Regional cooperation in health governance - the case of the South-eastern Europe Health Network

Alain Nellen

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Regional cooperation in health governance – the case of the South-eastern Europe Health Network (SEEHN)

Health – from a contributor to peace-building to an integral part of economic development and prosperity

Alain Nellen, Alumnus,
Graduate Institute of International and Development Studies,
Geneva, Switzerland

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ABSTRACT

This paper argues that through the South-eastern Europe Health Nework (SEEHN), the health sector has proven to be a post-conflict recovery platform after the conflicts in the former Yugoslavia, which were marked with regional political, social and economic turmoil. SEEHN contributed to reconciliation, peace and stability in south-eastern Europe. Serving as a platform for trust-building, it has brought countries to the same table to pool together resources among stakeholders and establish a shared vision by implementing joint regional projects on common health concerns. Over the years, SEEHN has shifted its vision towards promoting health as an integral part of economic development through a whole-of-government and whole-of-society approach. However, SEEHN is facing new and ongoing challenges, both internal and external, that put it at risk of operational stagnation and undermine its sustainability.

KEYWORDS

South-eastern Europe Health Network
Intergovernmental cooperation in health
Network governance theory
External partners
Health as a Bridge for Peace
Shared vision and trust-building
Health and economic development
Health in All Policies
Whole-of-government and whole-of-society approach
Health equality
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ABOUT THE AUTHOR

Alain Nellen holds a Masters Degree in Development Studies from the Graduate Institute of International and Development Studies, Geneva, Switzerland, and a Bachelor of Social Science, majoring in politics/international relations and geography (sustainability studies) from Curtin University, Perth, Australia. During his studies and extracurricular activities, he pursued his keen interest in understanding the interplay between conflict, peace-building, human and social development. Alain Nellen has previously undertaken an internship at the Swiss Embassy in Australia as well as at the Australian-based research institute Future Directions International. He has worked for the government of Western Australia and also conducted fieldwork for a NGO in Uganda focusing on various health-related development issues. He recently returned from a peace support mission in the Balkans where he was deployed as a military staff officer by Switzerland.

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FOREWORD

In 2016 the South-east European Health Network (SEEHN) celebrated 15 years of existence and development since its commencement in 2001. The regional collaboration for public health between its nine members today (Albania, Bosnia and Herzegovina, Bulgaria, Israel, Montenegro, Republic of Moldova, the Republic of Serbia, Romania and the former Yugoslav Republic of Macedonia) has proved to be of great value to all its national health authorities and systems. There are many examples of that, some of which are described and analysed in this paper. Some of SEEHN's achievements even extend beyond its geographical boundaries in Europe. The best example of that is the WHO Regional Office for Europe's European Action Plan for Strengthening Public Health Capacities and Services, endorsed by the 53 ministers of health of Member States during the 62nd Session of the Regional Committee in Malta in 2012. This Action Plan was started, piloted and finalized with the strong involvement and support of SEEHN.

In all these years, there has been no external independent evaluation of SEEHN, mainly for financial reasons. We have learned and developed based on our own experience and lessons learned and with the strong support of our founding partners, the Council of Europe, the Council of Europe Development Bank (CEB) and the WHO Regional Office for Europe. We are truly grateful to all of them.

Today, SEEHN is at a crossroads: how to continue, how to improve its performance and governance, how to strengthen further its structures. The forthcoming Fourth Health Ministerial Forum, to be held in April 2017 in Chisinau, Republic of Moldova, will have to take important decisions on the way forward to implementing the European health policy framework Health 2020, achieving the United Nations' Sustainable Development Goals (SDG) 2030, as well as our own South East Europe 2020 Strategy: Jobs and Prosperity in a European Perspective (SEE 2020).

It is for the above reasons, amongst others, that SEEHN values this paper, based on the Masters thesis of the author, Mr Alain Nellen, for the Graduate Institute of International and Development Studies, Geneva, Switzerland. It provides the political leadership of SEEHN with an independent review and analysis for the first time in our history. It formulates important recommendations for the future. We have already taken them into account in the new Memorandum of Understanding and the draft Chisinau Pledge to be endorsed at our Fourth Forum.

SEEHN expresses its gratitude to the author, The Global Health Centre, Geneva, Switzerland and all our partners.

Ruxanda Glavan

President, South-eastern Europe Health Network;
Minister of Health, Republic of Moldova

This paper is a shorter version of Alain Nellen's Masters thesis that makes a first attempt to provide an independent review of the achievements and failures of SEEHN in the roughly 15 years of its existence. This is hampered by the fact that there is very little written information and the most knowledgeable informants have a very high stake in the network – the author makes clear reference to this. Despite these drawbacks, the paper provides useful insights into the development of SEEHN, how it has changed, and what its future prospects could be. It will prove very helpful to the members and the partners of the network.

In analysing the evolution of SEEHN, he shows the difficult balancing act between political leadership and technical cooperation, and the role of many external partners, especially the WHO Regional Office for Europe. He successfully uses a mixed-methods procedure and shows how the development of SEEHN links to a range of concepts and approaches in global health development and how it aims to apply them. The governance structure, various key political documents and technical project phases are reviewed and analysed through the eyes of network theory and using the concepts of Health as a Bridge to Peace (HBP) and Health in all Policies (HiAP), intergovernmental cooperation in health and the link between health and economic development. In particular, the linking of SEEHN's activities to the new SEE 2020 economic strategy can be seen as a major success and opportunity for new relevance of the network. Given present population movements, this might prove to be even more important.

Professor Ilona Kickbusch

Director, the Global Health Centre,
the Graduate Institute, Geneva, Switzerland

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PREFACE

Cross-country cooperation in public health can serve as a useful mechanism in identifying and addressing health challenges that many countries and regions share. The World Health Organization (WHO) argues that "cooperation among countries can be an effective tool to strengthen, share and accelerate health development within countries and across regions. It involves creating, adapting, transferring and sharing knowledge and experiences to improve health – while also making the most of existing resources and capacities" *(1).* This paper looks at how SEEHN emerged in 2001 as an intergovernmental initiative for regional cooperation on health in south-eastern Europe, and how it has aimed to address public health concerns through regional cooperation.

The paper shows how the health sector, through regional collaboration, can contribute to regional reconciliation, peace and stability in a post-conflict environment as well as contributing to economic development and prosperity. The end of the devastating conflicts in former Yugoslavia acted as the contextual foundation for SEEHN's inception. These 10 years of conflict were marked by ethnic and political tensions that actively destroyed health systems, producing social and economic hardship that left whole populations in a very vulnerable position. Another focus is to illustrate how SEEHN's governance structure has evolved over the 15 years of its existence, including areas of policy-making, in a process of constant formation, review and reform. SEEHN has adapted its governance structure to changing political, social and economic circumstances; identified new health areas of common concern; and incorporated evolving international health governance trends in its policy approaches. SEEHN's evolution has resulted in important lessons being learned concerning both achievements and challenges that can be used by public health policy-makers across the world.

Three theoretical frameworks are outlined and applied in this paper: firstly, WHO's HBP concept *(2)*, which integrates the health aspect in peace-building within a conflict or post-conflict context. Primarily a concept fostering technical collaboration, it embraces support to the health professional community to implement initiatives for multidimensional policy-making. This concept contributes to the argument that SEEHN, particularly during its early years, became a mechanism for post-conflict reconciliation through the implementation of its regional projects at a technical level. Secondly, the HiAP framework is incorporated into various European health policy frameworks that have recently been guiding SEEHN member countries in their regional cooperation and domestic policy. For health sector policy-makers, HiAP is a

meaningful framework that offers a point of entry and key principles for cooperation with public policy-makers from other governmental sectors. This is important to enable the impact that other sectors' public policy decisions may have on health to be considered. HiAP helps to identify approaches that address the complexity of health issues, particularly health equity concerns. Thirdly, network governance theory (using Creech et al.'s broad definition of network as a concept in which "a group of individuals from different institutions choose to work together towards a common goal" (3)) has been applied throughout to illustrate the importance of a well established network governance structure at both political and technical level. This is important for SEEHN's sustainable operational capacity.

The original study faced some limitations, particularly in understanding health policy developments in SEEHN member countries, as the evidence in English is incomplete and sometimes out of date. The literature on SEEHN is mainly written by WHO Regional Office for Europe, which provided secretariat support, together with the Council of Europe, to the network until 2011. No independent major assessment study, which is vital for a critical analysis of the network's operational effectiveness, has been conducted since SEEHN's inception. In addition, there are currently not enough data in terms of empirical and statistical evidence provided by SEEHN to allow a comprehensive assessment of the impact of its activities, particularly on national health systems. There is, moreover, little evidence regarding follow-up assessments of individual SEEHN projects. In the original study, 13 individuals from different SEEHN stakeholder groups (ministries of health, SEEHN Executive Committee, national health coordinators, external partners and national public health experts) were contacted for interview. For various reasons, five stakeholders were ultimately interviewed. Most were open to sharing constructive criticism about the network's operations but weaknesses were shared only to a certain extent, possibly owing to interviewees' positions as stakeholders. Some interviewees offered a meaningful explanation and elaboration of the complexity of the network and its evolution since its establishment, particularly as regards the process of bringing previously warring parties to the same table.

Overall, this paper adds to the limited literature available regarding SEEHN and contributes to the overall scholarship pertaining to health as an integral part of post-conflict and economic development, the concepts of HBP and HiAP, and intergovernmental cooperation in health governance.

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This paper is a shorter, modified version of my Masters dissertation. I would like to express my deepest appreciation to Professor Ilona Kickbusch, who encouraged me to conduct this study about SEEHN and supported me during the development of my dissertation. Many thanks go also to Professor Mihály Kökény and Dr Elke Jakubowski, who at a very early stage shared their knowledge with me, which helped me to focus my research. My appreciation also goes to Dr Matthias Wismar, who introduced me to several public health experts from SEEHN member countries. I would like to express my sincere gratitude to Dr Maria Ruseva and Ms Neda Milevska Kostova, who supported me throughout my dissertation with much-needed clarification and literature. Special thanks are due to all the interviewees for their time and valuable contributions. My sincere appreciation goes again to Ms Neda Milevska Kostova, and also to Ms Oanh-Mai Chung, who found the time to peer-review my dissertation. Last but not least, many thanks go to the institutions that reviewed this shorter, modified version of the dissertation and for their editorial role in the publication process.

Alain Nellen
October 2016

ABBREVIATIONS

CEB	Council of Europe Development Bank
CMHC	community mental health centre(s)
FCTC	Framework Convention on Tobacco Control
HBP	Health as a Bridge for Peace
HiAP	Health in All Policies
NCD	noncommunicable disease(s)
NGO	nongovernmental organization(s)
RHDC	regional health development centre(s)
SDC	Swiss Agency for Development and Cooperation
SDG	Sustainable Development Goals
SEE 2020	South East Europe 2020 Strategy: Jobs and Prosperity in a European Perspective
SEEHN	South-eastern Europe Health Network
Stability Pact	Stability Pact for South-eastern Europe
TAIEX	Technical Assistance and Information Exchange instrument of the European Commission
WHO	World Health Organization

EXECUTIVE SUMMARY

SEEHN, an intergovernmental initiative for regional cooperation on health, was established in 2001 to strengthen health and stability in south-eastern Europe and to contribute to preparing the region for European Union integration. This paper examines why SEEHN emerged and how it has attempted to address public health concerns through regional cooperation. The paper will argue that through SEEHN's various activities, the health sector has become a post-conflict recovery mechanism after the devastating conflicts in former Yugoslavia, which led to regional political, social and economic turmoil. Serving as a platform for trust-building, the network has brought south-eastern European countries to the same table to pool resources among stakeholders and establish a shared vision by implementing joint regional projects on common health concerns. Cooperation at political and technical levels has also resulted in long-term partnerships between SEEHN member countries and numerous donor countries, international organizations and nongovernmental organizations (NGO) that have supported the network, both technically and financially. Over the years, SEEHN has shifted its vision towards promoting health as an integral part of economic development through a whole-of-government and whole-of-society approach. SEEHN has proved to have great potential as a sustainable initiative of regional ownership, particularly highlighted through the establishment of its own secretariat and regional health development centres (RHDC) across the region. However, the network faces new and ongoing challenges, internal and external, that put it at risk of operational stagnation and undermine its sustainability. The main challenges relate to political commitment, secretariat capacity, communication strategy, involvement of local actors in achieving health equity, and relationships with external partners to enhance information systems to conform to European Union standards.

Network governance theory approaches are used to illustrate the importance of a well established network governance structure at both political and technical level. This is important for SEEHN's sustainable operational capacity and the added benefits of cooperation.

This paper contributes to the limited literature on SEEHN available as at 15 June 2015 and to the overall scholarship pertaining to health as an integral part of post-conflict and economic development, the concepts of HBP and HiAP, and the notion of international cooperation in health governance. The findings concerning the network's achievements and challenges at both political and technical level can be used by public health policy-makers around the world.

1. THE EVOLUTION OF SEEHN'S GOVERNANCE STRUCTURE AND VISION

1.1 The rationale

Tozija *(4)* argues that countries in south-eastern Europe have faced similar challenges in responding to public health challenges as well as monitoring and gathering evidence in public health. Therefore, the establishment of a regional network[1] has been a meaningful and an intelligent instrument to engage in collaboration across governments, with the involvement of regional experts and the support of external partners, and jointly find practical solutions to minimize public health issues of regional concern. According to network governance theories, governance networks include a wide range of multilevel and multisector participants with different backgrounds. A governance network not only benefits from aggregated financial resources but is designed so that its stakeholders bring together various resources to contribute to the effectiveness of the network. The crucial goal of network initiatives led by governments is to meet public goals by assigning tasks and responsibilities to each member, observing implementation performance and ensuring a structural information flow. One of the most important rationales behind these collaborating efforts is to ensure the most effective undertaking to address public goals which one single member alone could not as effectively accomplish *(3,5)*. Moreover, collaborative visioning results in shared values and creates trust. In network governance theories, creating trust is another fundamental factor to ensure sustainable and effective governance of a network. These crucial factors will be discussed in relation to the evolution of SEEHN's governance structure and cooperation at the technical level.

As the south-eastern European countries are relatively small in geographical size and have limited resources, they struggle to be heard in European and global health policy-making. By identifying common issues and goals, regional networked cooperation gives these countries an opportunity to be heard as one voice in international health governance negotiations. This practice can be directly linked to what Kickbusch et al. *(6)* describe as the goal to incorporate

1 Throughout this paper, the term 'network' follows Creech et al.'s broad concept of "a group of individuals from different institutions choosing to work together towards a common goal" *(3)*.

"multi-level and multi-actor negotiation processes that shape and manage the global policy environment for health". SEEHN can directly influence the European policy landscape in health. This was witnessed in 2012 when the SEEHN member countries delivered joint statements[2] regarding draft resolutions at the 62nd session of the WHO Regional Committee for Europe concerning action plans such as Health 2020: the European policy framework for health and well-being, and the European Action Plan for Strengthening Public Health Capacities and Services. During negotiations, for instance, delegates representing all SEEHN member countries together engaged in dialogue, meaningfully contributing to the final draft of those policy frameworks *(7)*. Lessons learned from engaging in health policy negotiations at the European level give SEEHN member countries great potential to be influential actors when engaging with one voice in negotiations at the annual World Health Assembly.

"Health diplomacy has to be seen in its broadest context, outside the country's boundaries: for small states in particular, size is not a destiny and can be turned into an opportunity."

– Dr Mihály Kökény, Former Minister of Health of Hungary (8)

1.2 The establishment of SEEHN (1999–2001)

The break-up of the Socialist Federal Republic of Yugoslavia resulted in the establishment of newly independent countries: Bosnia and Herzegovina, Croatia, Slovenia, the former Yugoslav Republic of Macedonia, and the Republic of Yugoslavia (since 2006, Montenegro, and the Republic of Serbia). The human suffering that resulted from the ethnically driven Yugoslav conflicts was catastrophic in terms of deaths, large-scale forced migration and health consequences. Large-scale destruction of health-care facilities in the territories affected by the conflict, particularly in Albania, Bosnia and Herzegovina, Kosovo, and the former Republic of Yugoslavia, seriously undermined public health services. Many health professionals were killed or fled. The population suffered from preventable diseases and increasingly faced death. People with chronic diseases were particularly vulnerable. Yugoslav republics and neighbouring countries in south-eastern Europe were challenged by the large influx of refugees. Displaced people were very vulnerable to communicable diseases, psychiatric disorders *(9,10)*,[3] and noncommunicable diseases (NCD), and faced unequal access to health care due to poverty and discrimination.

2 For the full list of published SEEHN joint statements, please see http://seehn.org/category/publications/jstatements/.

3 A programme at Harvard University analysed psychiatric disorders among refugees from Bosnia and Herzegovina in 1996 *(9)*. A follow-up study in 1999 *(10)* indicated a higher level of disabling depression and post-traumatic stress disorder within the refugee community. The long-term effect of mental illness was emphasized by the follow-up study, which showed that 43% of those participants who remained in the Balkan region showed continuing psychiatric symptoms, mainly depression, three years after the first evaluation. Sixteen percent of participants without symptoms in the initial study showed psychiatric disorders three years later, particularly depression.

During the first decade of the post-conflict era, south-eastern Europe was subject to rapid political, social and economic transition which weakened countries' ability to respond to the severe health issues among the population, particularly across the newly independent countries. The region suffered enormous economic challenges in shifting from a communist economic model to a market economy, while ethnic tensions within countries and across the region still existed. The transition period saw the serious undermining of already fragile health and social systems owing to financial instability, inefficient organizational frameworks and a reduction of investment in these services.

In 1999, the Stability Pact for South-eastern Europe (Stability Pact) was created under a European Union initiative to re-establish peace and security in the region and to support the region for European and Euro-Atlantic integration. The Stability Pact brought international organizations and partners together with the signatories of south-east European countries to collaborate "in efforts and reforms aimed at sustainable peace, democratic development and economic well-being aimed at ensuring long-lasting stability to the region" *(11)*. Ruseva et al. *(12)* explain that in 1999 health was not considered a meaningful contributor to reconciliation, peace-building and stability, as "the non-productive social sector was deemed by the states as a consumer of income rather than as a producer of value". However, a wide range of international organizations and regional partners and countries agreed (after severe pressure from international actors like the Council of Europe, the CEB, the International Labour Organization and the European Trade Unions Confederation) to include social development in a holistic approach towards stability and economic development by "addressing the social issues that affect the daily lives of citizens of south-eastern Europe through regional approaches in the field of health, social protection, employment policy and vocational training, social dialogue and housing" *(13)*. As a result, social cohesion was added to the Stability Pact in 2001.

SEEHN, an intergovernmental initiative comprising the ministries of health of the seven south-eastern European countries at that point in time,[4] was established in 2001 as part of the Stability Pact's Initiative for Social Cohesion under the auspices and strategic guidance of the Council of Europe, the CEB and WHO Regional Office for Europe, with the aims of "fostering regional cooperation and stability of the south-eastern European countries and preparing them for eventual integration into the European Union" *(14)*. However, it could be argued that the establishment of SEEHN was already an achievement. Political instability, ongoing conflicts and mistrust led to poor relations among the countries of the region. The WHO Regional Office and Council of Europe, with the support of the Ministry of Health of Bulgaria, organized the founding meeting of SEEHN in April 2001 in Sofia, where the organizers were challenged to improve dialogue among representatives of the south-east European countries, which hardly

4 Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Romania, the former Yugoslav Republic of Macedonia and the Federal Republic of Yugoslavia.

spoke to one another. Dr M Ruseva (pers. comm., 24 March 2015), acting head of the SEEHN Secretariat and coopted member of SEEHN's Executive Committee, describes the encounter as "the most silent meeting of all the meetings I have seen in my life". At the second SEEHN meeting in Bucharest in June 2001, a cross-country study was presented by an international expert, outlining shared public health challenges for the countries at that point in time. The plan was to establish different projects for public health challenges of regional concern, with each country taking the lead on one. This afforded countries the opportunity to demonstrate leadership and increased prosperity, cultivating a greater spirit of cooperation among them.

1.3 Member countries and external partners

The founding political policy document of SEEHN, the Dubrovnik Pledge, was signed in 2001 by Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Romania, the former Yugoslav Republic of Macedonia and the Federal Republic of Yugoslavia. The Republic of Moldova joined SEEHN in 2002. Later, in 2006, the Federal Republic of Yugoslavia split into two separate countries: Montenegro, and the Republic of Serbia. In 2011, the membership request of Israel, a supporting country of SEEHN since its inception *(12)*, was approved by SEEHN, increasing its current membership to 10 countries (see Table 1).

Table 1. Member countries of SEEHN

Member country	Year of entry
Albania	2001
Bosnia and Herzegovina	2001
Bulgaria	2001
Croatia	2001
Israel	2011
Montenegro	2006*
Republic of Moldova	2002
Republic of Serbia	2006*
Romania	2001
The former Yugoslav Republic of Macedonia	2001

** 2001 under the Federal Republic of Yugoslavia*

Since the network's inception, its partners, consisting of international organizations, countries in Europe, NGO and other institutions (see Table 2), have shown strong political, technical and/or financial support and cooperation. Through trust-building, partners have contributed to the sustainable existence of the network by engaging in long-term partnerships. They have supported the network to strengthen regional health policy, implement health projects in key public health areas of common regional concern and helped to establish RHDC

within SEEHN member countries. Dr M Ruseva (pers. comm., 24 March 2015) explains that they have behaved like partners rather than donors. In biannual regional meetings, each partner has listened to the reports, participated in discussion without dominating it, and given the network flexibility to a certain extent in the use of their financial contributions to realize agreed activities and objectives. Strong friendships and partnerships have been established over the years as "it is not necessarily the amount of money [the partners] have given. It has been about their attitude, their behaviour and the partnership relations that have been maintained" (Dr M Ruseva, pers. comm., 24 March 2015). SEEHN partners' long-term support has highlighted the shift from a humanitarian agenda to one of development aid, as the transitional phase between these two sectors of support is often blurred.

Table 2. List of external partners of SEEHN by year of entry

Partner	Type of institution	Year of entry
Council of Europe	Regional organization	2001 (founding partner)
Council of Europe Development Bank	Regional development bank	2001 (founding partner)
WHO Regional Office for Europe	Regional organization	2001 (founding partner)
Belgium, France, Greece, Hungary, Ireland, Italy, the Netherlands, Norway, Slovenia*, Sweden, Switzerland*, the United Kingdom	2001	2001 (partner countries)*
International Organization for Migration	International organization	2005, but MoU** signed in 2013
Northern Dimension Partnership in Public Health and Social Well-Being	Policy framework partnership	MoU signed in 2007
European Health Forum Gastein	Regional forum	MoU signed in 2012
EuroHealthNet	Regional network	MoU signed in 2012
International Network of Health Promoting Hospitals and Health Services (HPH)	Network	MoU signed in 2012
Project Hope	NGO	MoU signed in 2012
Regional Cooperation Council (successor to Stability Pact)	Regional organization	MoU signed in 2013
Studiorum	NGO	MoU signed in 2013
European Center for Peace and Development (ECPD)	Research institution	MoU signed in 2014
South-East European Network on Workers' Health (SEENWH)	Regional network	MoU signed in 2014
European Commission	Regional organization	Observer

* *The period of partnership between SEEHN and individual partners differs according to the period of projects and initiatives which a particular partner supports. The partner countries were mainly involved in various regional projects between 2002 and 2011. Dr M Ruseva (pers. comm., 1 April 2015) explains that Switzerland and Slovenia are the current partner countries of SEEHN. Slovenia mainly provides technical guidance and shares experience, with a high attendance at events.*

** *MoU = Memorandum of Understanding*

In addition, Ms N Milevska Kostova (pers. comm., 25 March 2015), Executive Director of Studiorum, points out that external partners have a great incentive for being involved in SEEHN, because collaborative partnerships offer an entry point into 10 countries, while SEEHN benefits from new ideas brought into the region.

WHO Regional Office for Europe has been the key partner for SEEHN from the beginning. It has provided political, managerial, technical and financial support to establish the network's governance structure, delivering secretariat capacity and providing operational support across various regional projects. SEEHN has adopted several WHO action plans and frameworks. For example, crucial to SEEHN's current and future operations are the HiAP approach, the Health 2020 strategy, the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 and the European Action Plan for Strengthening Public Health Capacities and Services. Switzerland has also been a prominent partner country of SEEHN. Through the Swiss Agency of Development and Cooperation (SDC), it has helped by funding and/or providing technical guidance to several SEEHN projects and the RHDC on mental health, such as the 2012–2014 project on strengthening the capacities of mental health professionals and users' associations. The SDC also engaged in a project with SEEHN on strengthening institutional capacities for regional cooperation in health in south-eastern Europe during 2013 and 2014. Through that project the SDC supported the development of managerial capacities of the SEEHN Secretariat and health diplomacy capacity among member countries (for example, supporting an executive course on health diplomacy in 2014).[5,6]

As this paper shows, the importance of having multisectoral partners of a multilevel nature is fundamental to SEEHN's sustainability, because partners create a holistic understanding (information, knowledge and complementary implementation skills) of how to respond to complex policy scenarios in health.

1.4 Key policy documents

The South-eastern Europe Ministers of Health forums are the highest political body of SEEHN. So far, three have been held: in Dubrovnik in 2001, Skopje in 2005 and Banja Luka in 2011. These are a platform where the SEEHN mandate of regional cooperation in health is reviewed, updated and ratified by member countries in the presence of partners.[7] The reviewing and updating approach

5 The project brief for Strengthening institutional capacities for regional cooperation in health in south-eastern Europe is available at https://www.eda.admin.ch/deza/de/home/aktivitaeten_projekte/projekte.html/projects/SDC/en/2013/7F08445/phase1 (accessed 2 October 2016).

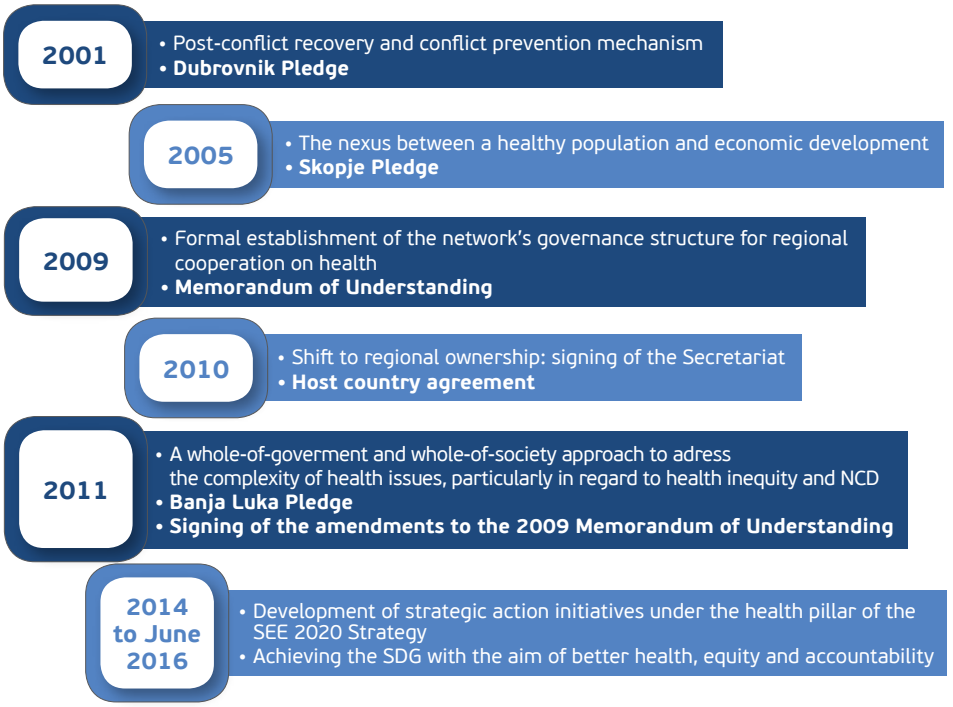
6 Ms M Zaric (pers. comm., 2015), Programme Officer for Health at the SDC office in Bosnia and Herzegovina, emphasizes that the motivation behind the SDC's year-long contribution to SEEHN is partly the overall development cooperation strategy of the agency in different sectors and fields across south-eastern Europe and the Swiss Health foreign policy agenda.

7 Each forum resulted in a correspondingly named pledge: the Dubrovnik Pledge *(15);* the Skopje Pledge *(16)*; and the Banja Luka Pledge *(17).*

is an important component of effective network governance. Huppé et al. *(18)* argue, based on the findings of several scholars, that individual stakeholders have a "restricted capacity" to have an impact on policy outcomes; thus, learning from and within other policy-making stakeholders is crucial. In other words, it is a learning-by-doing process with an approach rotating from "theoretical notions of the problem frame to concrete constellations in policy fields".

Through its key policy documents, SEEHN initially promoted reconciliation, stability and peace in south-eastern Europe, subsequently moving to an innovative forum that fostered collaborative efforts to put health on the agenda of economic development. SEEHN then acknowledged global health governance trends by adopting a whole-of-government and whole-of-society approach by putting health on a multilevel and multisectoral policy agenda to address the complexity of public health concerns, particularly in relation to health equity, accountability and NCD.[8] It is currently developing strategic action initiatives under the health pillar of the SEE 2020 as well as aiming to achieve the United Nations' SDG *(19)*. This progression is illustrated in Fig. 1.

Fig. 1. Evolution of SEEHN's vision



8 Ruseva et al. *(12)* explain that SEEHN saw the need to adopt a societal standpoint to address health concerns in the societal and economic diversity in the region which had also been complemented by "a rapidly changing national, European and global landscape". As a response, SEEHN extended partnerships (see Table 2) and adopted global and European guidelines like the HiAP approach, the Health 2020 strategy, the European Action Plan for Strengthening Public Health Capacities and Services, and the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016.

The process of establishing an effective institutional framework that enables regional collaboration together with national leadership was the result of an extraordinary partnership between the founding member countries, WHO Regional Office for Europe, the Council of Europe and CEB (within the framework of the Stability Pact), together with 11 donor countries[9] *(12)*. The Dubrovnik Pledge is the cornerstone agreement for taking the first steps towards regional, cross-border health development as an instrument to peace and stability across the region *(14)*. The Dubrovnik Pledge served as verification of member countries' willingness to fulfil SEEHN's aims, in particular to enhance "professional exchange" and "regional partnership" *(12)*.

Member countries committed themselves to mobilizing human and financial resources to address the health needs of common concern to their most vulnerable populations. They committed themselves to "ensure equity, health gain and a better quality of life and health care (including reduced inequalities in its infrastructure and balanced primary and secondary services and public health interventions for the populations of [south-eastern Europe])" *(15)*.

Identifying areas of common concern can be linked to the theoretical approach in network governance theory regarding collaborative visioning and vision sharing.[10] Not only are these theoretical notions crucial for trust-building,[11] they also provide the foundation for practical learning by giving stakeholders a direction as well as commitment and a purpose for collaborating *(18)*.

SEEHN moved to full regional ownership when the Regional Cooperation Council took over patronage of the network in 2008. The establishment of RHDC and the network's own Secretariat were embodied in the 2009 Memorandum of Understanding *(21)*, amended in 2011 *(22)*, followed by the signing of the Secretariat host country agreement in 2010. This progress demonstrated member countries' willingness to show leadership in regional health cooperation. To date, SEEHN's governance structure at the political level includes a six-monthly rotating presidency, biannual regional meetings, an Executive Committee, national health coordinators,[12] its own Secretariat and a Memorandum of Understanding that incorporates the network's statutes

9 Belgium, France, Greece, Hungary, Italy, Norway, the Netherlands, Slovenia, Sweden, Switzerland and the United Kingdom.

10 Huppé et al. *(18)* outline the relationship between shared visions and network governance as follows: "Shared visions enable participants' understanding of each other's expectations, what outcomes to measure and what theories are in application. Visioning is undertaken with the goal of identifying attractive system innovations and the commitment for collaborative governance."

11 Trust-building is important for a network to be effective in its governance and policy implementation process. In governance theory, trust is crucial to the concept of social capital. Cohen and Prusak *(20)* describe social capital as "the stock of active connections among people: the trust, mutual understanding and shared values and behaviours that bind the members of human networks and communities and make cooperative action possible".

12 The role of national health coordinators is embodied in Article VI of the Memorandum of Understanding *(21)* and Article III of its 2011 amendment *(22)*.

and principles of regional cooperation.[13] The roles of the Secretariat, as well as other functionaries like the Executive Committee, national health coordinators and RHDC, are vital for effective cooperation among all stakeholders within SEEHN, in keeping with Huppé et al.'s theoretical approach that the capability of networked governance can be meaningfully enhanced when the organizational and regulatory structure encourages institutional brokering *(18).*[14]

13 The principles are: regional ownership, partnership, transparency and accountability, complementarity, sustainability, equal and active involvement of all member states, distribution of activities and resources based on a country needs assessment, decentralization of activities and resources, and efficiency. All projects have to adhere strictly to these principles without deviation. These principles are still currently morally and legally binding and all network operations have to observe them (Dr M Ruseva, pers. comm., 24 March 2015).

14 Institutional brokering is a term used in network theory, meaning to facilitate links between several groups. In addition, "it brokers not only an appropriate flow and control of information, but also takes into account the various group dynamics such as motivations, resources asymmetries and worldviews in order to build trust, forestall conflicts, facilitate collaboration, identify opportunities, etc." *(18).*

2. MAIN ACHIEVEMENTS IN TECHNICAL COOPERATION

It can be argued that creating a high-level political governance framework that enables regional cooperation in public health among governments that are alienated in other sectors is already an achievement. Implementing strategies and cooperating at the technical level to meet political objectives is an additional challenge but essential for the network's effectiveness and sustainability in enhancing countries' health systems and contributing to reconciliation, peace, stabilization and long-term development in the region.

2.1 Projects covering common regional public health concerns (2002–2011)

Between the First Health Ministers' Forum in Dubrovnik in 2009, when the key public health areas of common concern were identified, and the Third Forum in Banja Luka in 2011, nine projects were implemented across several public health areas (see Table 3). These projects aimed to facilitate efforts to strengthen national health systems through regional cooperation. Countries committed themselves to lead one project of technical cooperation in their chosen area of common public health concern, which gave them a sense of ownership and leadership. This was also a vital factor in encouraging them to work together in initiatives led by other countries. A regional project office was established in each country to lead the respective technical project. These regional project offices facilitated, coordinated and observed regional technical cooperation by bringing together the professional community/experts from all the member countries with specific external partners to share knowledge, assess national health system status and help health ministries with policy-making and reform. In other words, these regional project offices combined created nine technical subnetworks within SEEHN, each covering a specific area of public health.

Table 3. SEEHN projects to 2011

Lead country	Project focus	Period	Partners/donors
Albania	Communicable diseases surveillance and control	2002–2008	Belgium, France, Greece, the Netherlands, WHO Regional Office for Europe
Bosnia and Herzegovina	Mental health	2002–2008	Belgium, Greece, Hungary, Italy, Slovenia, Sweden, Switzerland, WHO Regional Office for Europe
Bulgaria	Information systems for community health services	2005–2008	Geneva Initiative, Greece, Open Society Institute, Switzerland, WHO Regional Office for Europe
Croatia	Tobacco control	2005–2007	Norway, Slovenia, WHO Regional Office for Europe
Republic of Moldova	Maternal and neonatal health	2007–2010	Norway, WHO Regional Office for Europe
Republic of Serbia	Community-based care for children with disabilities	2009–2011	Belgium, WHO Regional Office for Europe
Republic of Serbia	Food safety and nutrition	2002–2008	Belgium, Greece, Italy, Slovenia, Switzerland, WHO Regional Office for Europe
Romania	Blood safety	2004–2011	Council of Europe, Ireland, Slovenia, Switzerland, WHO Regional Office for Europe
The former Yugoslav Republic of Macedonia	Public health services	2007–2011	CEB, Israel, Slovenia, United Kingdom, WHO Regional Office for Europe

Source: WHO Regional Office for Europe (23)

Chichevalieva et al. *(23)* describe these regional projects as a meaningful tool to "introduce participants to the whys and wherefores of international cooperation and coordination, policy formulation, harmonization and legislative and regulatory follow-through; the projects also gave them a chance to try out some implementation modalities based on best practices". This said, apart from jointly addressing public health concerns that one country alone could not necessarily do as effectively, regional projects had other benefits. Creech et al. *(3)* point out that "those who work in partnerships can better enrich the content of their programs, scale them up, intensify their outreach, and continue to support them". Intergovernmental collaboration reduces the risk of an individual country implementing counterproductive reforms and "a regional approach is more effective in raising public awareness and combating stigma, as the process gains in authority and scope" *(24)*.

Cooperation between the regional professional community and external partners, particularly across the first generation of regional projects (2002–2005), can also be linked to features of WHO's HBP concept, which primarily focuses on technical collaboration. The HBP approach, which integrates the health aspect in peace-building in a conflict or post-conflict context, embraces support to the health professional community in implementing initiatives for multidimensional policy-making. In this concept, "health personnel from conflicting sides have been producing a joint effort in policy, training and service delivery initiatives" *(25)*, and the same can be argued of SEEHN regional projects. Table 4 gives examples of HBP implementation *(25)* and its correspondence to the methodological approaches of SEEHN projects.

Table 4. Similarities between HBP and SEEHN project methods

Extract from examples of HBP implementation	Methods used in SEEHN projects
Health Policy: Reintegration of demobilized soldiers or minority groups within the national health system	Health equity is a core objective embodied in all Pledges and thus fundamental to all project strategies
Health Policy: Elaboration of strategic plans for health system reform involving all actors in the framework of post-war reconstruction	SEEHN came under the auspices of the Stability Pact's Initiative for social cohesion and thus crucial actors, particularly in health matters for post-war reconstruction, were present (WHO Regional Office for Europe, Council of Europe and CEB)
Training: Joint working groups on technical issues	National expert groups collaborated (with the support of external partners) to develop, strengthen or reform specific public health policies and legislation in respective health areas through regional projects
Training: Regular contacts between health professionals of all communities, through the promotion of multiple cross-community technical conferences, workshops and seminars	Training workshops/capacity-building was an essential part of most projects
Training: Exchange activities promoting international links among professionals of different groups	Through collaboration in regional projects, trust, shared knowledge and shared visions were developed with strong working and learning links to external partners that supported the process

As mentioned previously, external partners are crucial for SEEHN's effectiveness in regional collaboration in order to develop policies, legislation and institutions that help countries to provide the best public health services and systems possible. Between 2001 and 2011, partners donated approximately 7.2 million euros for projects *(23)*. In addition, since its establishment SEEHN has not only provided a platform for member countries to collaborate but has also enabled them to connect to major international organizations, partner countries and specific specialized partner institutions *(23)*. Many projects were therefore conducted using internationally agreed principles, goals and standards. This increased the capacity for policy-making, harmonization and advocacy because, as noted by Maurer and Murko *(24)*, "the transfer of knowledge and expertise as to what to do and how to do it is facilitated, while making it more difficult for a given individual country to ignore the consensus or delay reforms".

2.1.1 Case study I: the flagship project in mental health

The regional mental health project entitled Enhancing Social Cohesion through Strengthening Community Mental Health Services in South-eastern Europe served as a model for all the other SEEHN projects (Ms N Milevska Kostova, pers. comm., 25 March 2015; Dr M Ruseva, pers. comm., 24 March 2015) *(23)*. An examination of the structure and methodological approaches of this project illustrates its achievements as regards cooperation at technical level, such as trust-building, sharing information and establishing strong links among stakeholders, receiving technical guidance and financial support from external partners, following global and European health policy trends, enhancing regional policy harmonization, implementing policies at community level, as well as promoting the project at the European level.

As a result of war-related stress and socioeconomic pressures at a time of political, social and economic transition, there had been a large increase in mental health problems among individuals and groups in the region. Maurer and Murko *(24)* explain that "it becomes harder to maintain a reasonable standard of living; support groups become less effective and many even disappear; there is greater risk of isolation or social exclusion due to deracination, weakening social ties and institutions, and social atomization". The health ministers of the SEEHN countries jointly agreed that mental health was a vital factor to be addressed in the regional cooperation process to reform national health systems. The mental health project, therefore, was one of the first practical efforts to meet the policy implementation guidelines set out in the 2001 World health report on mental health *(26)*. In addition, project partners encouraged stakeholders to design policy strategies that aligned with European guidelines, such as the 2005 European Commission green paper on improving the mental health of the population *(27)*.

The mental health project was supported by WHO Regional Office for Europe and the Council of Europe. It was also the first project under the auspices of

the Stability Pact's Social Cohesion Initiative and the first collaborative action taken under SEEHN (Dr M Ruseva, pers. comm., 24 March 2015; Ms N Milevska Kostova, pers. comm., 25 March 2015) *(24)*. The project officially commenced in 2002 and ended in 2008. It included a political and managerial component to put theory into practice effectively. The political component was under the responsibility of a Steering Committee composed of representatives of the SEEHN countries, WHO Regional Office for Europe and Council of Europe, and representatives of the partner (donor) countries. SEEHN's Executive Committee, the regional project office and the individual country offices, including country project managers, shared responsibility for the managerial component across the member countries *(28)*.[15] The project period was divided into three phases. The first phase included approaches for sharing a common policy vision; the second covered the establishment of pilot community mental health centres (CMHC) and a management system; and the third focused on training programmes for mental health workers.

Funding for the project was crucial for its effectiveness. SEEHN raised 3.168 million euros from external partners over the project's six years of operation (see Table 5, which also shows how the donations were allocated over the three phases of the project). Greece, in particular, proved to be a vital donor for all three phases, contributing almost half of the total donations. Dr M Ruseva (pers. comm., 24 March 2015) emphasizes that Greece made clear from the beginning that it was going to support the project financially and technically. Maurer and Murko *(24)* give a possible explanation for Greece's generosity: Greece was committed generally to the Balkan region and was reforming its own national mental health system at that time, which gave it an understanding of the challenges and how to develop suitable implementation strategies in the region. Financial contributions from SEEHN countries were important for the second and third phases of the project. They provided resources for the establishment of CMHC (premises, salaries, equipment, etc.) and contributed to the sustainability of the reforms *(24)*.

15 These components were subsequently applied to the overall organizational structure of SEEHN projects.

Table 5. Project funds by donor and project phase, 2002–2008

Donor/ partner	Phase one (policy design)	Phase two (CMHC)	Phase three (training and advocacy)	TOTAL
	€ 000	€ 000	€ 000	€ 000
Belgium	-	131	388	519
Greece	539	600	400	1539
Hungary	-	9	-	9
Italy	74	280	-	354
Slovenia	50	32	22	104
Sweden	29	-	-	29
Switzerland	-	-	298	298
WHO	94	132	90	316
TOTAL	**786**	**1184**	**1198**	**3168**

Source: WHO Regional Office for Europe (24)

2.1.1.1 Phase one (2002–2004)

A regional project office was established in Sarajevo, the capital city of the project leader, Bosnia and Herzegovina. National offices and national teams of technical experts and public servants were established in all other participating countries. The country teams reviewed and assessed existing national mental health policies and legislation. Once the country assessments had been completed, all country teams worked jointly to design a common regional vision on mental health care, embodied in a Joint Statement and 12 principles[16] for regional mental health reform. Chichevalieva et al. *(23)* and Ruseva et al. *(12)* explain that this joint action resulted in the development or revision of national mental health policies, legislations and strategies across all SEEHN countries. Zatlokal *(29)* points out that the first phase proved to be particularly challenging, as only one country had an official mental health policy and every country needed drastic health legislation reform. However, joint cooperation with intense negotiations between countries and numerous technical workshops at regional level resulted in a stable regional framework and action plan for mental health policies. The successful completion of the first phase had a side benefit for the second phase, in the motivation and enthusiasm that had sparked among all stakeholders.

16 The joint statement and its principles can be found in *Approaching mental health care reform regionally: the Mental Health Project for South-eastern Europe*, pages 40-41 *(24)*.

2.1.1.2 Phase two (2004–2005)

By the start of the second phase, project stakeholders enjoyed "the benefit of solid teamwork, mutual trust, managerial competence and friendship" *(29)*. The national teams valued WHO technical guidance in designing national mental health policies and legislation *(24)*. National team experts pointed out that the review of existing national frameworks and legislation identified major challenges to effective policy implementation, which would need good relationships between policy-makers and user associations. Good relationships were essential for the second phase of the project because governments had to implement the proposed mental health policies at the local level through the establishment of national CMHC *(24)*.

In 2005, every member country established a CMHC, with two centres in Bosnia and Herzegovina and the former Republic of Yugoslavia: a total of 11 CMHC, covering more than one million people, became officially part of the SEEHN countries' primary health care systems. Ten regional recommendations on principles and standards for CMHC were drafted to ensure effective operation.[17] One of the major lessons learned during this phase was in regard to the importance of vision-sharing among the country teams. Maurer and Murko *(24)* explain that a shared vision:

"provided a valuable lesson in the importance of rendering explicit what are assumed to be common understandings – all too often they disguise real differences in viewpoint that can be overcome if discussed openly at the beginning of the process, but come to appear fundamental once implementation is already underway and the differences are instrumentalized in practice."

This is also linked to local engagement in multilevel knowledge-sharing, as scholars in network governance acknowledge that "agents at multiple levels can play an especially important role by providing leadership, building trust, developing visions and sense making ... as well as being brokers for connecting ideas, people and networks" *(18)*.

17 See *Healthy minds, healthy communities. Mental Health Project for south-eastern Europe (27)* for the full list.

"We all worked hard to implement the project and through our combined hard work we learned one of the most important lessons to date – a sense of togetherness. This derives from the project's regional dimension. There is no doubt that this sense of togetherness is the major factor that motivates each country in the project to sustain steady progress. It is also a source of support for countries in times of crisis, offering many opportunities for consultation and the exchange of advice, both formal and informal, which greatly facilitates conflict-resolution and decision-making."

– Dr Marin Kvaternik, Former Minister of Health of Republika Srpska, Bosnia and Herzegovina (29)

Stakeholders recognized the enormous benefit of information-sharing and saw the need to implement an effective monitoring and evaluation system that would contribute to the exchange of data for specific strategic policy guidance. The establishment of such a monitoring and evaluation system became a separate SEEHN project under the leadership of Bulgaria between 2005 and 2008, entitled Information Systems for Community Health Services.[18]

Project representatives were also able to take on an advocacy role when they were invited to the WHO European Ministerial Conference, Mental health: facing the challenges, building solutions, in Helsinki in 2005 to present and promote the project and share their experience regarding the benefits of regional cooperation in developing and implementing mental health policies and legislation. Zatlokal *(29)* states that this side event was attended by more than 130 individuals, including a large number of ministers and well known mental health authorities in Europe.

2.1.1.3 Phase three (2005–2008)

The final phase of the project was dedicated to capacity-building, particularly designing mental health training modules for mental health professionals working in the CMHC and primary health-care practitioners working in the CMHC catchment areas. For example, mental health professionals were trained in technical case management and strengthening community team leadership capacity *(12,23,29)*. General practitioners were trained in early detection and treatment of mental health issues, and learned about the benefit of having a CMHC as an alternative to a large institution for service provision and medication *(24)*.

18 This project demonstrates the importance of addressing and developing regional policy harmonization as well as standardization to implement regional information systems in any field of public health. It is also a good example of how the objectives of an individual regional project can be more easily achieved when two separate projects closely collaborate with each other, which can be applied to SEEHN's current and future initiatives *(14)*.

It could be argued that the success of the mental health project as a whole greatly contributed to the signing of the joint declaration, The Long-term Programme for Regional Collaboration and Development on Mental Health, by the south-east European ministers of health in 2007. The declaration's recommendations were subsequently implemented by all member countries as national action plans and strategies *(23)*, representing region-wide policy harmonization, from community to ministry level, and in line with emerging European and global frameworks. At the end of the project, a report was published which documented the project's process of joint collaboration in mental health policy reform and legislation.

2.2 The establishment of RHDC (2010 to date)

> **"The regional notion of 'balkanization' is changing from a synonym of fragmentation, partition and conflicts towards a model of cooperation."**
>
> *– Mr Alexander Vladychenko, Director General of Social Cohesion, Council of Europe (30)*

As many individual projects successfully achieved their aims, SEEHN health ministers, the SEEHN Executive Committee, external partners and individual experts involved in the projects recognized that technical cooperation[19] should proceed through institutions entrusted to provide, coordinate and facilitate specific technical expertise. As a result, most regional project offices and their experts were transformed into RHDC. Others were integrated into existing national institutions in the relevant technical field. The establishment of the RHDC was arguably crucial for SEEHN to meet its mandate as a sustainable regional public health initiative. RHDC facilitation in technical support represents an essential component in SEEHN fulfilling its mandate across multiple areas of regional public health concern.

The role and function of RHDC are embodied in Title III, Article VIII of the 2009 Memorandum of Understanding, while Annex 2 contains a detailed outline of their function and Annex 3 sets out the criteria for their designation *(21)*.[20] Tozija *(4)* argues that the RHDC are vital agents in ensuring regional technical cooperation by "supporting planned strategic objectives at the sub-regional and European region levels, enhancing the scientific validity of SEEHN's public

19 After 10 years of regional collaboration, SEEHN conducted a survey among its stakeholders, which showed that 78% of stakeholders perceived regional technical cooperation as extremely or very essential, 73% highly valued the strong professional relationships developed through the network, and 75% expected RHDC to make a meaningful contribution to regional collaboration *(23)*.

20 Key roles of the RHDC include promoting SEEHN's policies and priorities in specific technical areas, facilitating networking and cooperation among country representatives and partners in the technical work, providing training and undertaking administrative tasks for projects, programmes and activities, and promoting human rights, as well as interdisciplinary and intersectoral approaches in fulfilling their functions.

health work and developing and strengthening the institutional capacity of [south-east European] countries, and even beyond."

Given the role and function of RHDC, every RHDC could be viewed as an institutional agent that creates a subnetwork within SEEHN. This also reflects the networked governance that, for instance, leads to strong relationships and fosters technical cooperation among member countries, partners and specific technical partners for each individual health area. Chichevalieva et al. *(23)*, Ruseva et al. *(12)* and Ms N Milevska Kostova (pers. comm., 25 March 2015) suggest that like the projects between 2002 and 2011, regional collaboration through the RHDC brings meaningful value to the countries, as each can benefit from the specific scientific expertise of other countries without having to establish or maintain domestic centres in all the technical health areas at the same scientific level.

SEEHN currently has nine RHDC – in Tirana (communicable diseases), Sarajevo (mental health), Sofia (antimicrobial resistance), Zagreb (organ donation and transplant medicine), Chisinau (human resources for health), Skopje (public health services), Podgorica (NCD), Oradea (blood safety) and Belgrade (accreditation and continuous quality improvement of health care) – which provide a comprehensive collaborative response to jointly identified key public health challenges in the region. Each centre is under the leadership of one member country in collaboration with national counterparts (also called national focal points) from the other countries.

It should be pointed out, however, that some RHDC are not as developed as others. Ms M Zaric (pers. comm., 21 May 2015) believes that the concept of RHDC is a good idea with lots of potential, but from her experience there is a lack of commitment. Member countries are recognized as capable of hosting a RHDC in a specific health topic but often they do not invest in it. Ms N Milevska Kostova (pers. comm., 25 March 2015) explains that it depends on the manager's productivity and availability of time, resources and enthusiasm. Some RHDC are newly established and need time to develop. In addition, Dr S Rakic (pers. comm., 26 March 2015), from the Public Health Institute of the Republic of Srpska in Bosnia and Herzegovina, believes that an effective RHDC manager must have the time and know-how to approach donors and actively lobby for funding, as well as to bring experts together, and SEEHN should give more consideration to this. Some RHDC, such as the RHDC on mental health, are run by civil servants, who may not have the requisite skills – or time, as they also have to undertake other tasks within the ministry of health (Ms M Zaric, pers. comm., 21 May 2015) – to manage a centre effectively. Both Ms M Zaric and Dr S Rakic argue that it is difficult for civil servants to give adequate attention to RHDC activities which are crucial for a centre's effective operational sustainability. Ms M Zaric (pers. comm., 21 May 2015) says that the RHDC on mental health has not yet met expectations in terms of undertaking activities other than hosting regional meetings, training workshops, study visits and publishing newsletters and she is concerned that it

has lost capacity, as there is no ongoing overall project under implementation. Similarly, Dr S Rakic (pers. comm., 26 March 2015) says that as a focal point for the RHDC on human resources for health, he has been invited to only three meetings over the last three years, and no activities have been undertaken by the centre. Given that some RHDC face challenges regarding technical operations and managerial capacity as well as in initiatives, the potential of RHDC remains untapped. Ms N Milevska Kostova (pers. comm., 25 March 2015) emphasizes that "we need to make it attractive and competitive in order to make it a privilege to become a RHDC". SEEHN health ministers discussed how to strengthen the technical capacity of RHDC at the regional meeting in Belgrade in June 2015. The health ministers officially committed to financial contributions to the RHDC and revision of the current managerial mechanism to allow proper, sustainable functioning of the RHDC. The Decision on the performance of the RHDC was endorsed, with the accompanying Protocol, and the whole inserted as an additional chapter of SEEHN's Standard Operational Procedures, to be endorsed at the Fourth Forum in Chisinau in April 2017.

2.2.1 Case study II: the RHDC on Organ Donation and Transplant Medicine

The RHDC on Organ Donation and Transplant Medicine in Croatia represents an effective subnetwork framework which fosters long-term cooperation in implementing organ donation and transplantation systems within SEEHN countries. The centre has worked closely with the countries' health ministries to design, implement and constantly update country-specific plans which serve as independent and sustainable models to foster living and deceased donations and transplantations. The centre has done this by facilitating networking through an interdisciplinary approach using a widespread, transparent communication model (see Fig. 2). The communication protocol creates a platform for regional knowledge and data exchange, as well as expertise and assistance between the centre and health ministries, partners,[21] national focal points,[22] specialized external partners[23] and selected country delegates. Raley et al. *(31)* state explicitly that:

"regular communication with national focal points and delegates allows for pertinent knowledge updates helping to ensure forward moving momentum.

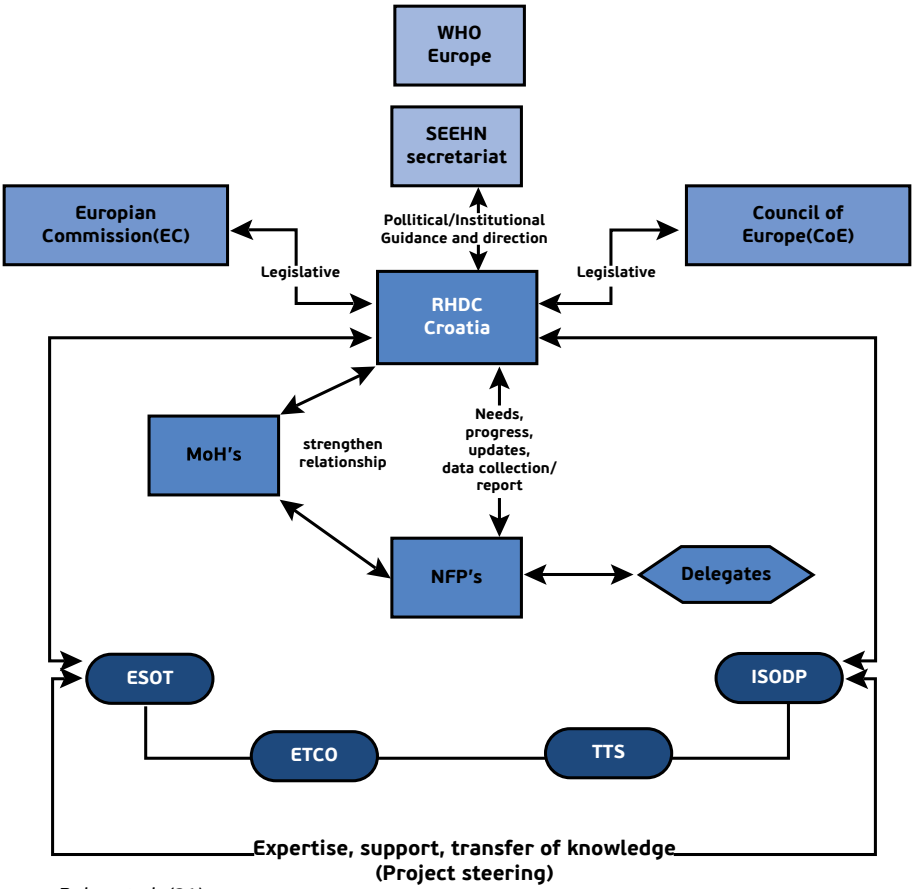
21 WHO Regional Office for Europe, the Council of Europe and European Commission, mainly through online conferences and email exchange.

22 The national focal point is a professional who acts as liaison officer and is responsible for the coordination of activities within a particular country and across countries. As such, focal points can be seen as agents of the theoretical notion of *intermediate modularity.* Scholars argue that this notion "allows different groups to develop partly distinct knowledge and perceptions of the problem at hand, which can then be conveyed across to other groups within the network" *(18)*, thus strengthening governance to enhance effective problem-solving procedures.

23 The Transplantation Society, European Society for Organ Transplantation, European Transplant Coordinators Organization and International Society for Organ Donation and Procurement.

Cultivating and fostering these personal relationships (including direct contact with national focal points from international expert collaborating partners) has been a crucial step in facilitating rapid change and effective communication exchange for professionals engaged in the RHDC Croatia project, and the officials from their Ministries of Health."

Fig. 2. RHDC Croatia – communication protocol [24]



Source: Raley et al. (31)

Cooperation is strengthened by a regional database for referencing and reporting, containing contacts, technical and legislative guidelines, official regional data, plus presentations from seminars, meetings and workshops *(31)*. September 2012 saw a milestone achievement, when a team of Croatian medical transplant professionals assisted their Montenegrin colleagues in the first ever organ transplantation in Montenegro. This was the result of a year

24 The diagram uses the following abbreviations: MoH's = ministries of health; NFP's = national focal points; ESOT = European Society for Organ Transplantation; ETCO = European Transplant Coordinators Organization; TTS = The Transplantation Society; ISODP = International Society for Organ Donation and Procurement.

and a half of cooperation between Croatia, Montenegro and specialized external partners under the facilitation of the RHDC *(32)*.[25]

The RHDC's report on in its accomplishments between 2011 and 2013 indicates several recommended actions for each of the SEEHN member countries *(33)*. This highlights the centre's support in the implementation of country action plans. It has coordinated different educational workshops in Croatia for over 350 regional professionals since its inception, with expert know-how and financial contribution from specialized external partners and the Technical Assistance and Information Exchange Instrument of the European Commission (TAIEX). Teaching modules were designed to meet the relevant specific country needs *(33)*. During 2014, the centre continued to provide educational courses and hosted a study visit for a delegation from the Bosnia and Herzegovina Federal Ministry of Health and for a delegation from the Republic of Serbia (Directorate for Biomedicine). It also facilitated discussions on the establishment of a new SEEHN initiative for a paired kidney donation system in the region *(33)*. Raley et al. *(31)*, in the context of their previous research on the interaction of people under the centre's mandate, note that:

"face-to-face events have enabled the creation of personal and trusting relationships amongst culturally diverse individuals working in the field. Individual socio-cultural perspectives have been set aside, focusing on the objectives of the project to increase donation and transplantation activity in the region together."

This statement demonstrates the fundamental aspect of effective network governance, namely creating social capital through sharing values and trust-building, which contributes to vision-sharing.

2.3 Capacity-building

SEEHN has facilitated numerous regional workshops through previous projects and RHDC, addressing drivers for effective policy-making to strengthen key public health areas of common concern and to stimulate the process towards European Union integration of its member countries. For such integration, each candidate country must meet a minimum standard of public health mechanisms. Strong ties with European Union institutions such as TAIEX are extremely important for SEEHN to help countries with the integration process. TAIEX supports "public administrations with regard to the approximation, application and enforcement of EU legislation as well as facilitating the sharing of EU best practices" *(34)*. SEEHN has admired the interaction of a large number of international and regional experts at TAIEX workshops in previous years, highlighted by resolutions and decisions that it could endorse, and wants to continue and expand workshops under this partnership. RHDC

25 The official statement from the RHDC, Croatia is available at http://www.eurotransplant.org/cms/mediaobject.php?file=montenegro_pressrelease_240912.pdf (accessed 6 October 2016).

submitted 18 requests in 2014 alone for multicountry workshops by TAIEX.[26] Approved workshops took place during the first half of 2015,[27] such as a TAIEX multicountry workshop on monitoring NCD and health inequalities related to NCD in Montenegro in January 2015. The NCD RHDC's target is to establish a joint NCD monitoring system, including regular reporting, for all SEEHN countries. Country profiles were reviewed and discussions took place among SEEHN countries, international organizations and European Union countries. The participants jointly agreed on a set of indicators on NCD which are also linked to health inequalities and which should be monitored and reported to the RHDC (cancers, cardiovascular diseases, chronic respiratory diseases and diabetes mellitus) *(35)*. Another TAIEX multicountry workshop, on public health policies regarding migration and health, was held in March 2015 in Albania, organized by the Communicable Diseases Surveillance RHDC and the Institute of Public Health, Albania *(36)*.

SEEHN has facilitated training for professionals to gain skills and learn about health diplomacy tools to engage in intersectoral and multilevel dialogue. In the Skopje and Banja Luka Pledges, health ministers committed themselves to address public health concerns through an intersectoral and multilevel HiAP approach, to put health higher on the political agenda of non-health sectors both nationally and regionally. In doing so, it has been acknowledged that owing to the intersectoral complexity of the determinants of public health issues, they cannot be solved by the health sector alone. SEEHN is currently implementing the intersectoral framework Health 2020 across its initiatives. Additionally, it has successfully put health on the economic agenda of the region, as demonstrated by the inclusion of a health pillar in the new SEE 2020 Strategy. This is a great opportunity for the SEEHN countries to engage in health diplomacy across the regional cooperation process. Milevska Kostova et al. *(8)* emphasize that:

"health diplomacy is wide-ranging. It can and needs to be applied in a variety of contexts and political or economic settings, as a driver and a means of addressing health as part of a holistic approach, focusing not solely on curing disease but also on preventing ill health and poor well-being. This is a proven method for improving economic growth and prosperity, based on ample practice and evidence."

SEEHN organized two comprehensive executive courses on health diplomacy in 2012 and 2014. The 2014 course took place in the Republic of Moldova, coordinated by WHO Regional Office for Europe and the Global Health Centre of the Graduate Institute of International and Development Studies, with the support of SDC. Thirty public officials from the health, economic and foreign

26 Ms M Zaric (pers. comm., 21 May 2015) says that it should not be solely the task of SEEHN to apply for TAIEX workshops, as it has been SEEHN who has mainly been organizing meetings. However, SEEHN is developing four long-term regional initiatives that incorporate various RHDC under the health pillar of the SEE 2020 strategy. This can potentially encourage RHDC to expand their activities and enhance their operational capacity.

27 This information is taken from an unpublished summary report of the 34th Plenary Meeting of SEEHN, held in Skopje, Macedonia, on 19–20 November 2014.

affairs sectors shared individual experience and discussed measurements to address public health issues that require complex multisectoral engagement. The course was taught by regional and international experts in global health governance and health diplomacy and participants gained and enhanced skills in intersectoral negotiations by exploring the role of health diplomacy and discussing new tools and technologies of diplomacy *(8)*.

3. CURRENT POLICY IMPLEMENTATION AND WAY FORWARD

3.1 Underinvestment in national health systems and health equity problems

Since the break-up of former Yugoslavia, economic hardship in the region has contributed to limited government spending on health systems, resulting in increased health inequity among the population. In particular, private out-of-pocket payments[28] and inadequate health coverage have been prime reasons for low–income groups to avoid accessing health provision, undermining the notion of universal health coverage. Rural areas, where most low–income groups tend to live, have struggled to gain appropriate quality health services owing to the migration of health professionals and displacement of facilities to urban areas.[29] A group that is particularly vulnerable to health issues is the Roma community.[30]

> **"Although most of the countries have free access to health services, such access is in reality not equitable." *(37)***

3.2 Emerging health threats

Over recent years, all countries of the region have been subject to emerging health threats, particularly the rising occurrence of NCD, which contribute to the majority of preventable years of life lost and are the main cause of mortality across SEEHN countries. In a study by Sedgley and Solar *(38)*, seven countries indicated that NCD accounted for over 80% of years of life lost across their populations in 2011. Similarly, Stanculescu and Neculau *(39)* state that the burden of NCD is increasingly having a negative effect on the health landscape across the region. Their study concludes that circulatory diseases

28 Stanculescu and Neculau *(39)* give historical country facts on out-of-pocket payments for health care provision.

29 See Stanculescu and Neculau *(39)* for an overview of poverty trends and health care services in rural areas in the region.

30 For more information about the nexus between underinvestment in national health systems and health equity issues in the region, see Bartlett et al. *(49)*, Bohr *(37)*, and Stanculescu and Neculau *(39)*.

and neoplasms were the two major causes of death across the region between 2009 and 2011.[31,32]

Both NCD and communicable diseases are correlated with the environment people live in, the economic performance of countries and, most importantly, socioeconomic factors. NCD in particular are heavily influenced by social determinants of health such as tobacco and alcohol use, diet and physical activity *(37,39)*. Countries have recognized the need for an intersectoral approach to address the burden of NCD and social determinants of health. Action plans have either been implemented by individual countries themselves or through a regional approach which SEEHN has facilitated, and will continue to facilitate.

3.3 Fostering the HiAP approach

SEEHN countries have recognized the need to implement HiAP[33] across government activities. For example, Montenegro used an intersectoral approach when designing its 2009 strategy to prevent and control NCD. Citizens, journalists and NGO actively took part in the dialogue on the strategy's content. Most of the actions implemented – such as the establishment of recreational facilities (for example, cycling and running tracks) or offering healthy meals to students in educational institutions – took place outside the health sector *(38)*. In terms of tobacco control, the Montenegrin Ministry of Health collaborated with the Ministry of Economy on the pricing and taxing of tobacco products, had meaningful dialogues with the Ministry of Tourism in regard to smoking in restaurants, and collaborated with the Ministry of Education regarding the use of tobacco products on school property *(41)*.

The Law of Public Health in the former Yugoslav Republic of Macedonia places strong emphasis on collaboration and intersectoral partnerships, setting out steps for interaction across national, regional and local levels through the establishment of national and local public health councils *(41)*. Romania has introduced the National Sustainable Development Strategy 2013–2020–2030, an intersectoral instrument to align the country with European Union development values. It is a holistic, nationwide approach in which public health is a component, predominantly to improve the lifestyle of vulnerable groups and increase access to health care, infrastructure and quality of health care provision.[34] Sedgley and Solar *(38)* note that "Serbia made specific reference to government commitments to poverty reduction and social inclusion linked to the European Union integration process".

31 No data from Kosovo and Croatia.

32 Stanculescu and Neculau *(39)* use country examples to outline factors that influence the occurrence of NCD in the region.

33 For more information on HiAP, see the *Adelaide Statement (40)*.

34 For more information on the Romanian National Sustainable Development Strategy 2013-2020-2030, see http://www.un.org/esa/dsd/dsd_aofw_ni/ni_pdfs/NationalReports/romania/Romania.pdf (accessed 6 October 2016).

The inclusion of a whole-of-government approach was already acknowledged in SEEHN projects between 2002 and 2011. For example, the lessons learned from the mental health programme clearly indicated the importance of intersectoral collaboration to address mental health issues. Maurer and Murko *(24)* explain that:

"the importance of inter-sectoral links was brought home to the team members, both as a result of discussions with experts with experience in conducting such reforms in other countries and as a clearer vision of the role of the community mental health centres developed. The needs of people with severe mental illness require an integrated approach from different perspectives – social, medical, educational, financial and juridical."

The 2005–2007 SEEHN project, Public Health Capacity-building for Strengthening Tobacco Control in South-eastern Europe (Tobacco control project), under the leadership of Croatia, is a good example of lessons learned by using a HiAP approach to implement the first international treaty under the auspices of WHO, the 2005 Framework Convention on Tobacco Control (FCTC). The first phase was designed to establish a political platform to discuss approaches to implementing the FCTC. SEEHN, with the support of Norway, organized a multisectoral conference in Sofia in 2005 supplemented with national multisectoral meetings. The success of the first phase was illustrated when "most countries [had] seen an active process of legislative initiatives and updates and capacity-building" *(42)*. The second phase saw regional collaboration in preliminary work and enhancing intersectoral capacity-building to establish national anti-tobacco strategies and initiatives.[35] Phase three was designated for raising public awareness. In regional workshops, anti-smoking media campaigns and behavioural change programmes were designed and applied. The Tobacco control project succeeded as a result of numerous factors: tobacco control received space in all countries' political agendas and the convention was promoted throughout the region; intersectoral links were established and strengthened; anti-tobacco initiatives increasingly received public support; and the process resulted in legislative initiatives *(42)*. At the end of the project, all SEEHN countries except one had signed and ratified the FCTC[36] *(23)*.

In 2012 SEEHN, in partnership with WHO Regional Office for Europe, finalized an assessment of the intersectoral collaboration landscape within member countries to prevent and control NCD *(41)*. In addition, in partnership with the Regional Office and the European Commission, it published a study in 2013 entitled *Opportunities for scaling up and strengthening the health-in-all-policies approach in south-eastern Europe (38)*. These assessments are fundamental for the countries to learn from each other by exploring existing tools to design

35 Strategies and Initiatives were formulated on tobacco prices, taxes, advertising bans, smoking in public places, smoking in the workplace, health warnings and packaging, information and advocacy campaigns, and smoking cessation programmes *(23)*.

36 All SEEHN member countries have now ratified the FCTC to date (2016).

strategies that effectively further strengthen their national health systems through a HiAP approach across several public health issues.

At the Extraordinary Ministerial Meeting of SEEHN in Skopje in November 2014, ministers adopted Health 2020, WHO's new European policy framework that supports action across government and society for health and well-being. Health 2020[37] is an ambitious framework that aims to "significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality" *(43)*. SEEHN now positions itself as an entity that continues to strengthen its promotion of healthy populations and health equity through an intersectoral and whole-of-society approach. Health ministers confirmed political will and commitment, in the 2014 Skopje Pledge, to use Health 2020 as a framework and guide for action at regional and individual country level. SEEHN is currently working on implementing the Health 2020 components within the health pillar of SEE 2020.

"Social and economic integration in south-eastern Europe is fast becoming a reality. We should take this situation as an opportunity also to address both health challenges and opportunities in our subregion. Working together is part of the history of our populations, and that is the only way for us to respond to challenges, embrace opportunities and create a climate for innovative mechanisms to enhance our collaboration in the best interest of our populations' health."

– Nikola Todorov, Minister of Health of the Republic of Macedonia, at the Extraordinary Ministerial Meeting of SEEHN in Skopje, 18 November 2014 (8)

3.4 The health pillar in SEE 2020

Scholars argue that traditionally, social services have faced challenges that have led them into limbo for funding. Snoy and Kadric *(44)* note that "investment in social sector projects is in general given less priority than in sectors such as transport and energy as their link with economic growth is more difficult to demonstrate". However, it has been increasingly broadly acknowledged that fostering equal access to health services and education, enhancing employment opportunities, and scaling up housing and other social services enhances economic growth and social cohesion. SEEHN succeeded in putting health on the regional economic development agenda by incorporating a health pillar into SEE 2020, adopted in November 2013 by the ministers of economy of south-eastern

37 The complete Health 2020 framework can be downloaded from http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2013/health-2020-a-european-policy-framework-and-strategy-for-the-21st-century
(accessed 25 October 2016)

Europe. This was the first time that health had become an integrated pillar of economic growth strategies in the region. Dr M Ruseva (pers. comm., 24 March 2015) explains that this inclusion represents a changing view of health, from it being a narrow, money-consuming sector to the acknowledgment that it contributes to employment and offers an entry point for governments to prosper their ambitions for fairer, more inclusive and cohesive societies.

SEE 2020 reflects the commitment of all governments in the region to cooperate closely, politically and economically, in areas of common concern in order to address current socioeconomic challenges and to assist in the eventual integration of south-east European countries into the European Union. The vision of SEE 2020 is to enhance long-term determinants of economic development in the region through a holistic, common approach with five interlinked components: integrated growth, smart growth, sustainable growth, governance for growth and inclusive growth.[38]

The health dimension of SEE 2020 is embodied in the inclusive growth pillar. It promotes factors that develop skills and employment, including fostering equal participation in the labour market and access to health systems. However, it was recognized that inclusive growth was not only about growth in gross domestic product. Tackling inequalities in health, for instance, is vital for inclusive growth. The pillar must be regarded as cross-cutting, particularly to the smart growth and sustainable growth pillars. The SEE 2020 report clearly states that "Inclusive growth will only become a reality if there is strong investment in human capital, such as training, social inclusion and the improved health of people, but also infrastructure investment and capacity and institution building in these sectors" *(45)*.

In addition, operating within SEE 2020 gives SEEHN an opportunity to develop or enhance collaboration with other governmental sectors, academia, NGO, civil society organizations, the private sector and media to show that health is a meaningful contributor to social and economic development.

3.4.1 Four key strategic actions developed under the health pillar

Four key strategic actions have been developed with the objective to enhance the health status of all individuals in the region (Table 6). The fields of action are presented in the SEE 2020 report *(45)*.

38 More information about each of the five development pillars can be found in Regional Cooperation Council *(45)*.

Table 6. Fields of action in the health pillar of SEE 2020

Field of action	Extract from SEE 2020
Universal health coverage	Introduce policy measures to improve the health gain of the populations, with a focus on **low-income and vulnerable groups**, by strengthening the delivery of **universal** and high-quality **health-promoting services**
Governance for health	**Strengthen** the institutions and **improve intersectoral governance** of the health sector at all levels, including **health information** infrastructure and regional cross-border information exchange
Cross-border promotion of public health systems	**Harmonize** cross-border public health and **public health services legislation**, **standards and procedures**; develop mutual recognition and trust to enable the creation of a Free Trade Area from a public health perspective
Cross-border public health cooperation for human resources for health	Strengthen human resources in the health sector, **harmonize** the **qualifications of health professionals** in the region, **monitor** human resources for health (HRH) mobility

Source: Regional Cooperation Council (45)

WHO Regional Office for Europe supported SEEHN in developing the SEE 2020 health pillar, including its strategic actions, and is continuing to give technical guidance. SEEHN is currently designing one initiative for each of the four key areas of action outlined in Table 6. It is establishing permanent regional working groups and allocates relevant RHDC for each of these initiatives, to establish methods to design a clear, commonly agreed strategy. These initiatives can potentially encourage RHDC to work with each other while enhancing their activities by engaging in long-term projects. This is important for SEEHN to avoid the risk of operational stagnation. For instance, the universal health coverage initiative, which focuses on improving national health system performance, would be led by a collaboration of three centres: RHDC on public health services in the former Yugoslav Republic of Macedonia, on accreditation and continuous quality improvement of health care in the Republic of Serbia, and on NCD in Montenegro. The initiative is still to be potentially supported by external partners such as the Regional Office for Europe, SDC and the ministry of health of Slovenia.[39] SEEHN employed a small team to undertake analytical cross-country research on universal health coverage, health promotion, disease prevention and

39 Dr M Ruseva, *SEEHN – history, achievements, current status, challenges and needs*. Power Point presentation for a SEEHN Country Day held at the WHO Regional Office for Europe, Copenhagen on 9 March 2015.

inequalities and is to establish a working group on health for inclusive growth. A health delivery model will then be designed and implemented according to the specific needs of each country, followed by the implementation of a quality improvement mechanism in the form of a quality registry. The initiative aims to update health service legislation and regulations on health care provision, disease prevention and patient safety. An effective regional monitoring and evaluation mechanism will be introduced into national health systems, which is central to guarantee enhanced transparency and accountability.[40] Finally, the initiative aims to establish a "SEEHN intergovernmental stakeholder platform on health promotion and health improving policies, to broaden understanding of these interrelated issues, and to review and promote good practice".[41]

All long-term strategies under the umbrella of SEE 2020 will be presented at the Fourth Health Ministerial Forum in 2017 and are constantly monitored by the Regional Cooperation Council. This will also be an opportunity formally to recognize SEEHN's achievements in incorporating the objectives of European health-related action plans, particularly Health 2020, into the policy design of its initiatives, in accordance with its commitments under the Skopje Pledge.

Through its governance structure, together with its years of experience in regional cooperation at political and technical level, the network shows great potential in effectively implementing policy approaches to meet the ambitions of these key areas of the health pillar until the implementation period of SEE 2020 ends in 2019. However, SEEHN faces new and ongoing challenges, both internal and external, that undermine its operational sustainability, which will be discussed in the next chapter.

40 This formed the subject of a regional workshop on strengthening health information systems, organized by WHO Regional Office for Europe, which was held in Tirana, Albania, 16–17 November 2015. The report from the workshop is available at http://www.euro.who.int/__data/assets/pdf_file/0008/309680/SEEHN-meeting-report.pdf (accessed 13 November 2016). It is expected that Albania will take the lead in setting up a new RHDC for this issue, which it is expected will be agreed at the Fourth Forum in Chisinau in April 2017.

41 This quotation is taken from an unpublished summary report of the 34th Plenary Meeting of SEEHN, held in Skopje, Macedonia, on 19–20 November 2014.

4. CHALLENGES AND RECOMMENDATIONS

As mentioned in the previous chapter, some RHDC are subject to operational and managerial capacity challenges. In addition, SEEHN faces other challenges that put the network at risk of operational stagnation.

4.1 Ensuring political commitment

The political commitment of health ministers has been the most important asset for SEEHN's evolution since its establishment in 2001. The health ministers, as SEEHN's highest political body, have shown leadership to establish an innovative political and technical governance structure for regional collaboration. Ruseva et al. *(12)* explain that "external donors and partners had an important role in guiding the network's development at its inception, but it was the national stakeholders who knew how to take advantage of the guidance and achieve operational ownership of the initiative". The continued political commitment of health ministers is therefore crucial for the network's future work and also to its continuing to serve as a platform that keeps the countries together despite ongoing political and ethnic tensions in the region. However, given the political circumstances in the majority of member countries, with constant changes in health ministers and health ministry representatives, the political commitment can fluctuate. Dr L Lazeri, Head of WHO Country Office in Albania, argues that owing to the constant change in political leadership the process of trust-building is ongoing, with a need to re-establish commitment as the membership also comes with administrative burdens and a membership fee (pers. comm., 27 March 2015). Mr J Grpovski, National SEEHN Coordinator, State Councillor, Ministry of Health of the former Yugoslav Republic of Macedonia, believes that this constant change undermines SEEHN's operation, as "it requires permanent high-level political efforts to inform, advocate, explain, lobby, and convince new Ministers of the need to support SEEHN, to use it as an added value, etc."[42] He points out the importance of the engagement in the process of independent advisors, such as WHO and the Regional Cooperation Council, to ensure the political commitment of member countries. Dr M Ruseva (pers. comm.,

42 This quotation is taken from an unpublished summary report of the 34th Plenary Meeting of SEEHN, held in Skopje, Macedonia, on 19–20 November 2014.

1 April 2015) explains that WHO is aware of this issue and the Regional Director has brought together SEEHN health ministers twice a year at their own ad hoc meetings, or additionally during international events such as the World Health Assembly and sessions of the WHO Regional Committee for Europe.

Given the current operational landscape of SEEHN, which is shaped by the RHDC, and a new vision of policy-making such as a whole-of-government and whole-of-society approach, a ministerial forum could be organized once a year to make ministers aware of the political commitment needed to guarantee the development of these very complex policy approaches. In this sense, the issue of political commitment and the new vision of SEEHN can be linked to a theoretical network governance point of view that considers that "unless mechanisms are in place to make these nodes (high-ranking positions) easily replaceable, centralized networks are less resilient (adaptive) to change" *(18)*. As SEEHN is a high-level, politically driven initiative, its survival depends on the political commitment of member countries.

4.2 Strengthening the Secretariat

Although the Secretariat was formally inaugurated in Skopje in 2013, it has not been effective in managerial and administrative support to the network owing mainly to a lack of human resources. Ms M Zaric (pers. comm., 21 May 2015) explains that the SDC project Strengthening institutional capacities for regional cooperation in health in south-eastern Europe is on non-cost extension as some objectives, particularly regarding managerial capacity of the Secretariat, have not yet been met. From a theoretical perspective, an efficient Secretariat, particularly in administrative support and coordinating activities, is fundamental for SEEHN's sustainable functioning. Huppé et al. *(18)* state that "the process of networked governance itself introduces an additional component of complexity. This complexity, if unmanageable, can undermine the problem solving process."

Dr G Cerkez, Chair of SEEHN's Executive Committee, explained at the 34th Plenary Meeting in 2014, "there are still many challenges in front of us and we will work together to realize all of them and after the establishing of the Secretariat the Network will be more efficient and more effective".[43] In May 2016, SEEHN announced that the Secretariat was fully established, with eight staff members combining the functions of administrative support, technical, financial and legal consultancy[44] to the network. The secretarial staff focused on the establishment of various working documents for the 37th plenary meeting of SEEHN held in June 2016 and the Fourth Health Ministerial Forum in Chisinau. As it continues to evolve, the past and current presidencies of the network are revising its

43 This quotation is taken from an unpublished summary report of the 34th Plenary Meeting of SEEHN, held in Skopje, Macedonia, on 19–20 November 2014.

44 The legal team comprises three members who are responsible for two major documents: the addendum to the SEEHN Memorandum of Understanding of 2008 and 2011, and Standard Operational Procedures (SOPs). The information on the staffing of the Secretariat was received by the author in an email with the subject Corporate Contacts of the SEEHN Secretariat, from Dr M Ruseva, 20 May 2016, 22:51.

statutes to embody clear responsibilities for the Secretariat, and also for RHDC and national focal points *(46)*. Mr J Grpovski suggests that owing to the revision of SEEHN's legal documents and procedures, which are expected to be approved at the Fourth Health Ministerial Forum, an additional Legal Officer position at the Secretariat might be useful. He also points out that additional Technical Officers might be needed to monitor and evaluate SEEHN's activities in SEE 2020.

The increase in human resources in the Secretariat, together with managing SEEHN's new vision and activities, will most likely bring more responsibility to the Secretariat but also raises the need for more financial resources. Member countries therefore need to review their contribution to SEEHN and collectively find the best ways to support the Secretariat for its efficient functioning.

4.3 Strengthening the communication strategy

The poor transparency of SEEHN's activities and effectiveness illustrates a significant lack in its governance structure. The old SEEHN website was outdated and the new website, after a year of outsourced work, was formally launched at the 34th SEEHN Plenary Meeting in November 2014 *(47)*. As at October 2016, the new website was still far from complete, with insufficient, undynamic content. Not all links to past, current and ongoing initiatives had content and the website only carried outdated information on RHDC activities. Similarly, most of the RHDC websites, with the exception of that of the Southeast European Center for Surveillance and Control of Infectious Diseases, were outdated, had no content or did not exist. There was no mention on the SEEHN website of the activities of external partners within SEEHN, other than a link to the Memorandum of Understanding between SEEHN and an external partner. The poor transparency of SEEHN's recent activities could have been caused by the transition of the Secretariat from the WHO Regional Office to the network. In an analytical perspective, Mr J Grpovski argued at the 34th Plenary Meeting that "communication of SEEHN and its achievements is a must; this has to be done through actual data, evidence, true life stories in the countries, etc."[45] Since its inception in 2001, there has been no overall independent impact assessment of the network's effectiveness. Internal reports or authors who are connected to the network highlight the effectiveness of the network but mostly without the support of empirical or statistical evidence. It is highly recommended that SEEHN collect and archive all its activities at political and technical level, as well as collecting people's stories, data and evidence. The data need to be transparent so that a sophisticated internal and external analysis of its performance across its various activities can be undertaken in the future.

Furthermore, the website should be a platform where SEEHN can archive non-confidential work and promote its activities and achievements, with direct

45 This quotation is taken from an unpublished summary report of the 34th Plenary Meeting of SEEHN, held in Skopje, Macedonia, on 19–20 November 2014.

links to the websites of the RHDC. Alternatively, the website could serve as a central platform where all RHDC can upload their activities and achievements under the relevant headings. In addition, a link to the SEEHN website should be available on all partners' websites for promotion purposes, and vice versa. If updated, the website could be a valuable instrument of digital health diplomacy. Through the website and engagement in social media, SEEHN could inform the health sector, other governmental sectors, the international community, NGO, the business sector, academia and the wider public about its daily work. The use of new information communication technologies would allow SEEHN to gain public attention, and financial, technical and much-needed political support. Milevska Kostova et al. *(8)* note that "the social media outreach of the Croatian Prime Minister during his cabinet's efforts to gather and channel assistance for the public health emergency of the spring 2014 floods, for example, gained massive attention, technical and financial support."[46] Given the potential of new digital information technology, a Communication Officer should be employed at the Secretariat, or training workshops in communication should be offered to relevant individuals in the Secretariat and RHDC.

SEEHN has acknowledged its lack of transparency: Issue 5 of the SEEHN Newsletter reported that the Serbian presidency of SEEHN was revising the Standard Operating Procedures for communication methods and tools *(46)*. Ms N Milevska Kostova (pers. comm., 25 March 2015) notes that the International Network of Health Promoting Hospitals and Health Services dedicates two pages to SEEHN news in its journal. This international network has over 800 hospital and health service members in more than 40 countries. Additionally, five newsletters on SEEHN activities have been published on the SEEHN website.

4.4 Involvement of local actors

SEEHN's commitment to implementing the HiAP approach across its initiatives, particularly within the health component of SEE 2020, is an effort to tackle health inequity in vulnerable ethnic groups such as the Roma community. Through this approach, all sectors can benefit from including the determinants of health in their policies to enhance social and economic equality, which is a vital component for economic development. Kickbusch et al. *(48)* emphasize, for instance, that equal access to goods and services as well as health care minimizes social and economic inequalities.

46 Regarding public emergencies, Dr L Lazeri (pers. comm., 27 March 2015) explains that SEEHN can be very effective in dealing with natural events like floods. Member countries can communicate with each other to cooperate on public health preparedness and response. Similarly, Ms N Milevska Kostova (pers. comm., 25 March 2015) cites the public health emergency (an outbreak of mumps) in the former Yugoslav Republic of Macedonia in 2008–2009. The health ministry communicated requests for help through SEEHN. The Bulgarian health ministry responded by sending about 20 000 vaccines to the former Yugoslav Republic of Macedonia. After internal consultations, the Bulgarian health ministry declared its emergency aid as a donation. She also notes that the network established closer relationships between former Yugoslav and non-Yugoslav countries which previously did not have strong ties.

For the implementation of effective policies to achieve health equity, good governance practices are essential, particularly external multistakeholder engagement such as collaboration with community-based institutions, expert consultants, mass media and NGO *(41)*. Although SEEHN has acquired a comprehensive amount of information and expertise through its projects and initiatives, and has increased partnerships over recent years, it still needs to engage with more partners, particularly at local level. This is vital to enhance knowledge through data collection regarding health equity concerns from the bottom up, to establish comprehensive health policy strategies. Dr S Rakic (pers. comm., 26 March 2015) explains that at local level, including the health workforce, awareness of SEEHN is weak. SEEHN needs to enhance awareness at local level of its objectives and activities and engage local actors in its activities. Historically, local actors have rarely been included in health reform design in most south-east European countries, which has failed to improve accountability, transparency and approachability for the needs of the public. In a national survey in 2010 in Bulgaria, for example, 76% of participants indicated dissatisfaction with the health system and 91% felt that further health system reforms were needed *(49)*.

Local actors and authorities could be included at subnetwork level, namely the RHDC. This is crucial to ensure a comprehensive policy-making process by creating a multilevel collaborative platform. From a theoretical point of view, Huppé et al. *(18)* emphasize the benefits of involving local actors in policy-making as follows:

"By stimulating local actors' involvement in such entrepreneurship, empowering them to learn-by-doing, and connecting their innovative ideas to institutional resources and opportunities, it is possible to support the emergence of new social structures and practices that might develop to meet the social organization needs that are not currently being met under a certain governance approach."

Even if the governance structure of SEEHN, from the highest political level to the local level, is in place and functioning well, specific actions and results at local level must be ensured. SEEHN's slogan is "Together for the Health of the People", but a resource mobilization strategy is yet to be implemented, according to Mr J Grpovski. Such a strategy needs external funding for regional actions as well as financial resources from both regional and national sources for specific initiatives at country level, otherwise there will be no technical action within countries.

4.5 Strong relationship with external partners

Although SEEHN has gained full regional ownership, its sustainable operational capacity continues to depend on technical guidance and financial resources from external partners, making the network vulnerable as regards fulfilling its operational capacity. Mr J Grpovski describes the current situation thus:

"SEEHN will need the political and technical support of WHO Regional Office for Europe at least the next 5–10 years until politically and financially the countries become mature."[47] At the moment, WHO Regional Office for Europe is providing technical support to SEEHN in implementating SEE 2020, helping to mobilize resources from other potential partners and strengthening capacities of RHDC. However, dependence on WHO's support, and having a limited number of partners, is not a sustainable option for SEEHN. To avoid operational stagnation SEEHN would benefit from promoting itself to attract partners for its various planned activities. Ms N Milevska Kostova (pers. comm., 25 March 2015) describes how SEEHN participated in the leading European Union health policy forum, the European Health Forum Gastein, in October 2014. In a joint workshop with its partners Studiorum and EuroHealthNet, the network presented itself as regional coordinator of the health pillar of SEE 2020 in order to attract partners and potential investors to think about the goals and approaches of the strategy, with health being an entry point.

SEEHN would benefit from a strong partnership with European Union institutions, especially in strengthening information systems.[48] This is a crucial step towards the region's integration into the European Union. Tozija *(4)* notes that "the appropriate use of data, data quality, and scope of data collection are still a challenge in most SEE countries". Similarly, Dr M Ruseva (pers. comm., 1 April 2015) believes that the public health community is eager to work on equity challenges but basic information is missing, owing especially to a lack of disaggregated data. Dr S Rakic (pers. comm., 26 March 2015) explains that the long-term problem in collecting statistical data has been separate reporting and separate data collection techniques. Strong partnership with the European Union and WHO would support SEEHN in advocating best practices and technical guidance to transform national health data into internationally comparable information which will benefit the process of regional policy harmonization. This will also help governments, international organizations, academia and NGO to assess the health landscape in the region and individual countries. Health data harmonization would enable proper health impact assessments, which are essential for HiAP reporting and strategic implementation procedures. Tozija *(4)* believes that European Union regulations and measures on public health statistical indicators, such as European Community Health Indicators (ECHI), need to be implemented and translated into south-east European languages as these legal requirements are essential for European Union integration.

47 This quotation is taken from an unpublished summary report of the 34th Plenary Meeting of SEEHN, held in Skopje, Macedonia, on 19–20 November 2014.

48 The Information Systems for Community Health Services project has shown how effective the implementation of regional information systems can be in the mental health field when regional policy harmonization and standardization is addressed. Overall, regional policy harmonization and the implementation of information systems in other fields of public health is still a challenge across the region.

5. CONCLUSION

This paper illustrates how SEEHN has emerged and the path it has taken to address public health concerns through regional cooperation. SEEHN has done this through cooperation at political level by providing leadership, designing key policy documents, areas of policy-making and governance structure, and at technical level by bringing together regional health professionals to design policies and best practices through projects in public health issues of common concern. SEEHN has proven to be an innovative initiative of regional cooperation in public health owing to its leadership, as well as its ongoing evolution, by forming, reviewing and reforming its governance structure and areas of policy-making. This is represented in the network's key policy documents: the Dubrovnik Pledge, Skopje Pledge and Banja Luka Pledge. These highlight the network's vision, from a post-conflict recovery mechanism to an initiative that adopts international health governance trends by stimulating health as an integral part of economic development.

Serving as a platform for trust-building, SEEHN has brought south-east European countries to the same table to pool together resources and to establish a shared vision through a spirit of openness, transparency and accountability. This was particularly important during the years following the devastating conflicts in former Yugoslavia. SEEHN has since evolved to become an initiative that promotes the nexus between a healthy population and economic development in the region. Given the complexity of health issues, SEEHN's current vision is to implement a whole-of-government and whole-of-society approach in its policy design, to enhance social and economic development in the region. Regional challenges require collaboration and negotiation, not only among intergovernmental health sectors but also with non-health sectors across all levels of society. This approach is crucial for SEEHN to ensure and benefit from a comprehensive policy-making process. This, together with the adoption of WHO frameworks such as HiAP and Health 2020, is of great advantage in meeting the goals of the SEE 2020 health pillar as well as health, well-being and prosperity in the region in the framework of the SDG.

SEEHN has proved its potential as a sustainable initiative of regional ownership, highlighted through the establishment of its own Secretariat and currently nine RHDC across the region, representing a cooperative regional framework in public health. RHDC form a subnetwork within SEEHN to facilitate cooperation among various specialist stakeholders in a particular public health area. The network's potential was demonstrated when it succeeded in putting health on the regional economic development agenda by incorporating a health

pillar into the new SEE 2020. SEEHN has also organized various expert and educational workshops through previous projects and the current RHDC, addressing drivers for effective policy-making to strengthen key public health areas of common concern and to stimulate the process towards European Union integration.

However, SEEHN faces new and ongoing challenges, both internal and external, that put the network at risk of operational stagnation, which undermines its sustainability. Despite this, it provides an innovative governance structure as regards the RHDC, with great potential that is yet to be realized, as the centres are not similarly developed and/or active, often owing to limited managerial and financial capacities. Operational, managerial and financial capacities for RHDC need to be reviewed by SEEHN. Frequent changes in health ministers and government representatives mean that political commitment, conviction and trust-building are an ongoing challenge. External partners like WHO Regional Office for Europe play a vital role in ensuring political commitment. Additionally, the SEEHN Secretariat has performed its role and responsibilities poorly since its inauguration in 2013. An effective administrative and coordinating body for the network needs to be in place, and the Secretariat must have enough human and financial resources. Although SEEHN has gradually proceeded to full regional ownership, strong links with external partners are still required owing to the political and financial immaturity of member countries. A limited number of external partners may make SEEHN vulnerable to operational stagnation. External partners are important in terms of providing financial support and technical guidance to the network's various initiatives, such as enhancing regional policy harmonization and data collection practices, and the European Union integration process. In particular, increasing inclusion of local partners is vital to enhance knowledge on health equity concerns from the bottom up to establish comprehensive health policy strategies. Last but not least, the poor transparency of SEEHN's activities and effectiveness illustrates a significant weakness in its governance structure. It needs a more effective communication strategy, particularly to raise awareness of its activities and capacity-building using information technologies. A sophisticated and active communication strategy would help SEEHN to gain public attention that might lead to financial, technical and much-needed political support for its operational capacity. SEEHN needs to collect and archive all its activities at political and technical level, with data evidence and people's stories, and be transparent about them. This will also allow sophisticated internal and external analyses in the future, of its performance and effectiveness across its various activities, to explore and strengthen its potential. No independent impact assessment of SEEHN's activities has been undertaken since its inception, as insufficient data evidence and stories are available.

Overall, SEEHN has shown the benefits of cross-country cooperation in public health by facilitating a platform to identify and address health challenges

shared by the countries of the region. Establishing SEEHN as a network for cross-country cooperation has proved to have added benefits. Firstly, cross-country cooperation can be used as a tool for collective standing in international health governance negotiations, giving individual countries more power and a stronger voice. This can be of particular benefit for countries with shared interests, limited resources or of a relatively small geographical size. This practice is seen among SEEHN member countries when, for instance, they have published joint statements on draft resolutions at sessions of the WHO Regional Committee for Europe. Another benefit is pooling together resources and sharing knowledge to design best practices for health policies and legislation, while establishing strong partnership among all stakeholders, including external partners, so that collective engagement tends to be more efficient than individual action.

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ANNEX 1. INTERVIEW PARTNERS

Name	Function	Date
Dr Severin Rakic	Head of Health Management Centre, Public Health Institute of Republika Srpska, Bosnia and Herzegovina	26.03.2015
Ms Neda Milevska Kostova	Executive Director, Studiorum Centre for Regional Policy Research and Cooperation, former Yugoslav Republic of Macedonia	25.03.2015 27.05.2015
Dr Ledia Lazeri	Head of WHO Country Office, Albania	27.03.2015
Dr Maria Ruseva	Acting head of the SEEHN Secretariat, and coopted member of the SEEHN Executive Committee	24.03.2015 01.04.2015
Ms Maja Zaric	Programme Officer for Health, Swiss Agency for Development and Cooperation, Cooperation Office in Bosnia and Herzegovina	21.05.2015

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