of the project partners and a recognizable benefit for the population. The main hindering factors were financial issues and the amount of existing administrative work. Analysis linking the promoting factors

and the project conditions confirm the importance of project partners' personal commitment, support with funds and adequate political support both for scaling projects up and down.

Points raised in discussion included:

- the possibility that responses might have been different had someone else with a different role in the project completed the questionnaire;
- the need to understand how to increase motivation; and
- the need to ensure that extending initiatives to include more people will not increase inequalities or leave them untouched.

6.4 SCALING UP IN PROJECTS: THE DECLINING AGEING AND REGIONAL TRANSFORMATION (DART) PROJECT

The DART project arose because demographic changes in Europe, including ageing and rural depopulation, require innovative solutions. The DART (45) partner regions aimed to be forerunners in Europe in identifying these solutions and spreading their use. Lower Austria joined because it had increasing life expectancy and a decreasing birth rate, and very uneven population development with people moving out of rural areas.

The project involved 14 partners, 13 European regions and 11 countries focused on three thematic fields: the traditional and innovative economy; education, lifelong learning and the labour market; and health care and social services. The target for the project period was to identify 26 good practices and transfer 13. In fact, 89 good practices were identified and described.

Initially, preparatory meetings with discussion on the topics of common concern were held. Subsequently, workshops were held to identify good practices and proposals and to permit group work and assessment of proposals. The topic and number of the selected good practices were: economy – 6, education – 11, health – 5 and social services – 4. These were examined in study visits to the relevant hosting region.

The practices were presented in thematic conferences and after each of these, evaluation workshops matched source and target regions and drafted recommendations on European, national and regional/local levels. On health, DART searched for a qualitative solution related to three areas: fostering good health in an ageing Europe, protecting citizens from health threats, and supporting dynamic health systems and new technologies.

Lower Austria was particularly interested in a pilot project to address a regional shortage of health care workers in Limburg, the Netherlands and visited them in 2012 to learn more about it.

Two important lessons on project management were identified. The first was the way in information sharing was organized. Communication, dissemination arrangements, roles and processes were well defined. The other was the attention to system readiness. The focus was very much on learning from other regions with similar problems; in Lower Austria, leadership was top-down, with vital political support, and careful involvement of all the stakeholders needed for implementation.

6.5 PROMOTING SCALING UP IN BORDER REGIONS – euPREVENT

Euregio Meuse-Rhine (EMR) is an area where parts of the Netherlands, Germany and Belgium had agreed to work together as one. It includes 3.2 million inhabitants, three languages and five cultures. Despite huge policy differences, cross-border cooperation was needed for many practical reasons, and the area offered a natural laboratory for cross border cooperation and scaling it up.

Initial collaboration on health had focused on acute care but in the last 10 years, public health had come to the fore and is now one of five priorities of EMR. Innovative approaches had been developed, and well-established networks and bases for collaboration had significant experience scaling up successful interventions and projects.

To strengthen this work, cross-border actors had established a separate entity to support preventive action called euPrevent, involving some 50 health organizations. It aimed to bring together practice and science to improve the quality of life of the inhabitants of EMR via cross-border public health activities. It had a bottom-up approach, focusing on helping partners overcome differences in structures, decision-making processes, and internal communication and external collaboration processes. It acted at local and regional levels.

Examples of rescaling activities included transfer from the local to the regional level or to other localities, transfer from the regional to the local level or to other regions, and innovations from the EU level to the regional and local levels.

A structure like euPrevent can mitigate some of the general hindering factors in scaling up, like difficulties in applying for funds, the volume of administrative work and the search for project partners. It can also address some specific cross-border hindering factors, like language and legal problems.

Regarding tools and theories, practitioners do not generally work through a series of steps in transferring practices to their area, but simply pick them up and try to apply them. euPrevent can help them manage this. It can also help when administrators impose change on local practitioners, so practitioners achieve effective outcomes despite a potential lack of motivation.

Even an organization that is, in general, a so-called innovation system fit – open to and ready for innovation – may not easily be able to adopt innovation from a neighbouring country. Cultural differences are important as well.

In cross-border situations, dedicated time and resources are essential. Needs, motivation, values and goals may be subtly different in adjoining regions in different countries, and personal and political factors matter greatly. Having an organization that is attuned to the differences and can help is crucial.

6.6 CONCLUSION

Closing suggestions from the speakers on how best to succeed in rescaling were:

- just start, looking for good entry points;
- look at the available tools and ask others with experience;
- identify all the stakeholders and get them round a table; and
- start with a proposition that is attractive, but with a clear understanding of what makes it attractive.

Session 7. Quality health information systems in small European countries and regions

7.1 INTRODUCTION

This session was jointly organized by the Islands & Small States Institute of the University of Malta; the WHO European Office for Investment for Health and Development in Venice, Italy; and the European Public Health Association section on public health monitoring and reporting. The session was particularly important to support the eight countries in the small countries initiative (1).

People understand what they measure. Data and information are essential for evidence and policy-making, evaluation and management, and should be available when needed and comparable. Small states and regions have certain advantages relating to information such as high coverage and relatively short distances to bridge between those responsible for statistics and policy. They also have disadvantages, such as limited resources, but often face the same demands for information as larger, better resourced peers.

7.2 EUROPEAN HEALTH INFORMATION INITIATIVE: RECENT DEVELOPMENTS AND RELEVANCE FOR SMALL COUNTRIES

This session presented how WHO can help small countries and others with information, especially regarding harmonization.

Small countries tend to have low levels of mortality and high life expectancy, and good health information systems with high-quality data and high population coverage. Yet three countries did not report to WHO on the majority of Health 2020 monitoring indicators in 2014, and five countries reported data that, for some indicators, were 3–4 years old. Two particular issues for small countries were that small changes in incidence could produce high fluctuations in rates year on year and the heavy burden of reporting demands from multiple organizations. Not all of these requests were appropriate or well-coordinated. Following a request from ministers of countries participating in the small countries initiative, WHO is undertaking an internal mapping of survey requests and establishing a gatekeeper function to reduce their number.

Several general issues were raised. Despite the importance of health information, evidence and knowledge is dispersed, incomplete and difficult to access. Health information activities often lack sustainable funding, and international data collections are poorly harmonized. Persistent health information inequalities exist.

Hence, WHO and the EU agreed in 2010 to collaborate on working towards a single integrated health information system for WHO's 53 European Member States, and OECD joined as a partner in 2012.

The resulting European Health Information Initiative (46) is a multipartner network providing guidance for health information activities in and partners across the WHO European Region. The six key areas for action it identified are:

1. development of information for health and well-being with a focus on indicators;
2. improved access to and dissemination of information;

3. capacity building;
4. strengthening of information networks;
5. support for health information strategy development; and
6. communications and advocacy.

A workplan and next steps were agreed, and an extensive mapping exercise of existing indicator sets looking at quality, feasibility and relevance has begun.

A number of health information networks support this work, including the Evidence-Informed Policy Network launched in the European Region in 2012 to improve use of research evidence in policy-making using multistakeholder country teams and small country networks. Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan formed the Central Asian Republics Health Information Network, and the South-eastern Europe Health Network is also discussing setting up a health information network.

The benefits of small country networks are that they offer a strong platform for the exchange and mutual support of countries with common systems, history and epidemiology, and they can promote joint priorities, joint reporting, joint capacity building and quality improvement, and a stronger regional presence.

At a meeting of ministers of countries participating in the small countries initiative in September 2015, chaired by the Minister of Health of Malta, it was agreed to establish the Small Countries Health Information Network. Terms of reference and a scope and purpose were agreed, and the next stage is for countries to nominate network focal points, with a first meeting scheduled for early 2016.

The Regional Director wishes to see countries actively engaged in the European Health Information Initiative, and small countries can do so effectively and efficiently through the chairs of these networks playing a part.

In the discussion, it was noted that small was a relative term. The small countries initiative includes those with a population of less than 1 million, but larger countries had similar challenges.

7.3 FACTORS AFFECTING DATA AVAILABILITY IN THE EUROPEAN REGION – POPULATION SIZE

The United Nations uses 1 million people as a criterion for small; the European Commission uses 1.5 or 2 million and scholars often use 3 million, indicating the lack of a commonly agreed standard. Population was a better measure than gross domestic product (GDP) or territory in the field of health, as health relates to people.

Timely, publicly available, comparative health data is important for health system assessment, assessing progress with the objectives of Health 2020 and to support policy-making and evaluation. This is especially true when, as recently, an economic crisis can so quickly and badly affect mental and child health.

The Islands & Small States Institute of the University of Malta, the Department of International Health at Maastricht University in the Netherlands, and the Directorate for Health Information and Research of the Ministry for Energy and Health in Malta jointly conducted a study. The study used a three-level population split, a pragmatic analytical approach, using a threshold of less than 3 million as small, between 3 and 30 million as middle and over 30 million as large.

The study's objective was to explore potential predictors influencing data availability in the European Health for All Database, chosen because it was the richest and fullest international health database.

The indicators chosen were:

- demographic and socioeconomic
- mortality-based
- morbidity, disability and hospital discharges
- lifestyles
- environment
- health care resources
- health care utilization and expenditure
- maternal and child health.

A score was allocated to each country based on the availability of data in the European Health for All Database for the years 2010, 2011 and 2012.

Multiple regression analysis looking at three factors found that EU membership was a significant determinant of data availability for over 60% of the indicators reviewed; GDP accounted for nearly 14% and population size for less than 6%. GDP was most relevant for data on lifestyle, where smaller economies had poorer data quality.

The study concluded that important differences in data availability exist between European countries. EU legal obligations and GDP appear to be important in influencing data availability. Population size does not appear to determine data availability, with the exception of rare diseases and rare events.

The study questioned whether there is an inverse data needs phenomenon: countries with lower GDPs, lower health status and less developed health care systems have weaker health information systems even though their need for timely, accurate health information is paradoxically more pressing.

EU legislation requires development in health information systems.

Comments after the presentation confirmed that many small countries felt so-called survey fatigue through a constant stream of requests for information and wanted some relief.

7.4 A WEB-BASED SYSTEM GLOBALLY MONITORING RARE DISEASES: THE EXPERIENCE OF VENETO REGION, ITALY

Rare diseases are a numerous and heterogeneous group of 6000–8000 conditions involving all ages, aetiologies, and body systems and functions. For those affected, the results can be severe, often with chronic, disabling problems; yet information is poor and therapies are not consistently available. Though rare locally, many people were affected across Europe, so it constituted a public health priority at European level.

Because only about 500 rare diseases are listed in the International Classification of Diseases, tenth revision, many diseases are invisible in conventional information systems. The nearly 600 registries

across Europe may be a problem in itself. Population-based registries do not need to monitor single rare diseases, but a group of unrelated rare diseases. Population-based monitoring systems are needed to collect and provide information on rare diseases for clinicians, patients, industry and policy-makers.

A 2001 Italian law on rare diseases established a list of diseases and a benefits system linked to confirmation of diagnosis by a small number of selected centres of expertise. It required the designation of centres of expertise for specified groups of rare diseases and set up rare diseases regional registries. The information system established in Veneto Region brings together patients, benefits entitlement and treatment details, and links centres of expertise, local health districts, pharmaceutical services and other local hospitals and services, using a modular approach. The system has been adopted by other regions and, after 13 years, covers a population of 24 million and includes over 100 000 patients.

The system has made things much clearer, for example, showing that less than a quarter of patients are children. Mapping incidence and prevalence is easier, as is seeing how the mix of conditions changes through the life course; it is also easier to analyse how mortality among those affected differs from the general population, with a large proportion occurring in people aged 60–70 years. This assists both population and individual treatment planning. It provides a more precise understanding of the number of people affected (1.3–2%) compared with broad-brush European estimates (6–8%) but equally a better understanding of the costs incurred to the system and patients (47).

Among the lessons learned are that a simple system helps clinicians, giving real-time information. Clinicians and patients see the benefit in keeping it updated. It works well in many different regions and supports patient mobility. Interoperability is not just a technical issue but also a matter of attitude and willingness to work together. The situation will continue to evolve, especially in light of the development of telemedicine and European reference networks.

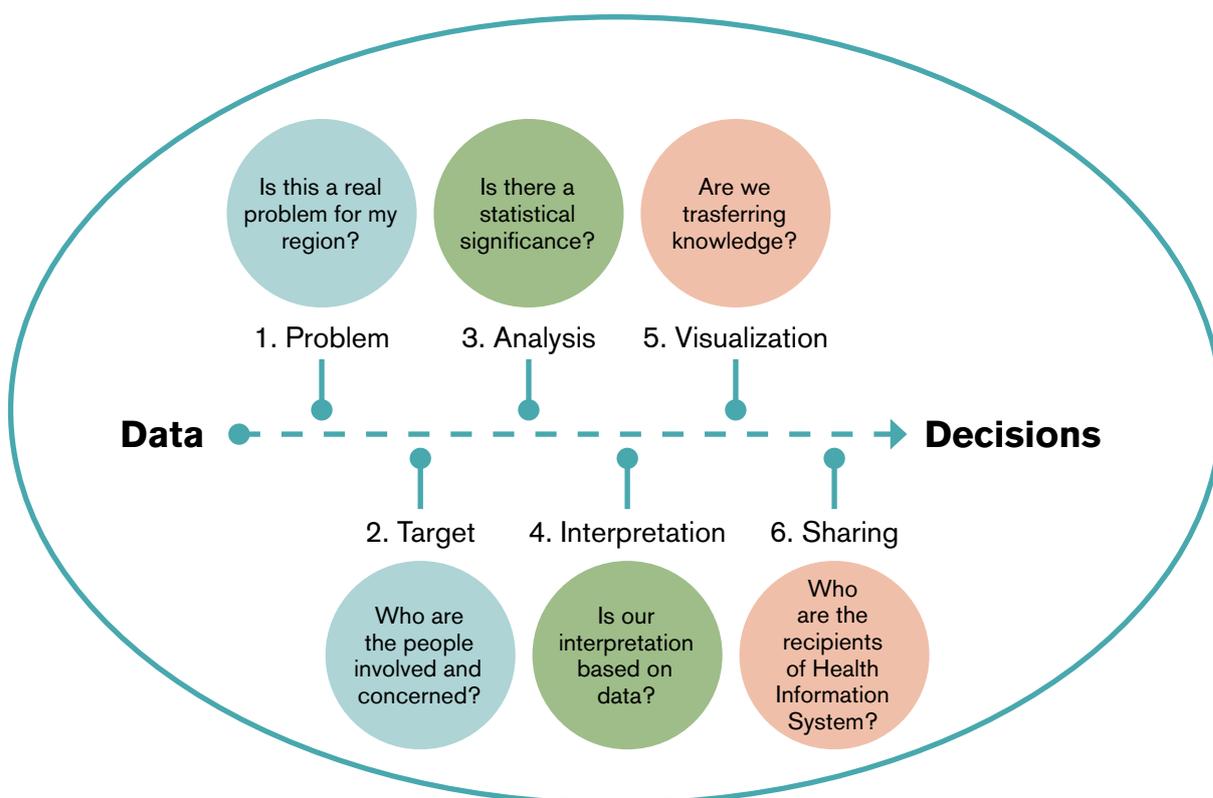
At national level, countries may have a large number of (different) rare diseases that may exist in their population. However, at regional level (or in small countries), the population may have a limited number of rare diseases or, on the country, a higher than expected number of patients due to the founder effect (someone with a condition long ago had a large number of affected descendants still living locally) or to genetic clustering (families with the same conditions may live in just one region of the country).

The usefulness of benefit entitlements as a way of stimulating people to place themselves on a register was also noted.

7.5 PROMOTING HEALTH: FROM DATA TO DECISIONS

The ultimate goal of collecting information should be better decisions and the canton of Switzerland had reviewed existing procedures over the previous two years with that aim in mind. It is important to emphasize that the issues are not just technical (the quality of the data, the statistical methods, the technology and resources) but about clarity of thinking.

Fig. 2. Data-based decision-making process



The first step is to be clear about a problem as an undefined problem cannot be solved. Not all problems are the health sector's problem. Answering certain questions is important such as what is the problem? Where and when does the problem occur? Who is involved? Why it is happening?

The second step is to clarify the target. The problem is not itself the target and does not automatically clarify what the target is.

The third step is analysis. Simplicity is important, but there is no point in pushing this too far: "Don't Torture the Data until it Confesses!" (48). Analysis must suit the data and purpose, with a clear understanding of when a difference really is a difference and a proper respect for statistical rigour.

The fourth step is interpretation. Interpretation should not be based on opinion, and those leading this step need to be aware that it is not an error-proof process. They need to pay attention to those factors that can mislead them – confounders, biases, hidden factors and so on – and should also take into account the perceptions of other interested players, including the public and professionals.

The fifth step is visualization. Analysts are not users and should not assume that their way of understanding data is the same. A well-designed graph can act as a bridge, telling a story in a language that everyone can understand. The key aim is to pass on knowledge, not a set of figures.

The final step is sharing. The traditional approach is for the health information system to pass information to institutional decision-makers, who then engage the public. However, making it available directly to the public helps educate the wider population and improve health literacy and can promote

engagement, discussion and consensus-building between the public and those who traditionally take decisions on their behalf.

A Facebook campaign (49) is aiming to engage the public using these principles and help turn the public from a passive audience into active users and in time replace noncommunicable diseases by communicable health.

Although the approach has six elements, a seventh step is also vital: commitment.

In the discussion, the point was made that interpretation is often neglected, with a focus on other technical aspects. It is important to involve those working in the field on health issues and to build links with the public. This is also a way of addressing the situation that some journalists often find public health issues uninteresting. One idea is to train doctors to coach their colleagues in how to discuss information with the public. Social media offers a vital new tool in encouraging the public to understand and use health information.

7.6 A QUALITATIVE STUDY OF THE EXPERIENCES OF HEALTH INFORMATION PRACTITIONERS IN A SMALL EUROPEAN COUNTRY

The quality, timeliness and sustainability of health information systems depend on the contribution of health information practitioners. The Islands & Small States Institute of the University of Malta, the Department of International Health at Maastricht University in the Netherlands, and the Directorate for Health Information and Research of the Ministry for Energy and Health in Malta jointly conducted a study.

The aim of the qualitative study was to obtain an understanding of the features of health information systems in small countries through examining the views of health information practitioners in Malta. In the event, seven participated and were randomly allocated to either a written survey response or face-to-face interview. Content analysis was undertaken using the Health Metrics Network framework.

The results showed that practitioners feel like important stakeholders who influence policy-making through their close collaboration and geographical proximity to policy-makers. They feel they provide high-quality work but struggle with limited resources and population survey fatigue. Small numbers might lead to misinterpretation of, for instance, mortality rates, with the remedy seen as the use of moving averages and aggregate data.

The study showed that practitioners have a clear appreciation of their position, which can be used to improve the use of information. The study was limited in that the number participating was low, there were differences in views and the findings cannot be generalized to other settings. However, the interview guide can be applied to explore the experiences of practitioners in other small countries, as well as practitioners at regional level; the guide would be made available.

7.7 CONCLUDING COMMENTS

Mr Riley commented on the session, drawing out some general points. He noted that small countries and regions have common challenges in how to collect and store data, and translate them into intelligence that can be of value to politicians, organizations and individuals. Harmonization offers a

great opportunity to make cross-national registries more possible. Borrowing best practice from other countries presents great opportunities, and providing ways to share skills and best practice is important. He felt that improving the use of information was an important job to be done in educating politicians and journalists. He referred to the lessons learned from the canton of Ticino in Switzerland (see subsection 4.4).

There seemed to be a call for developing support to so-called slightly bigger than small nations, and he wondered how the European Health Information Initiative might help with that. He said that the European Public Health Association interest group on health information now included over 900 members whose work includes linking country and technical networks.

The co-chair Dr Julian Mamo (University of Malta) closed the session, identifying the important need to clarify how to understand better how what is good for large countries might be good also for the smaller ones and how to apply the lessons.



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Annex 1. Programme

WHO REGIONS FOR HEALTH NETWORK

22ND ANNUAL MEETING

PRE-CONFERENCE EVENT TO THE EUROPEAN PUBLIC HEALTH CONFERENCE

MiCo CENTRE, MILAN, 14–15 OCTOBER 2015

IMPROVING HEALTH AND EQUITY ACROSS REGIONS AND SECTORS

Overview

The World Health Organization (WHO) **Regions for Health Network (RHN)** is working to improve health and well-being through prioritizing equity, developing strategic delivery alliances and fostering good governance. Its members represent 25 regions from 20 countries across the WHO European Region. They work to promote excellence and effectiveness in their regions; share resources and good practice; exchange ideas and experience on structures, processes and skills; work across sectors to build new alliances for health; and openly discuss challenges and possible solutions to bring changes for health gain at the regional and local levels.

This **22nd annual meeting of RHN** will take forward the European Health 2020 strategy agenda focusing on effective approaches to achieve better health and well-being, and reduce health inequalities. Participants will explore a series of **key issues** across the session topics, namely:

- **background policies and evidence** (i.e. link to Health 2020 or national programmes, projects and good practices across the European Region; existing/needed research evidence and monitoring systems/health data at regional level; etc.);
- **practical approaches and driving change** (i.e. specific and practical examples such as urban/transport planning, environmental matters, new legislation/regulation, education and training initiatives, etc.);
- **participatory approaches and work across sectors** (i.e. implementing/examples of whole-of-government and whole-of-society approaches; multi-agency programmes and projects, including organizations across the public sector, as well as the private sector and nongovernmental organizations/communities; etc.); and
- **collaborative and European funding opportunities** (i.e. European Union (EU) and other income, which is instrumental and supports public health in a climate of austerity; relevant EU funding programmes and streams; possible cross-regional collaboration and joint funding applications; etc.).

The RHN annual meeting is by invitation only.

Programme at a glance

14 October (Wednesday)

Time	Activity	Organized by
13:30-13:40	Welcome, introduction and structure of the meeting	WHO Secretariat RHN Steering Group
13:40-15:00	Session 1: <i>Joining forces: citizens and regions for better health</i>	Skåne, Sweden
15:00-15:20	Coffee break	
15:20-15:50	Resuming Session 1	Skåne, Sweden
15:50-17:40	Session 2: <i>Starting people on a healthy life course – evidence, policy and advocacy</i>	Wales, United Kingdom
17:40-17:45	Closure of Day 1	

15 October 2015 (Thursday)

Time	Activity	Organized by
08:30-09:40	Session 3: <i>RHN business meeting</i>	WHO Secretariat RHN Steering Group
09:40-10:00	<i>Reporting back from the WHO Regional Committee for Europe</i>	RHN Steering Group
10:00-10:30	Coffee break	
10:30-12:00	Session 4: Tackling Health inequities at subnational level: grounding actions on data	Pomurje, Slovenia
12:00-12:10	Closure of the meeting	WHO Secretariat RHN Steering Group
12:10-13:00	Lunch	

The RHN annual meeting will be followed by the European Public Health Conference-EPH, which starts at 13:00 on 15 October 2015. Detailed programme of the EPH conference available at: ephconference.eu

See below for detailed outline of each session of the RHN annual meeting.

Chair of the meeting: Francesco Zambon (WHO RHN Focal Point)

Solvejg Wallyn (RHN Steering Group, Flanders)

SESSION I

Joining forces: Citizens and regions for better health

Organized and coordinated by Skåne, Sweden

Session overview

Topics:	Whole-of-society approach, intersectoral collaborations, citizens' empowerment
Moderator:	Dr Piroska Östlin, WHO Regional Office for Europe
Presenting regions:	Skåne (Sweden), Andalusia (Spain), Trento (Italy), Wales (UK), Maastricht University
Presentation focus:	Key messages from the Regions for Health Network's new publication <i>'Taking a participatory approach to development and better health: Examples from the Regions for Health Network'</i> will be presented to smaller groups to facilitate discussions and feedback around the topics.

Outline:

No actor can own, lead or steer a system. Instead we need to co-create by focusing on a common purpose or common issue, where each actor's capabilities are used to solve the common problem, rather than on one sector-driven development.

"Realising a joint strategy requires time, humility and trust. ... [It] requires cooperation, in which several actors and individual people act on a certain challenge at the right time. Acting alone is not conducive to the transition to a sustainable society."

The intentional consequences of participatory approaches go far beyond the health sector and more into the realm of creating positive, sustainable social change. Through the engagement of stakeholders, recognizing the value of each person's contribution to the process is not only practical, but also collaborative and empowering in finding solutions together. Of course, many different perspectives are given and assumptions are challenged; but this enables the creation of a space for new transformative insights offering fresh approaches.

The workshop draws on specific experiences from members of the WHO Regions for Health Network – Trentino (Italy), the Autonomous Community of Andalusia (Spain), Skåne (Sweden) and Wales (United Kingdom) – and looks at the need for participation and co-operation (Maastricht University, the Netherlands). Key messages will form the basis of small group discussions and feedback and will be useful for those wanting to adopt a participatory approach to tackle health inequalities and social sustainability.

Session programme

13.40 – 13.50	Welcome, introduction and session outline <i>Dr Piroska Östlin, WHO Regional Office for Europe</i>
13.50 – 14.00	"Participatory approaches" – some general remarks from the perspective of political sciences <i>Dr Kai Michelsen, Department of International Health, FHML, Maastricht University</i>

14.00 – 14.10	Overview - Key messages from ‘Taking a participatory approach to development and better health: Examples from the Regions for Health Network’ <i>Elisabeth Bengtsson, Director of Public Health, Region Skåne, Sweden</i>
14.10 – 14.45	Small group discussions around key messages Group leaders: <ul style="list-style-type: none"> • <i>Elisabeth Bengtsson, Director of Public Health, Region Skåne, Sweden</i> • <i>Pirous Fateh-Moghadam, Health Observatory, Department of Health and Social Solidarity, Trentino</i> • <i>Alberto Fernandez, Professor of Epidemiology and Public Health, Andalusian School of Public Health</i> • <i>Dr Kai Michelsen, Department of International Health, FHML, Maastricht University</i> • <i>Cathy Weatherup, Head of Health Inequalities and International Health, Welsh Government</i> • <i>Clare Arvidsson, Project Assistant, Region Skåne, Sweden</i>
14.45 – 15.00	Feedback from the groups with opportunities for further discussions and experiences from other regions
15.00 – 15.20	<i>Coffee break</i>
15.20 – 15.40	Continued; Feedback from the groups with opportunities for further discussions and experiences from other regions
15.40 – 15.50	Wrap up and summary <i>Dr Piroška Östlin, WHO Regional Office for Europe</i>

Presentations overview

“Participatory approaches” – some general remarks from the perspective of political sciences

Dr Kai Michelsen, Department of International Health, FHML, Maastricht University

Participatory approaches aim to overcome structural challenges regarding communication, cooperation and coordination. They might aim to broaden democratic participation, or to make better use of existing knowledge and resources. They can be seen as a consequence of the changing role of the state as well as of scientific knowledge in today’s societies.

Participatory approaches differ, due to differences between political and health systems and/or their major aims (e.g. assessment, agenda setting, policy formulation, implementation and/or evaluation). At the same time, they have to deal with similar challenges.

Case studies are an adequate way to stimulate mutual learning with regard to common challenges, by taking context specific differences of participatory approaches into account.

Overview - Key messages from ‘Taking a participatory approach to development and better health: Examples from the Regions for Health Network’

Elisabeth Bengtsson, Director of Public Health, Region Skåne, Sweden

Why the need for this publication and what do we hope to achieve by it? The intentional consequences of participatory approaches go far beyond the health sector and more into the realm of creating positive sustainable social change. By sharing the experiences from the regions through

the key messages identified, we hope to encourage others to take a collaborative and participatory approach to tackle health inequalities.

Small group discussions around key messages

Group 1. Key message: Find the common purpose

Cathy Weatherup, Head of Health Inequalities and International Health, Welsh Government

“Find a common purpose for stakeholders. Emphasize the potential of the common good or the common issue when working as a connected whole, and enable people to see beyond their boundaries.”

How has the process of engagement informed Welsh legislation by involving organisations, networks and individuals from across Wales? The well-being goals (enshrined in the legislation) represent a common purpose shaped, understood and owned by people, communities, and businesses. Through the ‘duty to involve the citizen’ the public will have an ongoing role in shaping policy and provision in planning and setting objectives at local level. This process can be applied to improvements in health services and the principles of co-production and the successful behavioural change interventions.

Group 2. Key message: Focus on the process

Alberto Fernandez, Professor of Epidemiology and Public Health, Andalusian School of Public Health

“Focus on the process rather than the product. Creating ownership and involvement from all stakeholders is much harder than producing a policy product. Identify the common driving force as to why everyone is doing this, and determine the new behaviour and norms everyone wants.”

The process of sharing health and well-being goals in order to be included in the policies of other sectors is never-ending, but is well accepted and acknowledged. The health sector has to be ready to facilitate additional information and resources in order to satisfy new demands. All together, we must learn new communication languages, priority setting procedures, and efficient cooperation. Inclusion in the processes of those more in need remains a major challenge.

Group 3 Key message: Trust the process

Clare Arvidsson, Project Assistant, Region Skåne, Sweden

“Trust the process. Be a sounding board that moves in between stakeholders like a free agent (or a broker or convener), and guide the process by being receptive and flowing with rather than controlling it. Trust that stakeholders will jointly make the best-informed decisions for the Region.”

To conduct a meaningful participatory process, such as with a regional development plan, it is essential to be a mediator and listen to the people involved, so that each person feels that their contribution to the process is recognised. It is also important to stay within your mandate and not make any promises so as to avoid disappointing stakeholders. The process has its own logistics and trust is a two-way relationship.

Group 4 Key message: Create ownership in the process

Dr Kai Michelsen, Department of International Health, FHML, Maastricht University

“Create ownership of the process through leadership and ambassadors, and engagement with networks and alliances that will ultimately drive the process and maintain its momentum.”

Kickbusch, I., Gleicher, D. (2012): Governance for health in the 21st century. Copenhagen, WHO: “[...] legitimacy depends on the ability of the process to engage stakeholders in a meaningful dialogue, in which they feel ownership and the possibility of deriving benefits. This requires full transparency, openness and respect. Nascent multi-stakeholder processes can be seriously jeopardized if the partners do not regularly verify the transparency of the perceptions and expectations of participation [...]”

“In some cases, health institutions might be better by not taking the lead and instead giving ownership and playing a supporting role to other sectors and non-state actors.”

Group 5 Key message: Involve and empower other sectors

Elisabeth Bengtsson, Director of Public Health, Region Skåne, Sweden

“Involve and empower other sectors (not only health) by engaging the whole of the public sector, as well as communities and industries to share purpose, objectives and benefits.”

By involving others at an early stage of planning and in open-minded planning meetings enables people to feel engaged in the process and initialises their trust. To facilitate meaningful collaborations, it is essential to really listen and use a common language so people feel connected to each other rather than remaining in professional silos.

Group 6 Key message: Joint mobilisation requires leadership

Pirous Fateh-Moghadam, Health Observatory, Department of Health and Social Solidarity, Trentino

“Joint mobilization requires leadership characterized by courage, a willingness to take risks and, at the same time, an openness to invite all stakeholder views and initiatives in order to challenge prevailing ideas and adapt to new circumstances.”

To implement a participatory approach leadership is needed at various levels and stages of the process. In situations where you have to abandon more traditional planning processes in favour of a participatory approach a strong political top down leadership and input is needed to get started. This is necessary but not enough to succeed. To actually transform the political will into practical action, intermediate, technical and more widespread leadership is requested to move the bureaucracy in the new direction. But what is leadership really, except a buzzword, a term that risks to become a boring cliché? The writer David Foster Wallace thinks that “a real leader is somebody who can help us overcome the limitations of our own individual laziness and selfishness and weakness and fear and get us to do better things than we can get ourselves to do on our own.” And what can be done to create such a kind of leadership and to make it widespread? Let’s find out together in the group discussion.

SESSION II

Starting people on a healthy life course - Evidence, policy and advocacy

Organized and coordinated by Wales, UK

Session overview

- Topics:** Life-course approach, inter-sectoral collaboration, early childhood experiences, school years, childhood inequalities
- Moderator:** Mrs Monika Kosinska, WHO Regional Office for Europe
- Presenting regions:** Wales, Flanders, Slovakia, Croatia and EuroHealthNet
- Presentation focus:** Each contribution will present briefly (10min) specific regional / project experience focusing on key messages, data, achievements, challenges, lessons learnt, etc.

Outline:

The session will focus on key life-course stages and relevant social, economic and cultural factors shaping individuals' life and health. Cumulative effects on later health may occur not only across an individual's life but also across generations. Solid evidence exists that social and environmental exposures, especially poverty and deprivation in early years, can strongly influence life course trajectories with implications for health and wellbeing in later life. School age and adolescence are also highly susceptible and important periods, providing various opportunities for intervention. Early years development and experiences will be explored, addressing issues such as alleviating poverty, child abuse and neglect; social and health inequalities/vulnerability; interacting with education, social and physical environment. Examples of adverse childhood experiences; 'healthy child' projects/ programmes; communication tools, strategies and media campaigns; support to family centres and local networks of services; and tackling unhealthy lifestyles will be presented. Participants will be involved in active discussion around multi-disciplinary, participatory and cross-sectoral approaches, key stakeholders and effective mechanisms for advocacy, investment and prevention strategies.

Session programme

15:50 – 16:00	Welcome, introduction and session outline <i>Mrs Monika Kosinska, WHO Regional Office for Europe</i>
16:00 – 16:10	Childhood adversity and its impact on health across the life course <i>Professor Mark A. Bellis OBE, Director of Policy, Research and International Development, Public Health Wales, Wales, UK</i>
16:10 – 16:20	Why Slovak children don't like school? Evidence from Health Behaviour in School-aged children study 2014 <i>Dr Jana Holubcikova, Department of Health Psychology, Faculty of Medicine, University of PJ Safarik in Kosice, Slovakia</i>
16:20 – 16:30	The Healthy Child Wales Programme <i>Mrs Cathy Weatherup, Head of Health Inequalities and International health, Welsh Government, Wales, UK</i>
16:30 – 16:40	Flanders child and family policy of diversity <i>Ms Kathy Jacobs, Policy Officer, Preventive Family Support, Flanders Child and Family Agency, Brussels, Belgium</i>

16:40 – 16:50	Public health campaign and role of the media - vaccination against HPV infection <i>Professor Marina Kuzman, Head, School and adolescent health service, Teaching Institute of public health „Dr. Andrija Stampar“, University of applied medical sciences, Croatia</i>
16:50 – 17:00	Childhood health inequalities - evidence from the DRIVERS project, 2012-2015 <i>Ms Caroline Costongs, Managing Director, EuroHealthNet, www.eurohealthnet.eu</i>
17:00 – 17:30	Discussion with all participants and Experiences from other regions
17:30 – 17:40	Wrap up and key messages <i>Mrs Monika Kosinska, WHO Regional Office for Europe</i>

Presentations overview

Childhood adversity and its impact on health across the Life course

Professor Mark A. Bellis OBE, Director of Policy, Research and International Development, Public Health Wales, Wales, UK

There is increasing evidence that abuse, neglect and other childhood stressors have substantive impacts on the health of individuals across the life course. The presentation will examine the extent and impact of such Adverse Childhood Experiences (ACEs) in Wales and more broadly across Europe. Europe is committed to reducing child maltreatment and other factors negatively affecting childhood. The presentation will review some of the mechanisms available for preventing ACEs and reducing their harmful consequences.

Why Slovak children don't like school? Evidence from Health Behaviour in School-aged children study 2014

Jana Holubcikova, Department of Health Psychology, Faculty of Medicine, University of PJ Safarik in Kosice, Slovakia

The results of Health Behaviour in School-aged children (<http://www.hbsc.org/>) indicate a high prevalence of children from Eastern Europe who don't like school. A supportive school environment is an asset for health-enhancing behaviours, health and life satisfaction, while a non-supportive school environment may constitute a risk. HBSC study provides us opportunity to explore a wide range of health related behaviour taking place in school. We have data on 9,200 adolescents aged 11 to 15 years from 2014 data collection.

Presentation will be focused on relevant factors of school environment which may influence adolescents' quality of life. Especially behaviours emerging in the last decades such as screen based behaviours, social networks use or high soft drinks and energy drinks consumption, discrimination should be presented.

The Healthy Child Wales Programme

Mrs Cathy Weatherup, Head of Health Inequalities and International health, Welsh Government, Wales, UK

The Healthy Child Wales Programme is an example of Wales-wide standardised cross-sectoral approach aiming at tackling the determinants of poverty and ensuring all children, from conception to school age, are offered a universal NHS service providing evidence based medical and social interventions. The programme also provides a risk assessment identifying families with higher needs and enabling families to receive enhanced and intensive interventions targeted proportionate to need (proportionate universalism).

Flanders child and family policy of diversity

Mrs Kathy Jacobs, Policy Officer, Preventive Family Support, Flemish Child and Family Agency, Brussels, Belgium

Kind en Gezin (Child and Family) is an agency that works actively in ‘Public Health, Welfare and Family’ policy area. This Flemish agency focuses on preventive treatment and guidance of young children geared to good outcomes in the future. We work hard to enable children to achieve their full developmental potential, physically, mentally, emotionally and socially, with respect for diversity and children’s rights. This principle holds good for all the different areas that we work in.

During the session we will focus on our policy of diversity. Different strategies in reaching out at and lowering the threshold for all people, especially the socially vulnerable families, will be explained: e.g. to work together with experts by experience; to use a range of communication tools and strategies; to develop tools for participation; to support family centres, as a local network of different services; etc.

Public health campaign and role of the media - vaccination against HPV infection

Professor Marina Kuzman, Head, School and adolescent health service, Teaching Institute of public health ‘Dr. Andrija Stampar’, University of applied medical sciences, Croatia

Vaccination against HPV infection was for several years in Croatia recommended, but the expenses were not covered by the health insurance. City of Zagreb was one of the first to offer vaccination free of charge, and vaccination was available for the aged 13-14. In spite of all efforts and activities provided by doctors and nurses, the vaccination coverage was very low. Last school along with public health activities media and young people themselves were actively involved.

One of the biggest media production, including daily newspaper, one popular radio station and two web portals aiming at the young people were included. In the period of two months the TV shows, radio interviews and information on the web portals were widely spread. The peak of the activities was a month in which at the weekly bases so called “debate club events” were organized in the secondary schools in Zagreb. The whole campaign was a great success, young people expressing real pleasure in the involvement of the process, and professionals were satisfied with so many positive reaction to the issue. At the end of this school year the vaccination rate in Zagreb was doubled, and in addition (not due to the campaign only, of course) Ministry of health of the Republic of Croatia decided to include vaccination against HPV infection in annual vaccination program for the girls and for the boys aged 15.

Childhood health inequalities - evidence from the DRIVERS project, 2012-2015

Ms Caroline Costongs, Managing Director, EuroHealthNet, www.eurohealthnet.eu

Evidence arising from the FP7-funded DRIVERS project 2012-2015 (<http://health-gradient.eu/>) will be presented, where EuroHealthNet was the co-ordinating partner. It will focus on the importance

of childhood health inequalities; evidence from DRIVERS about inequalities; and discuss the kinds of interventions that appear to help reduce inequalities in childhood health. The work of the EU Alliance for Investing in Children will be also linked as well as other relevant developments and opportunities at the EU level to improve childhood health.

SESSION III

RHN Business Meeting

Organized and coordinated by WHO European Office for Investment for Health and Development

Session overview

- Topics:** WHO RHN in Europe, Business Meeting
- Moderator:** Francesco Zambon (WHO RHN Focal Point)
Solvejg Wallyn (RHN Steering Group, Flanders)
- Presenting regions:** Euregio Meuse-Rhine, Østfold, Sunnekommuner, Trento, Wales, Skåne, WHO Secretariat

Outline:

The session will focus on the governance, administrative and developmental aspects of RHN, including new terms of reference, membership, communications, organization and financial issues, linking with other networks/organizations and development of a network of universities with interest in health inequities and regional governance.

Structure: short topic presentations; joint discussion

Session programme

RHN Business Meeting

08:30 – 08:35	Welcome, introduction and session outline <i>Francesco Zambon, Solvejg Wallyn</i>
08:35 – 08:45	Where we are with: - Terms of Reference of the Network and Letter of intent - Financial situation of RHN
08:45 – 09:00	Forthcoming publications. Presentations of outlines from: - Scaling up regional projects: Euregio Meuse-Rhine - Sustainable Development Goals and Health: Wales - Whole-of-Government, Whole-of-Society and Regional planning: Trento
09:00 – 09:10	RHN “hub” agreement: - the example from Norway Summekommuner
09:10 – 09:20	Partnership among Universities of RHN Regions: - Østfold
09:20 – 09:30	RHN communication activities - RHN communication consultants
09:30 – 09:40	Wrap up and way forward <i>Francesco Zambon, Solvejg Wallyn</i>

Reporting back from the WHO Regional Committee for Europe

09:40 – 09:50	Highlight from the Regional Committee <i>Elisabeth Bengtsson</i>
09:50 – 10:00	Discussion - All participants

SESSION IV

Tackling Health inequities at subnational level: grounding actions on data

Organized and coordinated by Pomurje region, Slovenia

Session overview

Topics: Health inequity monitoring, reporting and evaluation in the regional contexts, health and well-being profiles at regional level, monitoring of Health 2020 at subnational level, indicators on health status, perceptions and behaviours.

Moderator: Ms Tatjana Buzeti

Presenting regions: Saskatoon Region, Canada; Kaunas Region, Lithuania; Østfold County, Norway; Kosice region, Slovakia; Canton Ticino, Switzerland.

Presentation focus: Each contribution will present briefly (10min) specific regional / project experience focusing on key messages, data, achievements, challenges, lessons learnt, etc.

Outline:

The session will focus on issues related to health inequity monitoring, reporting and evaluation of programmes tackling health inequities. Participants will discuss health information systems at the basis of sound policy-making, the need for valid and comparable health and well-being indicators across regions, disaggregation of data at subnational level, health inequity atlases, skilled human resource capacity in management and analysis of data, and multilingualism. Focus is on how we can use regional data and profiles for creating and agenda and fostering action follow up on it and measure outcomes. We would like to make session as interactive as possible and allow enough time for discussion. Therefore, we ask that presenters have maximum of 6 to 7 slides supporting key messages and lessons learnt.

Session programme

10:30 – 10:40	Welcome, introduction and session outline <i>Ms Tatjana Buzeti, Pomurje region, Slovenia</i>
10:40 – 10:50	Data profiling and social marketing campaigns supporting health equity and poverty reduction strategies <i>Dr Cory Neudorf, Chief Medical Health Officer, Saskatoon Health Region, and Associate Professor, Univ. Of Saskatchewan, CANADA</i>

10:50 – 11:00	Role of universities and research institutes in creating regional profiles on health inequalities <i>Prof Irena Miseviciene, RHN focal point in Lithuania, Member of National Health Board, Vice-chair of Advisory Council, Health promoting Kaunas Region</i>
11:00 – 11:10	Knowledge from research on Roma health influenced national strategy on Roma health <i>Peter Kolarčik, Department of Health Psychology, Faculty of Medicine, P.J.Safarik University, Košice, Slovakia</i>
11:10 – 11:20	Are prevention activities against at-risk alcohol consumption well targeted? <i>Ms Martine Bouvier Gallacchi, Chief Medical Officer, Health Promotion and Evaluation Office, Ticino Canton, Switzerland</i>
11:20 – 11:30	Østfold County Health profile 2011. Health related social mobility. <i>Prof Niels Kr. Rasmussen, mag. scient. soc., Senior research advisor for Østfold County Council, Norway</i>
11:30 – 11:50	Discussion with all participants and Experiences from other regions
11:50 – 12:00	Wrap up and key messages <i>Ms Tatjana Buzeti, Pomurje region, Slovenia</i>

Data profiling and social marketing campaigns supporting health equity and poverty reduction strategies

Dr Cory Neudorf, Chief Medical Health Officer, Saskatoon Health Region, and Associate Professor, Univ. Of Saskatchewan, Canada

The use of health status monitoring and reporting has traditionally been limited to the presentation of basic descriptive epidemiologic analysis of population statistics for use in health planning. The Saskatoon Health Region has been using an enhanced approach to maximize the strategic use of health status reporting to inform and influence health and social program and policy making at the local and regional level. Innovative analytic techniques, stakeholder engagement and knowledge translation approaches have been used to enable the inclusion of key intersectoral recommendations for improvement in population health and health equity. This presentation will highlight some of these tools, techniques and campaigns that have been used with the public, local health boards, intersectoral planning groups and government agencies to set priorities and influence change. The presentation will include a description of the underlying data infrastructure and technical expertise required, as well as examples of the various outputs used (reports, maps, social marketing campaigns) with the public, decision makers and politicians as well as the results these approaches have achieved to date.

Role of universities and research institutes in creating regional profiles in health inequalities

Prof Irena Miseviciene, member of National Health Board, RHN focal point in Lithuania

Usually health inequalities on national and regional levels in Lithuania are measured using the data of the National Health Information Center (NHIC). Annually the reports describe the standardized mortality rates (total and due to different causes of death by age, sex, at regional level, i.e. in each of the 60 municipalities and total mortality rates for whole country). The diagrams and maps (with mortality rates in quintiles) are presented and the tables with enumeration of 10 municipalities with the highest rates and 10 with the lowest rates are presented too. The presentation will include the examples of good and bad practices as per how the interpretation of NHIC data can mislead

the politicians in describing the priority areas of health policy at regional level and will show the importance of universities and research institutes not only for collection of evidence based information, but also for the education of specialists working with health information data.

Knowledge from research on Roma health influenced national strategy on Roma health

Peter Kolarčík, Department of Health Psychology, Faculty of Medicine, P.J.Safarik University, Košice, Slovakia

In 2011 the study on Hepatitis B/C and metabolic syndrome among Roma and non-Roma population was conducted in Slovakia. Many differences in health conditions between Roma and non-Roma were found but socioeconomic status (SES) was not found to be associated with health and health related behaviour within Roma respondents. Such finding indicate different mechanism, which was not covered by the study measures. Health of Roma people is more likely associated with health literacy level than their SES. This conclusion was reflected into national strategy on Roma health where new aim of monitoring and promoting health literacy in Roma settlements was introduced and included into the national strategy.

Are prevention activities against at-risk alcohol consumption well targeted?

Ms Martine Bouvier Gallacchi, Chief Medical Officer, Health Promotion and Evaluation Office, Ticino Canton, Switzerland

Consequences of alcohol abuse are one of the most important public health problem in the WHO Europe region. While in the past habits of drinking were mainly related to a chronic at risk consumption, in the last decade, binge drinking is an emerging risk behaviour in young people. The analysis of the Swiss data shows the same trend. Surprising, in the Canton of Ticino the prevalence of abstinent is higher than in the French and German part of Switzerland while binge drinking is less frequent. Another unexpected difference seems to characterize this region regarding the chronic at-risk alcohol consumption: on the contrary of our beliefs, data show that this habit is more frequent in women than in man. Is this difference a statistical bias or is it a real health inequity? If it is a real fact, what should we do in order to reach this specific target group?

Østfold County Health Profile 2011. Health related social mobility

Prof Niels Kr. Rasmussen, mag. scient. soc., Senior research advisor for Østfold County Council, Norway

During the planning and the analyses of the profile, we were faced with two issues, which both relate to the potential social effects of poor or good health.

First we had to decide whether or not to include in the sample the segment of the population with other ethnic backgrounds than Norwegian in order to study any health differentials. For methodological reasons we decided not to. And afterwards we have developed a design to overcome these problems, and which we want to discuss. Eventually we invite partners to a shared project.

Secondly we found some interesting or alarming findings regarding the younger Norwegians indicating that poor health had a negative influence on their educational attainments, and probably subsequently on their future socio-economic position.

Annex 2. Programme of RHN parallel sessions, 8th European Public Health Conference

Thursday 15 October 2015

Parallel session 2.B. Workshop: Joining forces: citizens and regions for better health

Chair: Piroska Östlin, Acting Director of the Division of Policy and Governance for Health and Well-being, WHO Regional Office for Europe

Participatory approaches – some general remarks from the perspective of political sciences, Kai Michelsen, Department of International Health, University of Maastricht, the Netherlands

Taking a participatory approach to development and better health in Skåne – trust and involvement, Elisabeth Bengtsson, Director of Public Health, Region Skåne, Sweden

Taking a participatory approach to sustainable development and health in Wales– finding a common purpose, Cathy Weatherup, Head of Health Inequalities and International Health, Welsh Government, Wales, United Kingdom

Taking a participatory approach to health strategy development in the Autonomous Province of Trento – leadership and keeping focused, Pirous Fateh-Moghadam, Italy

Taking a participatory approach to health policy and strategy in the Autonomous Community of Andalusia – common purpose, Alberto Fernández, Spain

Friday 16 October 2015

Parallel session 3.D. Skills building seminar: scaling up (pilot) projects successfully – lessons from theories and experiences

Chairs: Francesco Zambon, Policy Development Officer, WHO Regional Office for Europe and Brigitte van der Zanden, Project Manager, Meuse–Rhine Euroregion, the Netherlands

Preparing the ground: effective scaling up – what is recommended in the literature? Kai Michelsen, Department of International Health, University of Maastricht, the Netherlands

The scaling up survey – an empirical check of theoretical assumptions, Odile Mekel, North Rhine Westphalia Centre for Health, Germany

Scaling up in projects – the example of DART, Judith Willert, Lower Austria Health and Social Fund, Austria

Promoting scaling up in border regions – the example of euPrevent, Brigitte van der Zanden, Project Manager, Meuse–Rhine Euroregion, the Netherlands

Saturday 17 October 2015

Parallel session 7.F. Workshop: quality health information systems in small European countries and regions

Chairs: Francesco Zambon, Italy and Julian Mamo, Malta

European Health Information Initiative: recent developments and relevance for small countries, Claudia Stein, Director of the Division of Information, Evidence, Research and Innovation, WHO Regional Office for Europe

Factors affecting data availability in the European region – does population size matter? Natasha Azzopardi-Muscat, President Elect of the European Public Health Association

A web-based system globally monitoring rare diseases: the experience of the Veneto Region, Italy, Monica Mazzucato, Rare Diseases Coordinating Centre, Veneto, Italy

Promoting health: from data to decisions, Ottavio Beretta, Department of Health and Social Welfare, canton of Ticino, Switzerland

A qualitative study of the experiences of health information practitioners in a small European country, Sanne Gathoni Thijssen, Department of International Health, University of Maastricht, the Netherlands

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From 14 to 15 October 2015, the 22nd annual meeting of the Regions for Health Network (RHN) was held in Milan, Italy. The main theme was improving health and equity across regions and sectors. This year, it was organized as a preconference of the 8th European Public Health Conference, including capacity-building-sessions and the RHN business meeting.

Capacity-building sessions addressed important scientific evidence and practical efforts to improve health and equity: joining forces – citizens and regions for better health; starting people on a healthy life course – evidence, policy and advocacy; and tackling health inequities at subnational level – grounding actions on data. These were put in the context of the WHO European health policy framework, Health 2020, and efforts to translate it into practice at regional level. The RHN business meeting provided its Steering Group and members with an opportunity to describe and discuss their main activities during the previous and coming year, including the revision of the terms of reference, a programme of publications and new ways of extending RHN's effectiveness.

In addition to the meeting, members also had the opportunity to organize and attend three sessions as part of the Conference programme. These are also covered in this publication.

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