STAKEHOLDERS

“Together for health equity from the start”

Second EU-wide stakeholder debate of the Equity Action

14–15 November 2012, Berlin, Germany

Documentation

EQUITY ACTION

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It should be emphasized that the “Together for health equity from the start” event held in Berlin, Germany on 14–15 November 2012 was attended by a diverse audience of participants united by a common interest in stakeholder engagement in pursuit of the aims of Work Package 7 of the Equity Action. The views expressed were therefore those of the participants, and may not represent views held more widely.

It must also be emphasized that the points of view expressed at the event, many of which are reported here, were made in a spirit of free and unhindered expression of opinion and belong to the participants. The ideas and views expressed by participants and summarized in this report do not necessarily reflect the views of the European Union, the Federal Centre for Health Education, Germany, or the National Institute for Health Development, Hungary. It is not possible to present in the report all the diverse views and ideas expressed at the event, and an element of selection and analysis has been adopted in its preparation.

Contents

Introduction

The early years are a key determinant of health. Giving every child the best start in life is crucial to reducing health inequalities across the life-course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years has lifelong effects on many aspects of health and well-being, from obesity, heart disease and mental health, to educational achievement and economic status. Action to tackle health inequalities should therefore start very early in childhood – preferably during pregnancy – and should continue throughout the years of education.

Tackling health inequalities and ensuring health equity from the start is an ambitious and complex task that requires cooperation and action from a wide range of stakeholders. It cannot be achieved by the health sector alone, and calls for shared responsibility across sectors. It is therefore crucial to involve stakeholders from sectors such as education, social welfare, transport and urban planning in actions to tackle health inequalities.

The first European Union (EU)-wide stakeholder debate, “Together for Health Equity from the Start”, was held 8–9 May 2012 in Budapest, Hungary. The second debate, on which this report focuses, was held in Berlin, Germany, on 14–15 November 2012 (see Annex 1 for agenda). A full list of participants of the second debate is shown at Annex 2.

Both debates were organized within the scope of Work Package 7 (WP7) “Stakeholder engagement” of the EU-funded Joint Action on Health Inequalities (Equity Action). The Equity Action (February 2011–February 2014) is coordinated by the National Heart Forum in England (United Kingdom) and involves 24 partners from 16 Member States. It focuses on developing capability across Member States to tackle socioeconomic health inequalities through different actions.

The first EU-wide stakeholder debate introduced the topics of health inequalities and health equity from the start and discussed stakeholder engagement models. The debate allowed exchange of experiences and learning and identified good practice examples in intersectoral action and stakeholder engagement. Problems and barriers to effective stakeholder engagement were also discussed. A full report from the debate can be found on the web site of the project (www.health-inequalities.eu).[1]

The second debate aimed to build on the discussions from the first to:

- improve alliances and working with stakeholders to tackle the social determinants of health and address health equity from the start;
- identify practical ways of cooperation with other sectors, entry points, barriers and possible solutions to overcome these;

[1] Direct link: http://www.equitychannel.net/uploads/Doumentation%20stakeholder%20debate.pdf

- allow international exchange on intersectoral action and stakeholder engagement processes on health equity from the start among Member States of the EU; and
- produce concrete results and recommendations on actions to be taken to strengthen intersectoral collaboration for health equity from the start.

The meeting consisted of presentations and debates featuring experts experienced in developing intersectoral action and stakeholder engagement to address health equity from the start. Participants shared experiences and worked together over the two days of the meeting.

Work Package 7 of the EU-funded Joint Action on Health Inequalities (Equity Action)

WP7 aims to develop and improve stakeholder engagement processes in Member States and at EU level in the priority area of “Health Equity from the Start”. The two EU-wide stakeholder debates held during 2012 aimed to allow core stakeholders from partner countries to share experiences, good practice and concrete examples of stakeholder engagement for equity from the start. Evidence of the mutual benefits of cross-policy engagement has been summarized in factsheets developed by WP7, and partners are organizing national workshops to engage stakeholders at national, regional and/or local level. Based on the results of the above activities, WP7 aims to develop a guide on how to identify, engage and support stakeholders in tackling health inequalities to promote health equity from the start.

WP7 leaders and partners

Leaders

- Federal Centre for Health Education (BZgA), Germany
- National Institute for Health Development (OEFI), Hungary

Partners

- Federal Public Service Health, Food Chain Safety and Environment (FPS), Belgium
- National Institute of Public Health (SZU), Czech Republic
- EuroHealthNet (EHN), Belgium
- National Centre for Social Research (EKKE), Greece
- Local Health T03, Piemont Region (ASL-T03), Italy
- Norwegian Directorate of Health (NDOH), Norway
- National Institute of Public Health, National Institute of Hygiene (NIZP), Poland
- Ministry of Health and Social Policy (MSPS), Spain

Welcome addresses

Helene Reemann, BZgA
The Berlin debate has been jointly organized by BZgA and OEFI who, in good cooperation, lead WP7 of the Equity Action, “Stakeholder engagement”.

The Equity Action project focuses on developing capability across EU Member States to tackle social and health inequalities through different acts. WP7 aims to improve the way we build alliances and work with stakeholders to tackle the social determinants of health and address health inequalities, focusing especially on promoting health equity from the start.

The debate is part of a series of actions taken through the project between 2011 and 2014. The first EU-wide stakeholder debate took place in Budapest, Hungary in May 2012. Following this event, many WP7 partners will have organized stakeholder engagement events in their countries by the beginning of 2013; ambitious plans have been developed as a result and positive processes are now being taken forward at national level. In addition, EuroHealthNet[2] will organize an important stakeholder event for nongovernmental organizations (NGOs), umbrella organizations and others at EU level.

Tamás Koós, OEFI
The first debate in Budapest, where fruitful discussions on stakeholder engagement and intersectoral action for achieving health equity from the start were initiated, focused on socioeconomic determinants of health inequalities and the importance of tackling them in the early years. Participants from different sectors in various EU countries were offered the opportunity to discuss stakeholder engagement models and share experience and good practice.

The aim of this second debate is to share information about more specific examples of stakeholder engagement processes and intersectoral cooperation and to jointly identify practical ways to proceed. It will again focus on good practice in stakeholder engagement and intersectoral work with an emphasis on cooperation between non-health and health sectors at national and local levels.

Sustainability requires not only active participation in discussions at the event, but also action at country level, including actively involving core stakeholders in the planning of national stakeholder engagement workshops being organized by WP7 partners for 2013.

[2] EuroHealthNet is a not-for-profit network of organizations, agencies and statutory bodies working to promote health and equity by addressing the factors that determine health directly or indirectly. EuroHealthNet offers advice and information for policy-makers, promotes good practice and innovation, and seeks to practice ethical and sustainable methods to achieve the aims and objectives set by its members and partners. For further information, access: http://eurohealthnet.eu/

A guide to identifying, engaging and supporting stakeholders to promote health equity from the start and tackling health inequalities, based on learning from all WP7 activities, will be developed in 2013.

Elisabeth Pott, Director, BZgA

Inequalities in health are a major challenge for public health in the EU. All EU Member States face a health gap between the lowest and highest socioeconomic groups. Reducing health inequalities is therefore one of the main challenges within the public health sector in Europe, and will become even more of a challenge due to the financial crisis.

BZgA is cooperating with a broad range of partners in the third EU-funded project on health inequalities, the Equity Action. In the first such project, Closing the Gap, which was coordinated by BZgA and EuroHealthNet, a comprehensive internet portal on good practice in tackling health inequalities in Europe was compiled. The second project, Determine, explored and discussed strategies on intersectoral work tackling the social determinants of health. The Equity Action is now looking at different sectors with the aim of developing strategies for intersectoral work.

Health is influenced to a large extent by social determinants, the conditions in which people are born, grow, live, work and age and which include social and community networks, living and working conditions, and the health system. Education also has an important influence on health, and inequalities in health are known to exist among children and young people.

Many of the major public health challenges faced by adults have their roots in the early years of life. Action to tackle health inequalities should therefore start in early childhood. Tackling health inequalities and ensuring health equity from the start requires cooperation and action from a wide range of stakeholders. This goal cannot be achieved by the health sector alone, but calls for shared responsibility across relevant sectors.

BZgA has experienced stakeholder engagement through two different channels. Stakeholder processes have been initiated by the health sector through the national Cooperation Network “Equity for Health”, and another policy sector has included the health sector as a strong partner in the federal “National Programme on Early Prevention”.

BZgA set up the nationwide intersectoral cooperation network “Equity for Health” in 2001 with the aim of identifying and collecting existing good practice and strengthening cooperation at national and federal-state level to tackle health inequalities. It aspires to support equal opportunities in health by disseminating good practice and mainstreaming effective interventions, raising awareness of the importance of equal opportunities. The network is supported by 54 national, regional and local organizations including NGOs, sickness funds, social welfare organizations, academics and now – very much welcomed – all umbrella organizations of the German municipalities.

The partner process “Growing-up Healthily for All”, which focuses on implementing integrated approaches that link services and offers for children and young people at municipal level, has recently been set up with the umbrella organizations and municipalities. Good-quality services for children and families exist at municipal level but are often not linked. The partner process concentrates on developing prevention networks (so-called “municipal integrated concepts”) with partners from different sectors to ensure consistent and strong coordinated support for children and families from birth through to employment training.

The German Federal Ministry for Family Affairs, Senior Citizens, Women and Youth set up the National Centre on Early Prevention (NZFH) at BZgA in 2007 to better protect children from neglect and abuse at very early stages. Parenting skills are being strengthened to allow children to grow up healthily and to promote their development. A central aim is to foster cooperation between children and youth services, health services and other relevant actors to jointly offer coordinated help to parents with specific needs. Children and youth services benefit directly from cooperation with health services: the health sector provides many ways of accessing families with specific needs and health services are usually well accepted by parents, who consider them to be supportive and nonstigmatizing. This allows early access to families with greater support needs, often during pregnancy. NZFH has been coordinating the federal initiatives “Early Prevention” and “Family Midwives” since July 2012.

Reducing health inequalities is a challenging and long-term task that requires high engagement from a variety of actors from different sectors. Awareness of its importance has increased in recent years, and developments such as the EU communication on reducing health inequalities, Solidarity in Health, and the new WHO policy framework for health and well-being, Health 2020, support efforts. Partnerships should further develop to increase joint actions for health equity.

Michael Hübel, EU Commission, Directorate-General for Health and Consumers
While the world economic crisis affects countries in Europe in different ways and at different speeds, very few countries could claim to be completely unaffected. Its effects on health and social systems on the one hand, and the health and social status of populations on the other, emphasize the importance of mainstreaming health and social inequalities across all policy areas.

General political commitment and leadership is important in tackling health and social inequalities, and the EU Commission has shown leadership in this area in recent years. Tackling health and social inequalities is built into the EU’s Structural Funds, which is probably the most important funding instrument provided by the EU to Member States. But it is clear at EU, regional and Member State levels that the health sector cannot move on its own – working across society and engaging key stakeholders is therefore crucial.

This is not about the health sector telling other sectors what to do. It is about building coalitions that create “win–win” situations across the board for all sectors, including the environment, education and the private sector. However, it starts at home, and it is important that the health sector plays its part. People providing health care and in hospital management and planning can do much to address the health gap.

Initiatives aimed at improving working across society in different areas of public health include the EU Health Forum and different stakeholder platforms. There were mixed views about the involvement of the food industry in the nutrition stakeholder platform and the alcohol industry in the Alcohol and Health Forum, but it is these kinds of difficult discussions that we need to be having to see how far we can work with partners across society in pursuit of health goals, with the inequalities agenda very much in mind.

Health and social agendas need to be brought together as much as possible and in a much stronger way than has been the case in the past. A good example of how this can be achieved is the work being taken forward as part of the EU framework for national Roma integration strategies. By raising awareness about this one vulnerable group, we also draw attention to how health and social welfare can be integrated and how systems can be made to address not just the most vulnerable groups in society, but also the social gradient. This is very much in line with WHO’s Health 2020 policy framework, and WHO is also increasingly embracing the idea of developing partnerships and working across society for health.

National and regional centres for health promotion have made an important contribution to the inequalities issue, as is captured in this important meeting. There are other encouraging signs of progress, including the European Charter for Health Equity and inequalities work being taken forward by the European Patients’ Forum, Mental Health Europe and other partners. This emphasizes the need to reach out beyond our own “turfs” to build effective coalitions with stakeholders – that is really what WP7 is all about.

In looking at practical ideas for how this can be achieved, this debate makes an important contribution. At the final meeting of the Equity Action, when all the WPs come together, the work of WP7 will show how addressing health inequalities is not the exclusive preserve of health policy, but presents a challenge to society as a whole, particularly in these times of economic hardship.

Keynote presentations

The Joint Action on Health Inequalities (“Equity Action”)

Marc Gamsu, Health Action Partnership International, England (United Kingdom)

We all live in democracies, and we can use the freedoms democratic traditions offer to engage with and motivate stakeholders. The stakeholder challenge is about engaging with people, seeing how far they are prepared to go in tackling health and social inequalities and doing our best to ensure we use the balance of power available to us, in partnership with others.

The people at this debate are champions for change. That is why Member States and the Commission have funded the debate. One of the challenges we now face is to ensure that we do not use the remaining year of the programme simply to achieve the deliverables and consider the job “done”. That is not why we are here – we are here because we have a commitment to addressing health inequalities, and that means we have to do more than just achieve the deliverables of the programme.

The political mandate we have is a tremendous asset. Each Member State has agreed at political level to participate in the programme, which gives us power and a mandate to take our work forward. We must continue to use it to open doors. The tools the programme is developing also represent valuable assets. These are being built from people’s experience and will increasingly become available from this year, providing opportunities to share learning and support. Social media such as Twitter also offer good opportunities for sharing.

The traditional approach to public health is to gather evidence, capture experience, produce reports and make the reports available. Reading long reports, however, can be onerous – most of the bigger reports we produce are for specialist interest only and are read by very few people. Reports are important, but we must also use other mechanisms to enable people to engage more easily with our work, such as very brief discussion summaries of reports that can be presented to partners and used to assess actions. In addition to the guidance manual on stakeholder engagement that has been identified as an output of the programme, WP7 will also produce short, sharp tools that we will be able to use to progress stakeholder engagement in early years. Participants will be able to use these to report back on progress in their countries.

Our ambitions are to continue to develop a network of champions, to ensure participants remain connected with each other and with all WPs, and to continue to use the Equity Action “brand” to generate evidence-based dialogue and action in Member States and at Commission level.

Joint actions for real needs

Clive Needle, EuroHealthNet

The message that “inequality matters” is beginning to have an effect in unlikely sectors, such as the industrial sector. It is doing so because it is becoming increasingly recognized that challenging inequality is necessary to the creation of cohesive societies. This provides us with a strong political mandate to pursue our goals. The challenge for all participants at this debate is: are we prepared to do something about it?

Professor Michael Marmot, who has consistently emphasized the importance of early years to health, has recently spoken of the “public health emergency” in Europe. He was not referring to alcohol, obesity or sexual health, but to the fact that too many young people are neither in work, education nor training. This issue needs to be on the public health agendas of all European countries. Young people not being in work, education or training represents a challenge not only to the present, but also to the future.

What are we doing to challenge child poverty across Europe? The “SPREAD” project that EuroHealthNet is involved in on behalf of the EU may present a model for dealing with problems as complex as child poverty. It focuses on developing a roadmap for research on sustainable development approaches towards 2050 and sets out a range of different scenarios on how we might proceed, describing the relevant conditions, determinants and steps.

There are things we can do that contribute to meeting public and societal needs at a time of change, with many opportunities being offered through, for example, the WHO Health 2020 policy framework, the EU Solidarity in Health statement and the Rio Declaration. If we are not downcast and are prepared to think imaginatively and in new ways, we can make a real difference. We need to be part of the solution, not part of the problem.

New European Commissioners will be in place in 2014. They will be looking for solutions to the problems in their areas. There will be European Parliament elections, and people from different sectors who have social inclusion at heart are not only getting involved, but are actually standing for election. The new EU programme period to 2020 will offer opportunities across all programme areas, and there may be new governments in some countries who will be interested in what we have to say to them.

Existing government finance ministers are acknowledging in EU forums that health spending contributes to better health, which in turn contributes to economic prosperity. They want to ensure universal access to quality care, equity and better health outcomes and improve health promotion and disease prevention within and outside the health sector. They are asking for our help, and we need to respond by saying “if you stand by your policies, we’ll show you how to achieve them”. We must not use the excuse that we need more evidence – we know enough now to act.

We do not need to reinvent the wheel on stakeholder engagement. Many effective models already exist, and EuroHealthNet is happy to share these. A focus on public (and private) incentives – spelling out to potential stakeholders what partnerships offer them – is a promising type of approach offering sustainable political benefits.

In the current economic situation, and for the foreseeable future, evaluation of multiple benefits and use of evidence are important in building systematic change and in convincing funders, but relevant evaluations are lacking. Evaluations do not need to be rocket science – there is more than one way to present evidence – but they do need to have scientific credibility. We need to share good work, so please tell EuroHealthNet about what you have achieved, and also about what you need now to move forward.

We need to learn the lessons about what influences decision-makers – again, this is well understood – and identify who the decision-makers are (civil servants are often very influential in this regard). This enables us to recognize what pressures they face and adopt strategies that will be attractive to them. The media continues to have a huge influence on decision-makers and we need to get smarter in working with all kinds of media.

In general, we have to be positive in working with decision-makers. It requires the right kind of information, in the right formats, delivered to the right people, at the right time. Our message should be that we are offering “win–win” solutions that will help them achieve their objectives.

Successful stakeholder engagement and intersectoral cooperation for achieving health equity from the start

Nicole Valentine, Technical Officer, WHO headquarters, Geneva

Child mortality levels, while decreasing, remain at around 7 million globally per annum, which is a shocking statistic. Global variations between regions in many cases mirror within-country or within-region variations, even in the EU. In view of these large numbers, reducing child mortality levels and inequalities is an important area of international concern. This is testified to in policy documents from various United Nations initiatives (such as Health 4+).

The health perspective in many initiatives tends to focus on medical interventions. In contrast, key recommendations of the WHO Commission on Social Determinants of Health and subsequent related initiatives in England and the WHO European review on social determinants of health and the health divide include intersectoral actions for addressing equity from the start.

These findings led to “intersectoral action” being defined as a key workstream for WHO in supporting country implementation of actions on the social determinants of health. Findings underpinning understanding of the health sector’s role in intersectoral action

were summarized early in the process at the Seventh Global Conference for Health Promotion held in Nairobi, Kenya in October 2009. These include the following.

- **The vision of health and society held by the health sector and other agencies**: this influences the type of relationships between health and other sectors and social participation. It is noted that when the health sector's vision of "health" is narrowly focused, it tends to concentrate on providing information to other sectors (telling them what to do and how to do it) and interventions focus on health care activity without the contribution of partners. When a wider vision incorporating concepts of well-being and taking a more societal view is deployed, the patterns of relationships with other sectors change, reflecting the need for the work of the sector(s) to be ordered by the needs of people and not by sectoral objectives.
- **Mechanisms for influencing other sectors:** these are important for motivating and sustaining action and include financing mechanisms.
- **The entry point for implementation**: there are various options for the implementation of intersectoral work, differing according to national and local contexts.

Subsequently, Orielle Solar developed a modified framework (based on Kingdon's "windows of opportunity") for the implementation of health in all policies, and WHO has used this to inform the development of capacity-building tools. Reflections from these pieces of work are described briefly below.

Building the case

Building the case for partnerships between health and other sectors needs to reconcile opportunities in the specific context (local or national) from different sectoral perspectives. Policy concerns need to be framed so that different parties can identify "common" concerns, particularly when health is promoting action by others. Possibilities for action need to be associated with non-health sectors' objectives.

Equity and social determinants of health lens in the design of interventions

Is equity explicit?

If equity is not considered explicitly or implicitly, the design of interventions will not address equity improvement. Equity could be defined as an explicit outcome of intersectoral action or of the drive to implement health in all policies.

Are interventions purely medical or do they include other sectors?

If targets relate to reducing inequalities in child health, then interventions usually require intersectoral work. WHO's knowledge network on reorienting public health programmes described the effectiveness of non-medical interventions in reducing inequalities in child health through cash transfers.

What are entry points for interventions? Identifying those in need

Universal health coverage is a key priority from the health sector's perspective, yet many of the barriers to achieving full health coverage depend on how well health and other services are integrated and how vulnerabilities identified by one sector are shared with other relevant sectors.

Organizing the work

Intersectoral collaboration requires revisiting how work is organized in view of different official mandates, departmental incentives and government levels. Different levels of government may initiate the work. Joint working mechanisms are needed to support dialogue and improve the capacity of stakeholders to understand each other’s language or sectoral culture.

Sustainability mechanisms or capacities

A solid information base is needed to enable analysis of equity and health in all policies. Personnel with appropriate public health training, negotiating skills and good knowledge of the policy-making system and structures are also required for translating assessments into action.

Parallel fora

Education and health

Moderator: ***Tamás Koós, OEFI***
Input: ***Zoltán Bogdány, Mondolat Consultancy Ltd., Hungary***

The presentation in the forum focused on latest developments in the Hungarian public education system through an equity lens. The main messages were about the structural differences between school owners/maintainers, with poorer municipalities having fewer resources available to support public education. Children in these municipalities consequently may be receiving poorer public education services. This can be considered a structural inequality that has the potential to generate health inequalities.

Reforms aiming to reduce inequalities have been introduced. Centralization of the education system through district- and regional-level education authorities has implications for better equity for poorer schools but may carry the risk of concentrating public education organization at regional level, which may hinder existing local informal cooperation focusing on promoting health and reducing inequalities.

It was suggested that many positive activities can be launched without extra finance, utilizing existing resources and local partnerships. Some participants doubted this assertion, however, and suggested that any such initiatives would necessarily be limited in scope: some kind of resource input will sooner or later be required to ensure sustainability.

Forum participants identified three layers of health inequalities in education: health inequalities have a huge impact on educational attainment and the level of education strongly impacts on life course and health inequalities. Health issues are present in educational establishments: schools identify and deal with health problems, and there is health-related education in public education.

The issue of approaches to reducing or preventing health inequalities was discussed. The health promotion approach is not the same as the preventive approach, which has a greater focus on disadvantage and tends to work at individual (rather than population) level. Health promotion requires greater participation, involvement and empowerment from stakeholders, so therefore relies on strong input from teachers in the public education sector. The preventive approach, focusing on individuals, depends on services being brought in from outside the schools and is therefore not so dependent on teacher effort, making partnerships between the health and education sectors easier to develop.

National-level formal partnerships have an important role in supporting local-level partnerships. Responsibilities for health and reducing health inequalities lie with different sectors and actors, but overall responsibility must remain with the state. Examples from

several countries of schools designed for children with special education needs being misused to segregate Roma children were cited: state and local governments have a clear responsibility to cease this practice.

The issue of overcoming resistance from teachers to change in their practice was raised. It was suggested that 40% of teachers are resisting change and not adapting their behaviours, while 10% are very committed and could be willing to adopt local "champion" roles. Concentration must now be placed on the remaining 50% who are "undecided": the government's tactics in this regard are very important in reducing resistance to change.

Social welfare and health

Moderator: ***Ilona Renner, NZFH***
Input: ***Barbara Filsinger, St Marien and St Anna Hospital, Ludwigshafen, Germany; Jürgen May, Youth Welfare Office, Ludwigshafen, Germany***

The Federal Ministry for Family Affairs, Senior Citizens, Women and Youth set up the National Centre on Early Prevention (NZFH), which is jointly coordinated by BZgA and the German Youth Institute, in 2007.

The NZFH aims to foster cooperation between the child and youth service, health services and other relevant actors to jointly offer help to parents with specific needs. NZFH has also been coordinating the federal initiative networks "Early Prevention" and "Family Midwives" since 2012.

A best-practice model of intersectoral collaboration within the work of NZFH in Germany involving a regional maternity hospital and youth welfare office was presented to the forum. The project, "Good start into life", achieved a "win–win" situation for stakeholders: the maternity hospital was able to identify families in need through its normal contacts, and the youth welfare office was enabled to offer help to meet the identified needs of the families. Good, effective and respectful cooperation has developed between the sectors, stimulating much discussion within the forum.

The project showed that while intersectoral collaboration started in a top–down fashion, those who work in the project should be supported to learn as it progresses and the project should be allowed to evolve according to experience to ensure a good fit with the situations and challenges found at local and regional level. It also showed that it is possible to change national policies through engagement processes.

Barriers to cooperation reflected the complexities of the political structure in Germany. Child protection measures and the structure of midwifery services differ between national and regional levels, which is not conducive either to creating consistent structures to underpin service delivery or to encouraging stakeholder engagement. Opportunities nevertheless exist to develop strong cooperation structures that fit local situations.

It is difficult to extrapolate how this project would translate to other country situations due to differing funding structures and roles and responsibilities of midwives. It would, however, be very interesting to look across borders to compare different systems and enable learning from each others' experiences.

Urban planning and health

Moderator: ***Helene Reemann, BZgA***
Input: ***Andrew Ross, Town and Country Planning Association, England***

The town and country planning process in England presents strong possibilities for greater cooperation between urban planners and public health practitioners. The forum heard about three major policy instruments that exemplify how the potential for synergy exists:

- the Localism Act, which presents the basis for developing neighbourhood plans;
- the Health and Social Care Act, which charges local authorities to take more responsibility for public health; and
- the National Planning Policy Framework (NPPF), which requires local authorities to work with public health organizations to identify and meet the needs of the population.

There is strong evidence of the importance of urban planning to health. Examples include the development of open spaces that make it easier for people to take part in physical activity, reducing traffic flows to lower air pollution and reduce road accidents, providing green spaces to promote mental health and installing better home insulation and heating. There are good opportunities for cooperation and intersectoral work to advance these ideas at national and local levels.

Obstacles to progress include the different "language" used by sectors and different understandings of time scales, with the urban planning sector tending to look at much longer timeframes than health. There are also varying levels of experience of intersectoral working involving urban planning and health sectors across countries. It was agreed, however, that it is important to try to engage civil society in some of the processes, as neighbourhood organizations are very important in supporting urban planning.

Other opportunities for intersectoral collaboration include engaging public health in assessing planning applications and improving cooperation between urban planning, health and wider actors: ideas such as these are already being taken forward in some cities in England. An excellent example of cooperation could be found in the Netherlands in the 1970s when, in response to increasing numbers of accidents involving cyclists and cars, a network of cycle lanes was introduced. A strong media campaign was instrumental in securing this change, and networks, such as the Healthy Cities Network, were also identified as being useful in enabling key messages to reach wider audiences, encouraging engagement and promoting intersectoral collaboration.

Parallel sessions

Stakeholder engagement and intersectoral action at governmental level

Moderator: ***Ray Earwicker, Department of Health, England***
Input: ***Pilar Campos* and *Ana Gil, Ministry of Health, Social Services and Equality, Spain***

In the context of the Spanish national strategy on health equity, an initial training process for public health professionals was carried out during 2010/2011. It focused on integrating equity and social determinants of health into health strategies, programmes and activities, and was based on the experience and technical documentation of the Chilean Ministry of Health on reviewing and redesigning health programmes. From this process, a methodological guide to integrating equity into health strategies, programmes and activities was developed.[3]

Intersectoral action and participation were key elements of the process throughout and were promoted through application of a model featuring the following elements:[4]

- **information**: presenting strategies and policies to stakeholder sectors;
- **cooperation**: promoting interaction between sectors and establishing ground rules for relationships;
- **coordination**: joint working leading to policies and strategies being amended to reflect sectoral interests; and
- **integration:** revised policies or strategies being jointly defined by the sectors involved.

The ultimate goal of this approach is to secure health in all policies, with health and inequalities issues being reflected in the objectives and work of non-health sectors. There are nevertheless difficulties in managing a practical approach to intersectoral action and social participation, and it was suggested that there is a need to develop methodologies to support the process.

A working team set up under the training process described above conducted an equity review of the Spanish national strategic plan for childhood and adolescence (PENIA) focusing on the strategic goal of health promotion, protection and prevention among 0–3-year-olds. The equity review analysed PENIA's process of stakeholder engagement, which

[3] *Methodological Guide to integrate Equity into Health Strategies, Programmes and Activities*. Madrid, Ministerio de Sanidad, Servicios Sociales e Igualdad, 2012 (http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/jornadaPresent_Guia2012/docs/Methodological_Guide_Equity_SPAs.pdf).

[4] Solar O et al. Moving forward to Equity in Health: what kind of intersectoral action is needed? An approach to an intersectoral typology. *Seventh Global Conference for Health Promotion, Nairobi, Kenya, October 2009*.

was mainly implemented through the Childhood Observatory (CO). The CO was established in 1999 as a working group of the Ministry of Health, Social Services and Equality and consists of representatives of all ministries with competence in the field of childhood (education, justice, foreign affairs, interior affairs, economy and finance, and migration) and other relevant stakeholders.

A "strengths and weakness" analysis of PENIA's health goal identified "intersectoral working" and "social participation" as strengths, but also found that intersectoral work required greater coordination. Recommendations included the need to facilitate technical coordination and cooperation mechanisms among institutions at all levels and improved participation of key actors. The strategy was subsequently revised to reflect active participation of all stakeholders and coordination of different organizations and agencies and now includes an objective on health equity from the start.

A SWOT (strengths, weaknesses, opportunities and threats) analysis of intersectoral action in Spain from a health sector perspective was conducted in preparation for the stakeholder debate. This concluded that intersectoral action and social participation are key elements in the social determinants of health approach, but their existence does not guarantee that equity will be achieved.

The experience in Spain emphasizes the challenges of intersectoral action and social participation, but also the benefits. The SWOT analysis was perceived in the forum as a strong model that could be used throughout the Equity Action process. Flexibility was identified as being important when communicating and coordinating with different sectors, particularly in times of financial crisis, and the necessity to establish a common "language" that empowers sectors in progressing the work was confirmed.

Stakeholder engagement and multisectoral networks at municipal level

Moderator: ***Raimund Geene, Magdeburg-Stendal University of Applied Sciences, Germany***
Input: ***Dr Frank Lehmann, BZgA*** **and** ***Holger Kilian, Health Berlin-Brandenburg***

The municipal partner process "Growing up healthily from the start for all!", initiated by BZgA as part of the nationwide intersectoral cooperation network "Equity for Health", aims to strengthen connections between existing services for children and families at municipal level by:

- developing prevention networks with a wide range of stakeholders from different departments (health, welfare, children, youth and family, education, urban development), family and community centres and job centres; and
- organizing coordinated, complementary, intersectoral support throughout the course of growing up ("municipal (health) strategies", also called "prevention chains").

Stakeholder cooperation is crucial, as families are simultaneously in contact with different systems and services (such as public and social services) and require integrated actions. The project chose a multilevel stakeholder approach by involving actors and partners at national level (such as municipal umbrella organizations and sickness insurance funds), federal level (federal working groups for health promotion) and municipal level (health authorities and youth welfare service).

Workshops, conferences and development tools were used at national level to engage stakeholders at the beginning of the process. It was recognized that a wide range of tools needs to be applied at municipal level, including facilitators and “translators” (experts who generate the engagement of more stakeholders by developing a common language and bringing others into the discussion). In some cases, the engagement process started as a consequence of a scandal (such as a child dying of neglect). Scarce resources (time, personnel and finance), professional “blinders” (such as silo thinking and focusing on only one side of a problem) and lack of a cooperation culture created barriers to the stakeholder engagement process. These can be overcome by learning and understanding the “professional logic” of potential partners and pointing out the benefit of cooperation.

The top–down approach was emphasized as a crucial element in ensuring sustainability of local actions and overcoming barriers due to “professional blinders”. As an example, the mayor plays a crucial role at local level in bringing sectors together and anchoring the intersectoral approach in municipal policies. Another example of the value of the top–down approach is the role of umbrella organisations who act as “facilitators” in reaching municipalities in many countries (in Germany, they also defend municipal rights at federal level).

Ensuring sustainability of networks in Germany requires different methods at each level:

- **at municipal level,** there is a need for someone who is close to the mayor and who organizes cooperation;
- **at state level,** new ideas are very important in making stakeholders active and counselling and organizing exchanges between municipalities is important; and
- **at national level,** a whole-of-society approach is crucial.

Based on other countries’ experiences, the best way to keep network members active is to find common goals that capture their interest and to develop win–win strategies (gaining the long-term benefits of being involved and providing input at the same time). The level of competence of different sectors within a network should also be clarified from the outset.

The success of projects with health aims but which do not run under the health “banner” was also emphasized. Sometimes health is not the best starting point for intersectoral action. Although incorporating health into other agendas presents a challenge, cooperation based on broader issues can be more long lasting. For example, intersectoral cooperation

in welfare issues can be stronger when stakeholders have responsibility for welfare issues regulated in law. The legal base is also a crucial point in engaging sickness funds: although they take a more competitive approach towards clients (preferring middle-class and healthy people to those who are disadvantaged), they are still cooperative due to the legal base for public health responsibility. Intersectoral cooperation in health issues also runs the risk of medicalization, which can be lessened if physicians are encouraged to contact the social welfare system when needed.

Panel discussion

Speakers: ***Piroska Östlin, WHO Regional Office for Europe***; ***Barbara Filsinger, St Marien and St Anna Hospital, Ludwigshafen, Germany***; ***Clive Needle, EuroHealthNet***; ***Frank Lehmann, BZgA***; ***Ray Earwicker, Department of Health, England***
Moderator: ***Raimund Geene, Magdeburg-Stendal University of Applied Sciences, Germany***

During the final panel, experts from local, national, European and international level discussed the main conclusions of the debate following guiding questions on how to succeed in stakeholder engagement and intersectoral cooperation. There was vivid discussion during this session, the main points of which are summarized below.

Main points from discussions

Promoting intersectoral collaboration

- Four key elements for success in intersectoral collaboration have been identified by EuroHealthNet within the Crossing Bridges project, which focuses on practical implementation of the health in all policies approach:
    1. have a common "language" among sectors, with clear objectives and goals defined;
    2. identify the relevant evidence base;
    3. possess a mandate and support from a higher level; and
    4. develop a sense of shared responsibility and ownership of implementation.
- It is also useful to remind ourselves of the steps towards intersectoral action described in the Spanish parallel forum presentation – information, cooperation, coordination and integration.
- Intersectoral work must appear attractive to all the stakeholders we want to include. It needs to be made attractive through incentives (positive (the benefits of being involved) and negative (the penalties on non-involvement)) and must have a structure or framework that allows people to see how they fit into the network and help those who are used to working only within their own sectors to reach out to others.
- Health should ask other sectors, "What can we do for you?" This means leaving our silos and learning about other sectors' goals and ambitions. Not only will this give us

ideas on how we can contribute to meeting their ambitions, but it will also indicate how they can contribute to achieving health goals.

- We have to understand the sectors and organizations we are seeking to work with, stay in contact with them over the long term and be prepared to answer any questions they have.
- Collaboration across formal government structures needs to be matched by social participation and civil-society involvement. Only by combining these two approaches – top–down, but also bottom–up – will we be able to get the buy-in and ownership that is necessary to make our work sustainable.
- It will not be possible to implement the new WHO policy framework for health and well-being, Health 2020, without intersectoral collaboration. This issue is addressed directly in the document, which seeks support for implementation not just from health ministers, but also from prime ministers and policy-makers in all ministries and at municipal level. Whole-of-government and whole-of-society approaches and health in all policies are central to Health 2020. This is not easy to accomplish but is not impossible: there are very good examples of how it can be achieved.
- It is necessary to reorient health policies towards national and local development agendas and ensure other sectors contribute. Scotland (United Kingdom), which has developed five goals in its national development agenda,[5] provides a good example of how this can be achieved, with all sectors being made accountable for achieving the five goals, backed by a clear performance assessment structure. This kind of approach reduces the dangers of "silo" thinking among sectors. Health goals should therefore be seen as part of development goals, in partnership with other sectors' goals, and a performance and continuity system that makes, for example, transport and education responsible for achieving health goals and health responsible for achieving transport and education goals should be built in.
- There are things people can be doing now on intersectoral action to ensure that it does not rely solely on individual inspiration and commitment, but is delivered through a systematic approach. This requires proactive thinking, such as has been shown by Norway, which is adopting a proactive multisectoral approach to addressing early school-leaving by focusing effort on kindergartens. In doing so, the country is proactively investing now to avoid problems 10 years or so down the line.

Overcoming barriers to intersectoral collaboration

- Barriers to intersectoral collaboration may be overcome by understanding the "professional logic" of potential partners (where they are coming from), pointing out the benefits of partnership to them, and taking a "deep breath" when conflicts arise – a process described as "unfreezing" in Kurt Lewin's model of change, which basically means overcoming inertia and dismantling the existing mindset.

[5] The Scottish Government has five objectives that underpin its core purpose. They are to make Scotland: wealthier and fairer; healthier; safer and stronger; smarter; and greener (see: http://www.scotland.gov.uk/About/Performance/Strategic-Objectives).

Promoting the Equity Action

- Forward movement does not necessarily occur through a giant stride being taken by one individual or organization – many people doing small things over time cumulatively leads to effective change.
- A one-size-fits-all approach to joint Equity Action in Europe will not work. A range of initiatives that can have differential impacts will be necessary.
- We must not forget that the Equity Action initiative, supported by all 16 countries represented at the meeting, gives us a mandate. It provides our "calling card" when we move out our silos to engage with stakeholders and provides legitimacy for our approaches to other sectors.

Engaging with politicians

- The most difficult thing a professional politician in a decision-making position ever has to say is "No". They have to decide what is affordable, what is acceptable politically and what will be capable of clearing party and legislature hurdles. This emphasizes how important it is, especially at times such as these, to consider presenting proposals to politicians that do not require vast resources and which are not particularly politically controversial.
- We need to get to know our politicians – what their principles, aspirations and prejudices are – and work out how best to approach them. Politicians will be looking for solutions to the societal problems that history and evidence tell us always follow a financial crisis. They will be seeking evidence-based solutions that fit their circumstances. There are suggestions that some political commentators are already thinking about "post-austerity" jobs and growth which involves, for example, governments acting to reduce the number of early school leavers to reduce pressure in the employment market. As the example from Norway and other initiatives being put in place across Europe show, we have something very useful to contribute to this. We can be part of sustainable development.
- When we approach politicians, we should not simply present the evidence on where the gaps are – we should also be prepared to suggest some solutions.

Developing and demonstrating evidence

- We have learned a tremendous amount about health inequalities and their causes over the last 15 years, which makes it much easier to consider solutions. When WHO invited Professor Michael Marmot to chair the European review on social determinants of health and the health divide, they asked not only for a description of the relevant factors between and within countries, but also for good practice examples that can inspire solutions. We now know so much more about what can be done and what good practice can deliver, which means it is much easier to advise politicians.

- If people taking projects and initiatives forward want others to replicate their work and wish to ensure their projects’ sustainability, they need to evaluate their work and provide evidence of benefits. A strong evidence base has to underpin not only the design and launch of multisectoral programmes, but also their sustainability over years. Evaluations of evidence-based programmes such as Sure Start in the United Kingdom, which has now been in place for over 10 years, show that benefits are being delivered. This strong evidence base has enabled the programme’s sustainability and basically explains why it has been able to run for over a decade.
- The example presented from Spain in the parallel forum showed how a SWOT analysis can be used to provide an honest appraisal of progress. An understanding of strengths, weaknesses, opportunities and threats, allied to recognition of the needs and preferences of the intended audience and the circumstances in which the work is being taken forward, is necessary to enable purposeful evidence to be developed.
- Putting together cross-sectoral indicators (which were used in the Norwegian kindergarten initiative, presented during the first stakeholder debate in Budapest) can open new opportunities. A range of tools, formal and informal, are available to support this.
- We can act now on the evidence we have – we do not necessarily need more.

Országos Egészségfejlesztési Intézet

BZgA Bundeszentrale für gesundheitliche Aufklärung

Annex 1

STAKEHOLDERS

Second EU-wide stakeholder debate of the Equity Action "Together for Health Equity from the Start", 14–15 November 2012, Berlin, Germany

Programme

Venue
Landesvertretung NRW (*Permanent Representation of the Federal State North Rhine-Westphalia (NRW))*
Hiroshimastraße 12–16, 10785 Berlin
Room: "Rheinland"

Day 1: 14 November 2012

***Moderator**: Prof. Dr Raimund Geene, Magdeburg-Stendal University of Applied Sciences, Germany*

12:00-13:00	*Lunch and registration*
13:00-13:50	Welcome and opening

- *Helene Reemann, Federal Centre for Health Education (BZgA), Germany and Dr Tamás Koós, National Institute for Health Development (OEFI), Hungary,* leads of Work Package 7 "Facilitating broad stakeholder engagement" of the Equity Action

Welcome addresses

- *Prof. Dr Elisabeth Pott, Director of the Federal Centre for Health Education (BZgA), Germany*
- *Robert Schüßler, Federal Ministry of Health (BMG), Germany*
- *Michael Hübel, EU Commission, Directorate-General for Health and Consumers, Luxembourg*

x	Keynotes
13:50-14:00	The Joint Action on Health Inequalities ("Equity Action"), *Mark Gamsu, Health Action Partnership International (HAPI), England*
14:00-14:30	Real actions for health equity from the start in challenging times, *Clive Needle, EuroHealthNet, Belgium*

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This work is part of EQUITY ACTION which has received funding from the European Union, in the framework of the Health Programme. The sole responsibility for this work lies with the author

14:30-15:00	*Coffee break*
15:00-15:30	Successful stakeholder engagement and intersectoral cooperation for achieving health equity from the start, *Nicole Valentine, WHO headquarters, Switzerland*
15:30-17:00	Parallel fora

Parallel fora discuss examples on stakeholder engagement processes and intersectoral cooperation between one specific sector (education/social welfare/urban planning) and the health sector for achieving health equity from the start. Each forum starts with an input presentation which is followed by a moderated discussion.

Education and health (room "Westfalen")

- ***Input**:* Latest developments in the Hungarian public education system through an equity lens, *Zoltán Bogdány, Mondolat Consultancy Ltd., Hungary*
- ***Moderation**: Dr Tamás Koós, OEFI*

Social welfare and health (room "Rheinland")

- ***Input**:* The German National Centre on Early Prevention and the project "A good start into life",
  Ilona Renner, National Centre on Early Prevention (NZFH), Germany
  Dr Barbara Filsinger, St Marien and St Anna Hospital Ludwigshafen, Germany
  Jürgen May, Youth Welfare Office Ludwigshafen, Germany
- ***Moderation:** Ilona Renner, National Centre on Early Prevention (NZFH)*

Urban planning and health (room "Düsseldorf")

- ***Input*:** Reuniting health with planning: healthier homes, healthier communities, Andrew Ross, Town and Country Planning Association, UK
- ***Moderation*:** Helene Reemann, BZgA

17:00	Closing of day 1, *Helene Reemann, BZgA and Dr Tamás Koós, OEFI*
18:45	*Departure for joint dinner, combined with sight-seeing bus tour* *(the bus leaves at 18:45 in front of the Motel One)*

Day 2: 15 November 2012

Moderator: Prof. Dr Raimund Geene, Magdeburg-Stendal University of Applied Sciences, Germany

09:00-09:45	Recap of day 1 and reporting back from parallel fora
9:45-11:15	Parallel sessions

Stakeholder engagement and intersectoral action at governmental level (room "Rheinland")

- ***Input:*** Intersectoral action for moving forward health equity: experience on stakeholder engagement in the Spanish national strategic plan for childhood and adolescence*, Pilar Campos and Ana Gil, Ministry of Health, Social Services and Equality, Spain*
- ***Moderated discussion***: *Dr Ray Earwicker, Department of Health, England*

Stakeholder engagement and multisectoral networks at municipal level (room "Westfalen")

- ***Input***: The partner process "Growing up Healthily for All" of the National Cooperation Network "Equity for Health", *Dr Frank Lehmann, BZgA, Germany and Holger Kilian, Health Berlin Brandenburg, Germany*
- ***Moderated discussion***: *Prof. Dr Raimund Geene, Magdeburg-Stendal University of Applied Sciences, Germany*

11:15-11:45	*Coffee break*
11:45-12:45	Final panel

Cornerstones and recommendations on "Engaging stakeholders for Health Equity from the Start"

- ***Speakers:*** *Dr Piroska Östlin, WHO Regional Office for Europe; Dr Barbara Filsinger, St Marien and St Anna Hospital Ludwigshafen, Germany; Clive Needle, EuroHealthNet; Dr Frank Lehmann, BZgA, Germany; Dr Ray Earwicker, Department of Health, England*
- ***Moderation:*** *Prof. Dr Raimund Geene, Magdeburg-Stendal University of Applied Sciences, Germany*

12:45-13:00	Concluding remarks, *Helene Reemann, BZgA and Dr Tamás Koós, OEFI*
13:00	End of meeting
13:00-14:00	*Lunch*

Annex 2

No.	Last name	First name	Country	Institution
1	**A**tkinson	Prof. Sue	United Kingdom	Public Health Action Support Team (PHAST)
2	**B**allesteros Vicente	Conchi	Spain	Platform of Childhood Organizations
3	Beenackers	Marielle	Netherlands	Erasmus MC, Department of Public Health
4	Belzer	Florian	Germany	Medical Centre for Children and Young People, University Hospital
5	Biasioli	Stefano	Italy	National Council of Economy and Labour (CNEL)
6	Bogdány	Zoltán	Hungary	Mondolat Consultancy Ltd.
7	Brookes	Chris	United Kingdom	Health Action Partnership International
8	Brzková	Martina	Czech Republic	Ministry of Health,Department of Health Care
9	Busert	Laura	Germany	Assistant
10	**C**ampos	Pilar	Spain	Ministry of Health, Social Services and Equality
11	Castellanos Delgado	José Luis	Spain	Ministry of Health, Social Services and Equality
12	Christakos	Nikolaos	Greece	Organisation for Social Integration (Nostos)
13	Costa	Giuseppe	Italy	Social Epidemiological Unit ASLTO3
14	**D**eliens	Christine	Belgium	Coordination Education & Santé (Cordes)
15	Díaz Huerta	José Antonios	Spain	Spanish Society of Social Paediatrics
16	**E**arwicker	Dr Ray	United Kingdom	Department of Health, England
17	**F**abisiak	Magdalena	Poland	Ministry of Labour and Social Policy
18	Filsinger, Dr.	Barbara	Germany	St Marien and St Anna Hospital Ludwigshafen
19	**G**amsu	Mark	United Kingdom	Health Action Partnership International
20	Geene	Dr Raimund	Germany	Magdeburg-Stendal University of Applied Sciences

No.	Last name	First name	Country	Institution
21	Gerits	Pol	Belgium	Federal Public Service Health, Food Chain Safety and Environment
22	Gil	Ana	Spain	Ministry of Health, Social Services and Equality
23	Giustetto	Guido	Italy	Ordine Provinciale Medici Chirurghi e Odontoiatri di Torino
24	Govaert	Katleen	Belgium	Kind en Gezin
25	Grüner Holthe	Bente Marie	Norway	Norwegian Ministry of Children, Equality and Social Inclusion
26	**H**alik	Rafal	Poland	National Institute of Public Health, National Institute of Hygiene Poland
27	Hofrichter	Petra	Germany	Hamburg Association for Health Promotion (HAG)
28	Hübel	Michael	Luxembourg	European Commission
29	**J**anatova	Hana	Czech Republic	National Institute of Public Health (NIPH)
30	**K**ammenou	Athina	Greece	Society for the Development and Creative Occupation of Children (EADAP)
31	Kaura	Claudia	Germany	Federal Centre for Health Education (BZgA)
32	Kazmer	Ladislav	Czech Republic	Department of Social Geography and Regional Development, Faculty of Science, Charles University in Prague
33	Kilian	Holger	Germany	Health Berlin Brandenburg
34	Koòs	Dr Tamàs	Hungary	National Institute for Health Development
35	Kowalewski	Mariusz	Poland	Union of Polish Counties
36	Kuipers	Yoline	Europe/ Belgium	EuroHealthNet
37	**L**ehmann	Dr Frank	Germany	Federal Centre for Health Education (BZgA)
38	Licata	Giovanna	Germany	Federal Centre for Health Education (BZgA)
39	**M**athieson	Alex	United Kingdom	Conference documentation
40	May	Jürgen	Germany	Youth Welfare Office, Ludwigshafen

No.	Last name	First name	Country	Institution
41	Mudra	Josef	Czech Republic	Government of Czech Republic
42	**N**eedle	Clive	Europe/ Belgium	EuroHealthNet
43	Nejedlá	Dr Marie	Czech Republic	National Institute of Public Health, Prague
44	**Ö**stlin	Dr Piroska	Denmark	WHO Regional Office for Europe, Copenhagen
45	**P**apaprokopiou	Anastasia	Greece	Society for the Development and Creative Occupation of Children (EADAP)
46	Pott	Prof. Dr Elisabeth	Germany	Federal Centre for Health Education (BZgA)
47	Poucet	Thierry	Belgium	Public health journalist
48	Pusztai	Dr Zsuzsanna	Hungary	Municipality of Budapest, Department of Education, Child and Youth Protection
49	**R**affael	Mónika	Hungary	Ministry of Human Resources, State Secretariat of Social Inclusion
50	Reemann	Helene	Germany	Federal Centre for Health Education (BZgA)
51	Renner	Ilona	Germany	National Centre on Early Prevention (NZFH)
52	Réthy	Dr Lajos A.	Hungary	National Institute of Child Health (OGYEI)
53	Richter-Kornweitz	Dr Antje	Germany	Association for Health Promotion and Academy for Social Medicine, Lower Saxony (LVG & AFS)
54	Roland	Nicole	Belgium	Office de la Naissance et de l'Enfance (ONE)
55	Ross	Andrew	United Kingdom	Town and Country Planning Association (TCPA), England
56	**S**aniewska-Kilim	Aleksandra	Poland	Ministry of Health
57	Schüßler	Robert	Germany	Federal Ministry of Health (BMG)
58	Strandrud	Janne	Norway	Norwegian Directorate of Health
59	**T**aller	Àgnes	Hungary	National Institute for Health Development
60	**V**alentine	Nicole	Switzerland	WHO headquarters, Geneva

No.	Last name	First name	Country	Institution
61	Vasselli	Stefania	Italy	Ministry of Health, Department of Public Health, General Directorate of Prevention
62	**W**iegand	Caren	Germany	Federal Centre for Health Education (BZgA)
63	**Y**aneva	Gergana	Bulgaria	National Patients’ Organization
64	**Z**dun	Paweł	Poland	Ministry of Regional Development