Health and well-being and the 2030 Agenda for Sustainable Development in the WHO European Region: an analysis of policy development and implementation

REPORT OF THE FIRST SURVEY TO ASSESS MEMBER STATES’ ACTIVITIES IN RELATION TO THE WHO EUROPEAN REGION ROADMAP TO IMPLEMENT THE 2030 AGENDA FOR SUSTAINABLE DEVELOPMENT
Health and well-being and the 2030 Agenda for Sustainable Development in the WHO European Region: an analysis of policy development and implementation

REPORT OF THE FIRST SURVEY TO ASSESS MEMBER STATES’ ACTIVITIES IN RELATION TO THE WHO EUROPEAN REGION ROADMAP TO IMPLEMENT THE 2030 AGENDA FOR SUSTAINABLE DEVELOPMENT
Abstract

This report presents an analysis of policy, governance and implementation arrangements to achieve health and well-being for all at all ages and the Sustainable Development Goals (SDGs) in Member States of the WHO European Region. The analysis was based on a survey in 2019 that was completed by 29 Member States. Results show that Member States have prioritized implementation of the 2030 Agenda for Sustainable Development and integration of the SDGs into relevant planning frameworks. Integration has been facilitated through the creation or adaptation of institutional arrangements with leadership from high levels of government and participation of all sectors of society. More action is required to advance governance and leadership for health and well-being through a more holistic lens that encompasses a life-course approach, considers the determinants of health and invests in preparedness, prevention and resilience. Mechanisms were identified that facilitated intersectoral collaboration and improved accountability. The findings can be used by health stakeholders to identify solutions that can be adapted to the specific contexts of their institution, community or country to support achievement of the health and well-being goals and ultimately the SDGs. Findings can also be used by multilateral organizations and development partners to inform their role in fostering change and creating an enabling environment for the achievement of the SDGs.

Keywords

2030 AGENDA, SUSTAINABLE DEVELOPMENT GOALS, VOLUNTARY NATIONAL REVIEW, HEALTH AND WELL-BEING, NATIONAL PRIORITIES, HEALTH FINANCING, HEALTH INFORMATION SYSTEMS
### Contents

**Foreword** ................................................................................................................................................iv  
**Acknowledgements** .............................................................................................................................. v  
**Abbreviations** .........................................................................................................................................vi  
**List of figures, boxes and tables** .........................................................................................................viii  
**Executive summary** ...............................................................................................................................xi  
**Introduction** ............................................................................................................................................ 1  
  - **Background**........................................................................................................................................... 1  
  - **Methodology** ........................................................................................................................................ 2  
**Results** .................................................................................................................................................... 5  
  - **Block 1: advancing governance and leadership for health and well-being** ......................... 5  
  - **Block 2: leaving no one behind** ........................................................................................................ 30  
  - **Block 3: preventing diseases and addressing health determinants by promoting multi- and intersectoral policies and action throughout the life-course** ..................... 36  
  - **Block 4: establishing healthy places, setting and resilient communities** ............................... 44  
  - **Block 5: strengthening health systems for UHC** ............................................................. 46  
  - **Block 6: investing for health and well-being** ........................................................................ 54  
  - **Block 7: supporting multipartner cooperation** ........................................................................... 56  
  - **Block 8: promoting health literacy, research and innovation** ............................................. 61  
  - **Block 9: monitoring and evaluation** ..................................................................................... 66  
**Discussion** ..............................................................................................................................................71  
**Conclusions** ........................................................................................................................................... 77  
**References** ............................................................................................................................................ 78  
**Annex 1. Survey strategy and analysis** ................................................................................................. 82  
**Annex 2. Survey sent to Member States** .............................................................................................. 87  
**Annex 3. Country profiles** ..................................................................................................................110
Foreword

With the endorsement of the Roadmap to implement the 2030 Agenda for Sustainable Development in 2017 by the WHO Regional Committee for Europe, Member States of the WHO European Region recognized that the 2030 Agenda provides a renewed commitment and an integrated multisectoral approach to advance the health and well-being goals.

Results of the survey show that Member States have leveraged this opportunity. Much is going on and it is impossible to showcase each and every actor and action, but with this report we hope to illustrate how countries have dealt with the challenge of the Sustainable Development Goals (SDGs) and innovated in their ways of working to ensure a whole-of-government and whole-of-society approach for better health and well-being for all at all ages.

One thing becomes clear, achieving the SDGs by 2030 remains a challenge. The COVID-19 pandemic has shown even more just how important strong and resilient health systems and settings are, not only for people but also for the social and economic development of a country.

We need to focus our efforts on building institutional and human resource capacity, and by doing so increase the role of health stakeholders in the development arena. We need to better understand how to remove financial, political, organizational, cultural or collaborative/logistical barriers to improve interministerial and/or intersectoral oversight, as well as to improve accountability, monitoring and evaluation. The health sector has also work to do to ensure that the SDGs are addressed in health policies and strategies and to raise awareness and empower and advocate for health in their work with other sectors and partners.

I thank all participating countries for taking the time to share their experiences. These findings are invaluable for the work of WHO and United Nations agencies and partners. They will inform the implementation of the WHO Thirteenth General Programme of Work and the European Programme of Work, as well as the Global Action Plan for Healthy Lives and Well-being for All.

I encourage all partners, but particularly academia and civil society, to build on this work. We need to dig deeper to better understand how some of the processes described work in practice, such as the delegation of authority, the enablers of intersectoral collaboration, and cooperation and engagement with non-state actors.

I wish you all an interesting reading.

Dr Bettina Menne
Coordinator health and sustainable development
Acknowledgments

This report of the first survey to assess Member States’ policy development and implementation activities in relation to the WHO European Region Roadmap to implement the 2030 Agenda for Sustainable Development was coordinated by the Health and Sustainable Development programme of the WHO Regional Office for Europe.

Emilia Aragón De León is the author of the report, with Priya Umachandran as contributing author (both from the WHO Regional Office for Europe). The report was peer reviewed by Pia Vracko (National Institute of Public Health, Slovenia) and Tatjana Buzeti, Teresa Costa and Govin Permanand from the WHO Regional Office for Europe.

Bettina Menne (WHO Regional Office for Europe) provided direction during all stages of the report production as well as technical advice during concept drafting, survey design, data collection, analysis, writing and review.

The survey was designed with support from Hilaire Armstrong, Christian Gapp, Valeria Santoro Lamelas and Tarang Sharma from WHO Regional Office for Europe and Florentina Furtunescu from WHO Country Office in Romania. Online administration of the survey was performed by Sergei Bychkov from WHO NCD Office in Moscow. Dissemination of the survey and follow-up was possible thanks to Jodie Littlewood from WHO Regional Office for Europe and colleagues in WHO country offices. Analysis of results has benefited from the expert advice of Hilaire Armstrong, Diogo Alves Lemos, and Assia Brandrup-Lukanowa from WHO Regional Office from Europe.

Special thanks to national counterparts from Armenia, Belarus, Belgium, Bulgaria, Estonia, Croatia, Cyprus, Czechia, Finland, Hungary, Ireland, Israel, Latvia, Lithuania, Luxembourg, Monaco, Norway, Poland, Portugal, Republic of Moldova, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, Turkey, Ukraine and the United Kingdom of Great Britain and Northern Ireland for participating in this exercise and for comprehensive feedback provided during revisions and consultations, ensuring accuracy and precision in the interpretation of their country responses.

We also thank Piroska Östlin for her strategic guidance at the beginning of this initiative, as well as to other WHO Europe colleagues, Chris Brown, Snezhana Chichevalieva, Emmanuelle Jouy, Marija Kishmann, Monika Kosinska, Joana Madureira Lima, David Novillo Ortiz, Ivo Rakovac, Christian Schweizer, Christoph Wipple, Yongjie Yon and Francesco Zambon for their technical input and comments in different stages of development of this product.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2030 Agenda</td>
<td>2030 Agenda for Sustainable Development</td>
</tr>
<tr>
<td>AMR</td>
<td>antimicrobial resistance</td>
</tr>
<tr>
<td>CIS</td>
<td>Commonwealth of Independent States</td>
</tr>
<tr>
<td>GDP</td>
<td>gross domestic product</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>HLPF</td>
<td>High-level Political Forum on Sustainable Development</td>
</tr>
<tr>
<td>NCD</td>
<td>noncommunicable disease</td>
</tr>
<tr>
<td>NDP2020</td>
<td>National Development Plan of Latvia for 2014–2020</td>
</tr>
<tr>
<td>NDP</td>
<td>national development planning framework</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>NHP</td>
<td>national health planning framework</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>Roadmap</td>
<td>Roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy for health and well-being</td>
</tr>
<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
</tr>
<tr>
<td>UHC</td>
<td>universal health coverage</td>
</tr>
<tr>
<td>VNR</td>
<td>voluntary national review</td>
</tr>
</tbody>
</table>
Delegates at the start of the 67th session of the WHO Regional Committee for Europe.
List of figures, boxes and tables

**Figures**

Fig. 1. Strategic directions and enablers of the Roadmap
Fig. 2. Health and well-being priority areas most frequently included by Member States in their NDPs (22 responding Member States)
Fig. 3. Health and well-being priorities referred to most frequently in Member States’ main health and well-being planning frameworks (29 Member States)
Fig. 4. Measures included in NHPs among the 19 responding Member States
Fig. 5. Challenges and barriers to implement an NHP among 19 responding Member States
Fig. 6. Leadership for coordinating the implementation of the 2030 Agenda
Fig. 7. Functions most commonly assigned to institutional and coordination arrangements for implementation of the 2030 Agenda
Fig. 8. Level of involvement by sector in the SDG coordination mechanism within the 27 responding Member States
Fig. 9. Measures to address the reduction of health inequities and/or improvement of social determinants of health in the policies of the 28 responding Member States
Fig. 10. Level of collaboration between the ministry in charge of health and the health-determining sector in the 27 responding Member States
Fig. 11. Action and measures taken to prevent disease and address health determinants by multi- and intersectoral policies and action
Fig. 12. Examples of measures to establish healthy places, settings and resilient communities included in NDPs and/or NHPs in the 29 Member States
Fig. 13. Specific actions or measures being taken by the 29 Member States to improve the dimensions of UHC
Fig. 14. Barriers or obstacles to strengthening health systems in pursuit of UHC in the 29 Member States
Fig. 15. Measures to promote investment for health and well-being and its determinants
Fig. 16. Non-state actors most frequently engaged in collaboration with the ministries in charge of health in the 29 Member States
Fig. 17. Measures taken to strengthen collaboration with non-state actors by the 29 Member States
Fig. 18. Actions to strengthen health literacy in the 29 Member States
Boxes

Box 1. National priorities aligned with the SDGs but within a country context ........................................6
Box 2. Cyprus: sectoral frameworks and SDG coordination ........................................................................8
Box 3. Strategizing health at the subnational level ..................................................................................11
Box 4. Portugal’s approach to strategizing health and well-being .........................................................15
Box 5. Examples of challenges and barriers to implementing health and well-being priorities ..........18
Box 6. Examples of health priorities referred to as underfunded or insufficiently funded .....................19
Box 7. Estonia: a network for collaborative leadership ........................................................................21
Box 8. Examples of roles of multilateral organizations in the implementation of the 2030 Agenda ....24
Box 9. Belgium: a collaborative process for assembling a VNR ...........................................................26
Box 10. Tajikistan: collaboration in the design of monitoring and evaluation instruments .................27
Box 11. Examples of mechanisms for intersectoral collaboration ..........................................................27
Box 12. Examples of committees with responsibility for coordination of the 2030 Agenda ............29
Box 13. Poland: SDG implementation review with cross-society stakeholders ....................................29
Box 14. Belgium: coordinating the reduction of poverty and inequality in a federated system ..........32
Box 15. Healthy Ireland: a framework for improved health and well-being 2013–2025 .....................33
Box 16. The importance of maximizing co-benefits for health and sustainable development ..........34
Box 17. Poland: reducing social inequities to increase life expectancy ...............................................35
Box 18. Lithuania: governance arrangement and coordination mechanism to ensure implementation of the state health programme .................................................................39
Box 19. Examples of mechanisms that facilitate intersectoral collaboration ........................................40
Box 20. Examples of collaborations and measures taken to prevent disease and address health determinants ................................................................. 41

Box 21. Luxembourg: key health and well-being priorities to be addressed within/by different sectors ........................................................................ 42

Box 22. Examples of how Member States express the commitment to the pursuit of UHC .................................................................................... 47

Box 23. Body or agency responsible for the pursuit of UHC ................................................................................................................................. 47

Box 24. Estonia: improving health insurance coverage for UHC ............................................................................................................................ 49

Box 25. Tajikistan: UHC Partnership ........................................................................................................................................................................... 50

Box 26. Ireland: improving timely access to affordable care ............................................................................................................................... 51

Box 27. Lithuania: financial challenges for better health-care services .............................................................................................................. 52

Box 28. Spain: programmes to promote healthy actions by other sectors ........................................................................................................ 55

Box 29. Belgium: engaging with non-state actors in a Federal Council for Sustainable Development .............................................................. 58

Box 30. Latvia: procedures for public participation ................................................................................................................................................. 59

Box 31. Portugal: promotion of health literacy ......................................................................................................................................................... 63

Box 32. Spain: health literacy schools .......................................................................................................................................................................... 64

Box 33. Tajikistan: reviewing data production ......................................................................................................................................................... 67

Box 34. Latvia: assessment of the National Development Plan of Latvia for 2014–2020 and its use in budgeting ..................................................... 68

Box 35. Open data platforms in Switzerland and the United Kingdom ................................................................................................................. 69

Table

Table 1. Approaches used in the 29 Member States to address the national health and well-being priorities ........................................................................ 12
Executive summary

In September 2017 at the 67th session of the WHO Regional Committee for Europe, Member States adopted the Roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy for health and well-being (hereafter referred to as the Roadmap). The Roadmap was developed to assist Member States in the implementation of the 2030 Agenda for Sustainable Development (2030 Agenda) and its Sustainable Development Goals (SDGs). The Roadmap proposed five strategic directions and four enabling measures to achieve better, more equitable and sustainable health and well-being for all at all ages in the WHO European Region.

- **Five strategic directions:**
  - advancing governance and leadership;
  - leaving no one behind;
  - preventing disease and addressing health determinants by promoting multi- and intersectoral policies throughout the life-course;
  - establishing healthy places, settings and resilient communities; and
  - strengthening health systems towards universal health coverage (UHC).

- **Four enabling measures:**
  - financing and investment for health
  - multipartner cooperation
  - health literacy research and innovation
  - monitoring and evaluation.

Resolution EUR/RC67/R3 requested the Regional Director to report on progress on the implementation of the Roadmap’s strategic directions and enablers. To comply with this commitment, an electronic survey was administered in July 2019 to assess the governance and policy development and implementation activities in Member States of the WHO European Region to achieve sustainable development. The survey was designed based on the Roadmap’s proposed strategic directions and enabler measures. The purpose of the survey was to enhance knowledge sharing by showcasing and exploring the variety of ways in which Member States are moving forward with the challenges of achieving the SDGs.

This report presents the findings of the survey divided into nine blocks related to the Roadmap’s strategic directions and enabler measures. It provides a robust account of the data collected and is a rich baseline for understanding health-related and development activities in the Region. This report complements the progress report on the Roadmap and the analysis of health and well-being in the voluntary national reviews (VNRs) produced between 2016 and 2020.

**It is worth noting that this survey was administered before the COVID-19 pandemic.**
In total, 29 Member States participated in the survey, representing 55% of all WHO European Region Member States. Those who responded were considered in three groups: 19 from the European Union (EU),1 five from the Commonwealth of Independent States (CIS) and Ukraine2 and five others with no assigned grouping.3

Results of this survey show that implementation of the 2030 Agenda is advancing in the WHO European Region, but current projections indicate that no Member State is fully on track to achieve the health-related targets and goals and that there is room for an increase in pace to advance implementation.

While the results show that most Member States have set/adapted governance mechanisms for intersectoral collaboration and most report engagement by civil society and local authorities, illustrating a pluralistic approach to implementation of the 2030 Agenda, interministerial and/or intersectoral coordination and collaboration continue to be a challenge. Only a small proportion of Member States indicated that they had implemented measures that promote investments for health and well-being and the pursuit of UHC, health literacy and other determinants of health that required intersectoral and multisectoral collaboration. Although it was not clear from responses what were the underlying reasons behind this trend, most challenges can be categorized as financial, political, organizational or cultural.

To overcome some of these challenges, Member States highlighted the importance of strengthening efforts and increasing capacities to advocate for the co-benefits of health and well-being to achieve other sustainable development priorities. Results also showed that there is space to improve processes for increased accountability, for example to support overcoming political challenges. These include:

- improved planning processes, including budget estimation
- increased coordination, partnership and innovation across all sectors
- improved coordination within the broader data ecosystem
- increased transparency, availability and accessibility of information for the public.

1. Bulgaria, Belgium, Croatia, Cyprus, Czechia, Estonia, Finland, Hungary, Ireland, Latvia, Lithuania, Luxembourg, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden and the United Kingdom.

2. Armenia, Belarus, Republic of Moldova, Tajikistan and Ukraine.

3. Israel, Monaco, Norway, Switzerland and Turkey.
Block 1: advancing governance and leadership for health and well-being

In all responding Member States, the implementation of the 2030 Agenda is a priority. To facilitate its adaptation to the national context, all Member States have created or adapted institutional arrangements, led mostly by those in high levels of government in charge of promoting horizontal coherence across ministries. The health and well-being sector was referred to as having either a high or a moderate level of involvement in these institutional arrangements. Of the 29 responding countries, 24 had nominated a focal point on the SDGs within the Ministry of Health.

In 86% of the responding Member States, a VNR was developed between 2016 and 2019 and presented to the High-level Political Forum on Sustainable Development (HLPF), with a high or moderate level of involvement of the health and well-being sector.

In 76% of responding Member States, there was an overarching national development planning framework (NDP), with 90% including health and well-being as a development priority. While NDPs aligned with the SDGs, all were adapted to the country’s own situation and priorities, particularly over the long term. In the remaining Member States, the SDGs were embedded across all or some government programmes or strategies.

While more than 90% of countries reported health and well-being as a development priority, most of them refer to specific thematic areas of health and well-being, with noncommunicable diseases (NCDs) most frequently mentioned in their NDPs.

Looking at the policies within the health sector, a high or moderate level of alignment with the 2030 Agenda was noted by Member States. Health priorities within the health sector were mostly related to aspects of promoting healthier populations and advancing UHC. There were some notable differences in the priorities listed according to geographical grouping: the most frequently listed priorities in EU Member States were related to healthier populations, whereas the most frequently listed priorities in CIS Member States were related to advancing UHC. Strengthening resilience and capacities to protect people from health emergencies was reported by only four Member States as a health priority.

Block 2: leaving no one behind

In 86% of participating Member States, there is a policy, plan or strategy addressing the reduction of health inequities and/or improvement of the social determinants of health, either at national or at subnational level. Of these, 60% of Member States had a specific policy dealing with the subject, while 40% indicated that health inequities and social determinants of health were integrated into policies or strategies of other sectors. The majority of Member States reporting having a strategy that addressed the reduction of health inequities were from the EU. Improving access to high-quality health and education services and protection from financial hardship in using those services was the measure most frequently referred to for reducing inequities, followed by “ensuring quality conditions for early childhood development, starting in places where children and their families live, learn, play and work”.
Block 3: preventing diseases and addressing health determinants by promoting multi- and intersectoral policies and action throughout the life-course

Member States indicated that the health sector most commonly collaborated with sectors dealing with welfare and social protection, environment, water and sanitation, education, labour and employment.

Some Member States referred to mechanisms that facilitated intersectoral collaboration; examples included merging different functions such as health, labour and social protection so that they were regulated under one ministry; using legal or other formal mechanisms, such as planning laws, conventions and protocols, to facilitate and regulate participation, empowerment and collaboration; identifying common principles to allow different sectors and groups to work together (e.g. the EU Sustainable Development Strategy); initiating action from the bottom-up, which is referred to in this report as localization, to facilitate integration of health into the actions of other sectors or non-state actors.

Setting up coordination structures between different stakeholders for intersectoral cooperation remained a challenge. Some of those challenges rested in financial and spending implications, conflicts of interest or lack of knowledge on health and well-being. Member States suggested solutions such as ensuring that health considerations are included in the actions of other sectors and improving coordination and intersectoral cooperation.

Block 4: establishing healthy places, setting and resilient communities

Localization of the SDGs was a theme highlighted by some Member States, particularly those with decentralized governance arrangements. Localization was expressed as central government, regions and municipalities adopting context-specific approaches for effective alignment and implementation. Localization also figured as an enabler to facilitate participation, collaboration, empowerment and enforcement of laws and regulations. The survey used high, moderate or low as qualifiers for questions on collaboration. High levels of collaboration with local levels were mostly reported by EU Member States. Setting up appropriate coordination arrangements (e.g. community or municipal health boards) were some of the solutions mentioned to enhance localization of SDGs policies and plans.

To encourage better implementation support at local levels, it is crucial not only to raise awareness about legal obligations or the requirements of statutory guidance but also to assess existing capacity to deliver and how best to build new capacity and know what is being done well and what needs improving.

Engagement with public agencies, spatial planners, voluntary bodies, business, industry and all other actors in taking action to implement the common SDG priorities was the measure most commonly referred to by Member States to establish healthy places, settings and resilient communities (72% of Member States).
Block 5: strengthening health systems for UHC

Almost all Member States (90%) reported that UHC was expressed in a national/subnational policy strategy or statement; this included all those in the EU group. The majority of Member States identified actions or measures being taken to improve all dimensions of health system strengthening. Commitments ranged from a vision of universally accessible care, to commitments focused on reducing barriers to access and/or improving quality of service provision, as well as ensuring good use of services from the demand side.

Regarding barriers or obstacles to strengthening health systems in pursuit of UHC, the most frequently selected option in the survey was an "ageing population" followed by "increased public demands for access to and use of new technologies, new medications and new models of care". Some Member States added the challenges of limited funding for the health-care system and coordination of care. "Inefficient, public spending on health" and "fragmentation in health services delivery" were identified as barriers or obstacles by 80% of CIS Member States.

Member States reported prioritizing improvements in all dimensions of UHC by implementing a number of specific actions or measures, some specifically related to financing and others to the improvement of the quality of care. At least 65% of Member States defined monitoring and evaluation activities to ensure progress.

Block 6: investing for health and well-being

A range of measures to ensure adequate investments in health and well-being and its determinants were identified by Member States, with 62% of all responding Member States, including 80% of the CIS Member States, referring to "prioritize and increase public funding for health at national and subnational levels by setting appropriate investment targets for providing essential public services for all consistent with national development strategies". Responses to questions in Blocks 1 and 3 also confirmed the view of Member States that to promote action for health and investments for health there is a need to establish common understanding on how the health objectives can contribute to the goals in other sectors; however, only 41% of Member States referred to using evidence-informed and innovative mechanisms to incentivize non-health sectors to invest in actions for health and well-being.
### Block 7: supporting multipartner cooperation

Engaging with key stakeholders was recognized as important for effective leadership. Member States identified a number of both formal and informal mechanisms for multipartner and intersectoral collaboration and to promote collaboration with non-state actors. In addition to interministerial coordination arrangements for SDG achievement, other mechanisms included the development of groups/platforms to promote cooperation between various stakeholder groups, such as commissions or councils at different levels of governance that included participation of non-state actors. Some of these groups or platforms were created with a specific time-limited role, such as the development of a VNR or a local health plan.

The non-state actors most frequently engaged by the health sector were organizations of professionals (e.g. medical associations and professional chambers), followed by groups representing specific or general interests (ranging from the most specific interest to the broadest issues of global welfare such as climate change) and academic institutions. These three non-state groups were engaged in a range of activities, but most frequently in “participating in formal structures such as consultative groups, public consultations, and lobbying”. Other types of collaboration most frequently reported were “generating evidence”, particularly with academic institutions (reported by 66% of Member States).

### Block 8: promoting health literacy, research and innovation

In 59% of responding Member States there was a national plan or strategy to strengthen health literacy of their populations; of these, 35% referred to a specific plan or strategy for strengthening health literacy.

To strengthen health literacy, 69% of Member States referred to “providing easy access to health information and services and navigation assistance” and “actions through media and digital health”. The least frequently reported action was “to support intersectoral work, political leadership and strategies to overcome cultural barrier into health literacy policy”, which was mentioned by only 24% of Member States. This finding disputes the wider general commitment to support intersectoral working and multipartner cooperation.

Regarding innovation, research and development, only 44% of Member States referred to have a national strategy/plan to promote them; most of these countries were from the EU grouping (77%).

Digital innovation and e-health were most frequently highlighted as means for advancing UHC, strengthening health literacy and reducing inequalities. Some Member States noted that they received international development assistance to enhance digital and e-health infrastructure. Other Member States indicated that they were increasing investment for research and building infrastructure for digital health service delivery and e-health.

Some Member States also reported using incentives to strengthen innovation power in the community. The need for effective coordination across the whole of government and whole of society to improve research and innovation was emphasized, for example between ministries dealing with employment, economy, education and culture, social affairs and health, as well as academic institutions and research centres, among others.
Block 9: monitoring and evaluation

The 2030 Agenda places the generation and use of equity-sensitive evidence-based information at the core of Member States’ abilities to make policies and measure their impacts. Effective implementation of the 2030 Agenda requires well-designed accountability mechanisms and “a robust, voluntary, effective, participatory, transparent and integrated follow-up and review framework”.

Review and follow-up mechanisms build on and go beyond quantitative data collection and include qualitative and analytical assessment. However, while 72% of Member States reported that they have begun the initial work of collecting and ordering data to support SDG monitoring, only 69% of Member States referred to having performed an SDG baseline analysis. Fewer Member States had carried out activities related to increase coordination, partnership and innovation across the broader data ecosystem and making this information available and accessible to the public.

To improve monitoring and evaluation, there is a need to strengthen analytical capacities in Member States and work collaboratively across governments and actors to complement official sources of data, fill gaps in data and/or supplement official reporting. Member States reported that they were strengthening their analytical capacities by:

- expanding the role of national statistical bodies to monitor the SDGs and health targets;
- working collaboratively across government and other groups;
- initiating the process of collecting and ordering data to support SDG monitoring;
- using technology to improve transparency, data collection and use; and
- promoting participatory process to involve stakeholders in determining together the country’s baseline.
Delegates at the 68th session of the WHO Regional Committee for Europe taking an active break during an afternoon session.
Introduction

BACKGROUND

Member States of the WHO European Region adopted the Roadmap for implementing the 2030 Agenda and its SDGs in 2017 at the 67th session of the WHO Regional Committee for Europe (1). The Roadmap proposed five strategic directions and four enabling measures to achieve better, more equitable and sustainable health and well-being for all at all ages in the WHO European Region (Fig. 1).

Fig. 1. Strategic directions and enablers of the Roadmap
In this context, a range of governance and policy development and implementation arrangements have been adopted and adapted in Member States to support achievement of the SDGs. To capture some of this progress and to support knowledge transfer between Member States, the WHO Regional Office for Europe invited Member States to participate in an electronic survey. The survey was based on the five strategic directions and four enablers of the Roadmap and was available in English and Russian. Official national counterparts within Member States could access the survey between July 2019 and February 2020. The survey has provided a robust collection of data and a rich baseline for understanding health-related and development activities of Member States in their efforts to achieve health-related SDGs. Additionally, the report has highlighted some of the challenges and has promoted new areas of research and innovation.

The report complements the analyses carried out within VNRs in 2016 to 2020 (2) and the progress report on the Roadmap (3). Together, these complementary reports respond to the request to the Regional Director to report on progress on implementation of the Roadmap (4).

**METHODODOLOGY**

The survey followed closely the structure of the Roadmap strategic directions and enabling measures and the report is provided in nine blocks:

**Block 1:** advancing governance and leadership for health and well-being

**Block 2:** leaving no one behind

**Block 3:** preventing diseases and addressing health determinants by promoting multi- and intersectoral policies and action throughout the life-course

**Block 4:** establishing healthy places, settings and resilient communities

**Block 5:** strengthening health systems for UHC

**Block 6:** investing for health and well-being

**Block 7:** supporting multipartner cooperation

**Block 8:** promoting health literacy, research and innovation

**Block 9:** monitoring and evaluation.

The survey was designed to use both quantitative and qualitative approaches and to capture progress, challenges and lessons learned from Member States in setting priorities, aligning their NDPs and NHPs with the SDGs, and setting effective multi- and intersectoral mechanisms to advance SDG policy implementation. Additionally, it aimed to capture the measures/activities included by Member States in their national and/or subnational policies that addressed each of the areas outlined in the nine blocks. Annex 1 give the survey strategy in more detail and Annex 2 gives the survey that was sent out to Member States.

Twenty-nine Member States (55%) responded to the survey. As the survey was distributed to WHO national counterparts, the person or team filling out the survey was based in the Ministry of Health or the country’s equivalent; consequently, all responses are considered official submissions on behalf of the Member State.
The data analysed in this report are mostly based on these 29 submitted responses. In some cases, the analysis extends to additional documents and other relevant information provided by the Member State (e.g. website content). One exception relates to the questions concerning the NDP and VNR (questions 1a–1f) where answers were crossed-checked from data gathered for the VNR analysis and/or were followed up with Member States’ focal points.

Responses were summarized by grouping Member States into commonly used regions, with similar geographical, historical, political and economic characteristics:

- **EU (19 Member States):** Bulgaria, Belgium, Croatia, Cyprus, Czechia, Estonia, Finland, Hungary, Ireland, Latvia, Lithuania, Luxembourg, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden and the United Kingdom;

- **CIS and Ukraine (five Member States):** Armenia, Belarus, Republic of Moldova, Tajikistan and Ukraine; and

- **a non-assigned group (five Member States):** Israel, Monaco, Norway, Switzerland and Turkey.

For the quantitative analysis, results were aggregated and percentages calculated. For conditional questions, conditional percentages were calculated. Some questions allowed Member States to select more than one option; consequently, calculating total percentages was not always possible.

For the qualitative analysis, a novel qualitative interpretive thematic approach was used (see Annex 1). The Discussion analyses the results using the E4A approach (engage, assess, align, accelerate and account) to better understand how Member States approached the achievement of the SDGs and health-related actions.

The data and analysis are limited by several factors:

- taking data from 29 Member States may not reflect the Region as a whole nor the range of challenges and activities that will exist among Member States;

- only information provided by Member States could be analysed and relevant information or examples may not have been captured within the questionnaire for every Member State; and

- paraphrasing case studies to facilitate presentation of the data and readability of the report may have created unintended bias, although this was mitigated by consultation with national counterparts once the report was finalized.
Aachen (Germany), Maastricht (Netherlands), Liège (Belgium), Hasselt (Belgium), 26–28 June 2019.

25th annual meeting of the WHO Regions for Health Network discussing how to keep people at the centre of health and sustainable development policies.
Member States have been encouraged and supported to strengthen leadership, governance and investment for health. Supportive measures proposed in the Roadmap include to:

- integrate health and well-being, and their determinants, into NDPs;
- integrate the SDGs into NHPs;
- align health and sustainable development policies, and ensure successful implementation;
- assess progress, identify targets and ensure compliance for the health-related SDG targets adapted to national contexts; and
- set up institutional processes and mechanisms for effective implementation of the 2030 Agenda, including within health ministries.

Block 1 asked questions related to these measures. To guide their responses, Member States were advised to use their NDPs\(^4\) and NHPs.

In their responses, Member States reflected their commitment to the SDGs and to taking action to adapt and integrate them within their own planning frameworks and mechanisms. They used phrases such as “concerted action”, the need for “sustained engagement” with stakeholders and the intention to “sustain momentum” for long-term impact.

Member States also referred to the adoption or adaptation of action plans, rather than broad commitments to the SDGs without specific policy paths. Strong commitment was also seen in the high number of Member States with targets and indicators on the health priorities identified, underlining the importance of setting targets and indicators that are specific and adapted to each Member State’s unique requirements.

Terms such as alignment are often used in narratives about the SDGs and become more meaningful when it is understood how Member States have aligned their activities. Within this survey, alignment with the SDGs was defined as how the scope and ambition of national health and well-being targets compared with those of the SDG targets. A high or moderate level of alignment between health and well-being priorities and the SDGs was reported by 93% of responding Member States, which indicates that most targets in their planning frameworks are aligned with the SDGs in scope or ambition, or both.

---

4. Alternatively, to use national sustainable development strategies, visioning documents or roadmaps that integrate economic, social and environmental objectives into one strategically focused blueprint for action at the national level.
In some instances, Member States situated their health and development strategies to be aligned to the SDG targets and indicators. However, all Member States varied their priorities to suit their individual situation and goals, particular over the long term. Some Member States reflected on the process and challenges of adopting and adapting the SDGs into their contexts, for example Slovakia referred to the need for “intense communication with partners to identify risks and barriers”. The Republic of Moldova referred to the challenge for countries in identifying their own equivalent indicators to monitoring progress within the SDGs and offered a possible solution (Box 1). Alignment was also related to varying ways in which Member States approached the SDGs, apart from referring to explicit links in their NDP or VNR.

Box 1. National priorities aligned with the SDGs but within a country context

The following comments were made in the responses to the survey with regard to adjustment to specific country contexts.

- **Belgium**: “administration is aligned with the SDGs for each strategic target but links have also been [identified] at each project level...”.

- **Estonia**: “The main [purpose] of the strategy is to answer the question[s] of what should be done to ensure successful functioning of the ... society and state also in the longer term rather than focusing on the SDGs alone”.

- **Israel**: “while Israel wholly supports the SDG-3 target goals as well as the global priority of ensuring all Member States reach the set indicators, many of the targets in SDG-3 are not as pressing in Israel, as many goals have been reached. While Israel is constantly working to improve indicators aligned with the SDG targets, there are many other unique issues facing the Israeli health system that the Israeli Ministry of Health must prioritize in the national planning framework.”

- **The Republic of Moldova**: in the case of indicators for which it was not possible to identify a national indicator equivalent to the SDG indicator, six proxy indicators were identified through a consultative process.

- **Slovakia**: the Office of the Deputy Prime Minister “benefited in 2017–2018 from the OECD [Organisation for Economic Co-operation and Development] project ‘Developing the intervention logic of strategic planning by central government authorities’ ...Part of the project was a Situational Analysis, including [assessing the] distance to [achieving] SDG targets.”

- **Sweden**: “overarching public health policy, together with the existing legal frameworks, covers most of the SDG health-related targets, especially regarding equity, gender equality, accessibility and quality”.
Adapting the SDGs to the local context, within regions and municipalities, was another theme analysed in Block 1. Some Member States referred to the adaptation of national plans or strategies at local level; others referred to strengthening the presence of regions and municipalities in national decision-making.

Some Member States mentioned the development of specific policy instruments for particular health issues that align with the SDGs. For example, in Hungary a targeted strategy on infectious diseases illustrated alignment between this priority area in Hungary and the SDGs. Estonia had separate plans and targets for specific health topics such as alcohol policy, tobacco policy, nutrition and physical activity.

Responsibilities for alignment and achieving the SDGs also rested with certain specific bodies. For example, in the United Kingdom, “every government department had embedded the Goals in its single departmental plan. Each department works with a range of organizations from sectors relevant to their areas of work. For example, the Department of Health and Social Care works with Public Health England to meet the SDG 3.”

To examine if adoption of the 2030 Agenda had inspired modification of NDPs or NHPs, Member States were asked about key reason(s) for modifications and when modifications took place. Reasons provided by Member States show that modifications in NDPs have been based on internal changes. For example, Estonia and Finland review processes predefined in their plans to ensure linkages with public financial cycles and allow for flexible planning and evaluation. In Israel, review processes are carried out routinely every year. In terms of what elements of the plans were modified, Bulgaria highlighted changes that reflected legislative changes and initiatives adopted with regard to the development of the country’s health-care system. Latvia’s plan was modified in response to a more recent national development plan: “The Strategy was initially developed for the period from 2011 to 2017, but it was extended to update the situation description, problem formulation, objectives, policy results, tasks included in the Public Health Strategy for 2011–2017 and to align them with the National Development Plan for 2014–2020 and with the new financial programming period, including the EU funding period.”

The following sections in this block explore more in detail the policy instruments and mechanisms.
HEALTH AND WELL-BEING PRIORITIES IN NDPs

NDPs are defined as “a coordinated, participatory and iterative process of thoughts and actions to achieve economic, environmental and social objectives in a balanced and integrative manner” (5). Experience shows that NDPs are most effective when they are multisectoral, participatory, location specific and embedded in multilateralism, and when the necessary resources and political will are available to ensure implementation (6).

- Twenty-two Member States (76%) had an NDP, while two (Spain and Portugal) had plans or strategies in the process of being approved. Three Member States commented that, rather than having one overarching NDP, the SDGs were embedded across government programmes, for example in individual ministries or sectoral plans (Croatia, Cyprus, Monaco and the United Kingdom) (Box 2).

- Some Member States emphasized that implementation of strategies was an evolving process. Belgium added a clarifying answer regarding their federate system of responsibility for the SDGs: an umbrella framework included some common commitments but each federal and federate entity has the responsibility to develop policies for sustainable development, including for health and well-being.

The inclusion of health and its determinants in NDPs could give an indication on leadership for health and well-being. Of Member States with an NDP, 90% reported health and well-being as a development priority within their NDPs. The priority areas for health and well-being most commonly chosen by Member States for inclusion in their NDPs were related to NCDs and risk factors (Fig. 2). The promotion of healthy lifestyles was included by 91% of all Member States (healthy eating, physical activity, tobacco, alcohol and/or improving air quality: SDGs 2.2, 3.4, 3.5, 3a and 3.9) and the management of NCDs by 95%. A life-course approach to health and its determinants was the next most frequently health and well-being priority area included in NDPs, followed by health systems strengthening for UHC.

Box 2. Cyprus: sectoral frameworks and SDG coordination

In its response, Cyprus referred to working towards a coordinated approach to the SDGs, despite not having an overarching national sustainable development framework, strategy or action plan. Currently there are “various sectoral frameworks, strategies or action plans devised by ministries or other national authorities” with relevance to the SDGs. These different approaches to the SDGs are coordinated and monitored by the Directorate General for European Programmes, Coordination and Development who has also “undertaken the task to map the various national policies and measures/actions addressing the 2030 Agenda Sustainable Development Goals”.

The overall aim is to work towards formulating a comprehensive strategy and the “establishment of a mechanism that will supervise and assess the implementation of policies related to sustainable development”.

Fig. 2. Health and well-being priority areas most frequently included by Member States in NDPs (22 responding Member States)

Note: SRH: sexual and reproductive health.
The priority areas less frequently included in NDPs were improving road safety (68% of Member States); addressing and preventing interpersonal violence (64%); all-hazard, multisectoral preparedness and response to health emergencies (59%); and aspects related to migration and health (55%). Only 50% of Member States reported including antimicrobial resistance (AMR).

Most Member States (90%) indicated a moderate to high level of implementation of the health and well-being priority areas included in their NDP, with action being taken on more than 50% of these. This agreed with the high proportion of Member States indicating that they had included targets (90%) and indicators (86%) pertaining to the health priorities identified. However, monitoring of health-related indicators was less common, with only half of Member States reporting a high level of monitoring (defined as more than 75% of health-related indicators monitored and reviewed at least once every two years to make decisions or change the course of action).

Health and well-being as a development priority needs to have a holistic approach that encompasses life-course aspects, considers the determinants of health and invests in health promotion, protection, preparedness, prevention and resilience. While more than 90% of Member States reported health and well-being as a development priority, most referred to aspects of NCD management. These results show that more effort is needed to advance governance and leadership for health. Considering that an NDP sets the overall developmental direction for all sectors of government, more focus could be placed on promoting and enabling healthy lifestyles, healthy ageing, healthier settings, education and lifelong learning, and on reducing environmental pollution and degradation. In this regard, the new forms of leadership, governance arrangements, policy measures and actions Member States reported as being taken to advance implementation of the 2030 Agenda have the potential to become avenues to be leveraged by health stakeholders in support of achieving health and well-being goals and ultimately the SDGs.

HEALTH AND WELL-BEING PRIORITIES IN NHPS

Since its endorsement at the 62nd session of the WHO Regional Committee for Europe in 2012, Health 2020, the European policy for health and well-being (7), has formed the basis of regional and national policies to achieve better, more equitable and sustainable health in the WHO European Region. Improved health and well-being depends largely on political commitment; both the 2030 Agenda and Health 2020 advocate for high-level leadership and strong intersectoral mechanisms to address the many risk factors and determinants of health. Additionally, both promote whole-of-government, whole-of-society and Health in All Policies approaches. Both strategies have also promoted the development of comprehensive plans for developing health and well-being, including developing and strengthening health services.

An NHP can take many different forms, for example to provide an overarching or umbrella policy. Such policies involve a comprehensive range of stakeholders and sectors focusing on improving population health and its determinants, as well as the interaction between the health sector and other sectors. Such a strategy can support shared values, foster synergy and promote transparency and accountability.
Survey responses showed that the approaches being used by the 29 Member States to develop health and well-being were very diverse:

- 25 (86%) referred to implementing an overarching health policy at the national level and subnational level, or at one of these;

- 15 (52%) were implementing strategies at the subnational level (Box 3);

- four (14%) referred to implementing thematic or disease-specific policies or strategies alone (Cyprus, Luxembourg, Monaco and Ukraine); and

- one referred to transitioning from a thematic/disease-specific approach to an overarching strategic approach (the Republic of Moldova) and is currently in the process of developing National Health Strategy 2030 in line with the National Development Strategy Moldova 2030.

Box 3. Strategizing health at the subnational level

Belgium: health policy in a federated system

Health policy in Belgium is devolved to its regional system, which is guided by federal and federated priorities: “As a Federal state ... policies are shared between the Federal authority and the Regions and communities. For instance, the funding of hospitals is a Federal competence, but disease prevention relies on the Regions and communities. Therefore, there is no explicit official integrated national policy framework for health, but several Federal and federated health priorities coexisting. The authorities can therefore shape their health priorities as strategic plans or ad hoc policies. A coordination mechanism is set up between the Governments through a Health Inter-Ministerial Conference.”

Ireland: local authorities address local and community development

Healthy Ireland recognizes that the achievement of the health goals depends on the participation of many sections of society. It proposes a shift towards a broader and more inclusive approach to governance for health, moving beyond the health service and across national and local authorities to involve all sectors of society and the people themselves. To this end, 19 out of 31 local authorities have produced health and well-being plans. Some examples are the Healthy Waterford Strategic Plan 2018–2021 (8) and Healthy Wicklow 2018–2021 (9), coordinated by the Wicklow County Local Community Development Committee and in partnership with representatives from Wicklow County Council, Wicklow Children’s and Young People’s Services Committee and Wicklow Local Sports Partnership, among others.
Table 1 outlines the approaches used to address the national health and well-being priorities within the 29 Member States.

Table 1. Approaches used in the 29 Member States to address the national health and well-being priorities

<table>
<thead>
<tr>
<th>Overarching health policy or strategy</th>
<th>Thematic or disease-specific strategies or plans</th>
<th>National and decentralized planning frameworks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armenia</td>
<td>✘</td>
<td>✗</td>
</tr>
<tr>
<td>Belarus</td>
<td>✗</td>
<td>✘</td>
</tr>
<tr>
<td>Belgium</td>
<td>✘</td>
<td>✗</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Croatia</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Cyprus</td>
<td>✘</td>
<td>✗</td>
</tr>
<tr>
<td>Czechia</td>
<td>✗</td>
<td>✘</td>
</tr>
<tr>
<td>Estonia</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Finland</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Hungary</td>
<td>✗</td>
<td>✘</td>
</tr>
<tr>
<td>Ireland</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Israel</td>
<td>✗</td>
<td>✘</td>
</tr>
<tr>
<td>Latvia</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Lithuania</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>✘</td>
<td>✗</td>
</tr>
<tr>
<td>Monaco</td>
<td>✘</td>
<td>✗</td>
</tr>
<tr>
<td>Norway</td>
<td>✗</td>
<td>✘</td>
</tr>
<tr>
<td>Poland</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Portugal</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Republic of Moldova</td>
<td>✘</td>
<td>✗</td>
</tr>
<tr>
<td>Slovakia</td>
<td>✗</td>
<td>✘</td>
</tr>
<tr>
<td>Slovenia</td>
<td>✗</td>
<td>✘</td>
</tr>
<tr>
<td>Spain</td>
<td>✘</td>
<td>✗</td>
</tr>
<tr>
<td>Sweden</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Switzerland</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>✗</td>
<td>✘</td>
</tr>
<tr>
<td>Turkey</td>
<td>✗</td>
<td>✘</td>
</tr>
<tr>
<td>Ukraine</td>
<td>✘</td>
<td>✗</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>✘</td>
<td>✗</td>
</tr>
</tbody>
</table>

*National Health Strategy to be approved by the end of 2020.
Member States were then asked to list up to 10 health priorities as expressed in their NHPs. The responses were analysed and grouped into three overarching categories: promoting healthier populations, UHC and addressing health emergencies. Each was divided into further subcategories based on the triple billion goals and outcomes in WHO’s Thirteenth General Programme of Work (10). Within the three main categories, the breakdown among the 29 Member States was:

- 26 (89%) listed at least one priority related to promoting healthier populations, the most frequently mentioned priorities referencing general aspects of a healthier population, reducing risk factors for NCDs (alcohol, tobacco and food and nutrition) and health equity;
- 24 (82%) listed at least one priority related to UHC, the most frequent mentioned priorities referencing general aspects of health systems strengthening, including aspects to improve coverage and service packages for NCDs, maternal child and adolescent health, and communicable diseases; and
- four (14%) listed at least one priority, which was related to addressing health emergencies.

Alignment between a Member State’s health and well-being priorities and the SDGs was also assessed:

- a high level of alignment was indicated by 20 Member States (69%), defined as more than 75% of the targets in the national planning documents being aligned to one or more health-related SDG targets both in scope and ambition;
- a moderate level of alignment was indicated by seven Member States (24%), defined as 50–75% of the targets in the national planning documents corresponding to one or more SDG targets, but not completely in scope or ambition; and
- moderate to high levels of alignment between health and well-being priority areas in NHPs and NDPs were indicated by 85% of those Member States with such frameworks, which is generally consistent with the findings of the survey.

The health priorities referred to most frequently in their main health and well-being planning frameworks have been grouped in Fig. 3.
Fig. 3. Health and well-being priorities referred to most frequently in Member States’ main health and well-being planning frameworks (29 Member States)

There were some notable differences in the priorities listed according to geographical grouping. In EU Member States, the most frequently listed priorities were related to healthier populations, with four Member States listing priorities related to healthier populations exclusively (Ireland, Lithuania, Sweden and the United Kingdom). In CIS Member States, the most frequently listed priorities were related to UHC, with two Member States listing priorities related to UHC exclusively (Armenia and Tajikistan). Box 4 outlines the strategies in one Member State (Portugal) for health and well-being.

Note: SRH: sexual and reproductive health.
In its National Health Plan, Portugal prioritized the following goals:

- reduce premature mortality;
- increase healthy life expectancy at 65 years;
- reduce the prevalence of smoking in the population aged 15 years and over and eliminate exposure to environmental tobacco smoke; and
- control the incidence and prevalence of overweight and obesity in children and the school population, in order to limit its growth by 2020.

Portugal also has 12 priority health programmes:

- healthy eating
- physical activity
- infection control and AMR
- smoking control
- diabetes
- cerebro- and cardiovascular diseases
- cancer
- respiratory diseases
- viral hepatitis
- HIV/AIDS
- tuberculosis
- mental health.

Furthermore, there are complementary initiatives for better health and well-being, such as plans, programmes, projects or actions, in the following areas:

- vaccination
- sexual and reproductive health
- child and youth health
- one health
- cross-border disease control and surveillance
- health literacy.
Examining categorization through the health priorities of the WHO European Region, relatively few Member States referred to AMR (two), road safety (two), mental health (five), tobacco control (five) and measures to reduce the harmful use of alcohol (five). The results for alignment were stratified by the Human Development Index ranking, Sustainable Development Index ranking (see Annex 3) and gross domestic product (GDP) per capita. Given the nature of the data and the number of Member States included, it was not possible to identify a strong inference or trend. However, it should be noted that a lower GDP did not mean a lower level of alignment. Some Member States with low GDP relative to the other Member States who responded to the survey (e.g. Tajikistan) indicated a high level of alignment to health-related SDGs. By comparison, Israel, with a relatively high GDP, indicated a low level of alignment.

For the 19 Member States with an overarching NHP, Fig. 4 summarizes the measures included in that policy or strategy. Reported intervention areas are consistent with the main health and well-being priorities (Fig. 3), with the most frequent intervention areas being related to aspects intended to improve coverage and service packages for maternal, child and adolescent health; communicable diseases; NCDs; and sexual and reproductive health. Other areas included aspects of health system strengthening, including transforming health services to meet current and future health challenges, and ensuring a sustainable and resilient health workforce and health information system.

**Fig. 4. Measures included in NHPs among the 19 responding Member States**

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCDs and risk factors</td>
<td>92</td>
</tr>
<tr>
<td>Communicable diseases</td>
<td>87</td>
</tr>
<tr>
<td>Health system strengthening for UHC</td>
<td>84</td>
</tr>
<tr>
<td>Life-course approach</td>
<td>81</td>
</tr>
<tr>
<td>Emergencies</td>
<td>81</td>
</tr>
<tr>
<td>Health determinants</td>
<td>65</td>
</tr>
</tbody>
</table>
IMPLEMENTATION, CHALLENGES AND BARRIERS

Most Member States indicated either moderate (33%) or high (61%) levels of implementation of the NHP priorities. Only one country selected low levels of implementation, defined as action being taken on less than 50% of health and well-being priorities.

Fig. 5 summarizes the challenges/barriers to implement the NHP. The challenge/barrier most often cited was “insufficient budget to meet the priorities”, which was selected by 72% of Member States with an NHP. Further explanations regarding this challenge and further context to the other challenges were provided in some cases (Box 5), for example a shortage of health workers at local levels because of migration abroad. Other challenges referred to were outwith the provided options. These related to political priorities oriented towards the short term and the election cycle, including frequent reform cycles and updates to regulatory frameworks. Worsening health issues, ageing demographics, increasing inequalities and problems with accessing care were other challenges noted. Norway also highlighted that, although there was progress in areas of collaboration and statistical data, there is always room for improvement.
Health planning, costing and budgeting are critical activities to inform policy development and implementation; they allow decision-makers to consider the extent to which policy objectives and strategic orientations are feasible and affordable. Having estimates of resource requirements readily available can help when advocating for and mobilizing additional resources from governments and partners in support of a health plan. However, only 52% of Member States indicated having budgetary requirements for implementation outlined in their NHP. This may lead to a misalignment between the health sector priorities outlined in overall strategic plans and policies and the funds that are ultimately allocated to the health sector through the national budgeting process. This misalignment can have negative consequences; for example, resources may not be used as intended, and accountability is weakened (Box 6).

Seven Member States (24%) indicated that their governments were currently receiving international funds/official development assistance to support implementation of the national health priorities; six of these were in the EU group and one was a CIS Member State. Examples of projects being funded included:

- improving mental health care (Czechia and Lithuania);
- strengthening or developing primary care (Estonia and Hungary);
- e-health projects (Czechia and Hungary);
- maternal and child health, NCDs and communicable diseases (Tajikistan); and
- maternal and child health, NCDs, communicable diseases and paediatric emergency care (Hungary).

Box 5. Examples of challenges and barriers to implementing health and well-being priorities

- **Hungary**: “development needs usually exceed available funding”, especially regarding infrastructure investment. Such limited funding means compromises in the extent and content of planned priorities/activities.
- **Latvia**: “current level of public spending on health is insufficient to provide good financial protection and timely access to a wide range of services with sufficient quality to be effective”.
- **Tajikistan**: provided more context to its financial challenges, explaining that over 90% of its budget is currently used to cover the salary of its public sector employees. The survey response also explained the challenges of limited availability of health professionals at local level because of their migration abroad. Implementation at local level is also challenged by rapid changes in local management. As a result of frequent reforms, regulatory frameworks require constant revisions.
Other priorities mentioned were optimizing hospital infrastructure, methodological development of the health-care system and creation of a complex public health screening programme.

There was a low level of response concerning barriers and challenges to accessing international funds/official development assistance for development and health, with “lack of information on the opportunities” as the most selected response by five Member States (17%). Estonia elaborated on their response, mentioning the challenge of “Finding international partners, limited time frame, for NGOs [nongovernmental organizations] lack of co-funding and capacity”.

GOVERNANCE ARRANGEMENTS AND COORDINATION MECHANISMS FOR IMPLEMENTING THE 2030 AGENDA

The large scope of the SDGs requires efforts to mobilize institutions around the SDGs in order to improve their function and to promote horizontal coherence across ministries and vertical coherence between government levels. This is intended to break down organizational silos, remove contradictions and dysfunctions in existing structures, and promote holistic and innovative thinking.
However a country decides to arrange its coordination (13), experience shows that factors associated with successfully delivering on a country’s sustainable development agenda include ensuring:

- robust political leadership and support from the highest level of government;
- an institutional arrangement with sufficient influence and the ability to mobilize necessary capacities and mechanisms to plan SDG implementation in a comprehensive, coherent and integrated way;
- an institutional arrangement that reflects the cross-sectoral and interinstitutional needs of the country and is not perceived as restricted or biased towards a specific sector; and
- the creation or adaptation of specific mechanisms for monitoring and reviewing, auditing and budgeting structures and processes.

Leadership for coordinating implementation of the 2030 Agenda varied from country to country (Fig. 6); 10 Member States (34%) have centralized leadership, with heads of government or state chancelleries coordinating implementation of the 2030 Agenda (Armenia, Finland, Latvia, Monaco, Norway, the Republic of Moldova, Slovakia, Spain, Switzerland and Turkey). Sixteen Member States (55%) had leadership at ministerial levels, referring to either a specific ministry having the responsibility for coordinating leadership for implementation or to an interministerial structure. Other systems included leadership resting with a government office for planning (Slovenia) or with an independent institution (Cyprus). The Ministry of Foreign Affairs and the Ministry of Environment were the institutions most frequently identified as responsible for leading the implementation of the 2030 Agenda in those Member States with leadership at ministerial levels. Two Member States referred to the Ministry of Economy and Trade and one Member State referred to the Ministry of Enterprise and Technology.

An interministerial coordination structure was the single most common structure (in 38% of Member States). One country (Estonia) referred to a commission with broader stakeholder participation, including civil society, involved in development of plans and strategies (Box 7). In Spain, the President of the Government created a High Commissioner for the 2030 Agenda in 2018. Belgium created an Inter-ministerial Conference for Sustainable Development “composed of all the ministers responsible for sustainable development and development cooperation – the IMCSD [Inter-ministerial Conference for Sustainable Development] is the central coordination mechanism for dialogue between the various authorities implementing the 2030 Agenda”.

Panel discussion on investing in workforce at the high-level conference on promoting intersectoral and interagency action for health and well-being in the WHO European Region.
In their development strategy, Estonia proposed a National Development Network as a possible model of collaborative leadership to ensure consideration of all key development challenges (14). This “would be a politically independent body of strategic development planning outside of political parties, which would be both developing long-term programmes and harmonizing the strategies of different sectors and monitoring their implementation”. The National Development Network would be built up from representatives of state authorities, the private sector, citizen associations, political parties and public agencies (universities and the Academy of Sciences). The role of the National Development Network would be to:

- draw up terms of reference for the preparation of development strategies, while the preparation of strategies would be ordered from both public and private analysis centres through public competition;
- organize discussions with third sector actors; and
- function as a strategic self-management instrument of the society.
The functions most frequently assigned to the institutional and coordination arrangement are summarized in Fig. 7. “Promote horizontal coherence across ministries” was the most commonly referred function (93% of Member States).

Four Member States provided additional information on the roles and functions of their institutional arrangements:

- to ensure vertical and horizontal policy coherence (Belgium);
- to circulate information and coordinate activities related to the HLPF and implementation in the EU (Portugal);
- to assist in the preparation of the VNRs (Czechia); and
- for “dissemination and promotion of SDGs, creating space for substantive debate, exchange of experience and good practices in the implementation of specific projects for SDGs” (Poland).

In general, all Member States indicated either a high or a moderate level of involvement of the health and well-being sector in the country’s coordination arrangement: 69% reported the health sector as having strong control over key decisions and acting as a partner in the development of alternatives and identification of preferred solutions; 24% reported the health sector having moderate participation, being mostly involved or consulted. A focal point for the SDGs based in the ministry in charge of health was reported by 83% of Member States replying in this area (two Member States did not reply to these questions). For the engagement of other sectors, in general, all sectors were highly or moderately involved (Fig. 8).

![Fig. 7. Functions most commonly assigned to institutional and coordination arrangements for implementation of the 2030 Agenda](image-url)
Fig. 8. Level of involvement by sector in the SDG coordination mechanism within the 27 responding Member States

<table>
<thead>
<tr>
<th>Sector</th>
<th>Number of countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and well-being</td>
<td>20</td>
</tr>
<tr>
<td>Environment and natural resources</td>
<td>19</td>
</tr>
<tr>
<td>Gender equality</td>
<td>17</td>
</tr>
<tr>
<td>Labour, employment and social affairs</td>
<td>17</td>
</tr>
<tr>
<td>Agriculture</td>
<td>16</td>
</tr>
<tr>
<td>Finance and economy</td>
<td>16</td>
</tr>
<tr>
<td>Education</td>
<td>15</td>
</tr>
<tr>
<td>Public administration</td>
<td>15</td>
</tr>
<tr>
<td>Rural development</td>
<td>14</td>
</tr>
<tr>
<td>Transport and infrastructure</td>
<td>13</td>
</tr>
</tbody>
</table>
Some Member States expanded on the options and referred to the different roles multilateral organizations have in SDG policy implementation (Box 8). In some Member States, multilateral organizations had a central role in leadership or reviews, while in others the work of multilateral organizations was seen as helping set international agendas, with Member States themselves contributing or participating. In different instances, Member States referred to the process of preparation of a VNR, which is a part of the formal follow-up and review mechanism of the 2030 Agenda. VNRs are voluntarily presented by Member States annually at the HLPF and will be discussed more in detail in the next section.

**Box 8. Examples of roles of multilateral organizations in the implementation of the 2030 Agenda**

- **Armenia**: the United Nations office in the country is part of the leadership for the SDG agenda.
- **Czechia**: all stakeholders with the exception of international organizations were invited to an open public consultation on the SDGs.
- **Latvia**: its national statistical body participates in the United Nations Statistical Commission, which develops and approves the global indicator framework for measuring progress towards the SDGs; this was given as an example of collaboration with international partners.
- **Poland**: WHO participated in reviews of SDG policy implementation.
- **Switzerland**: the Swiss Federal Department of Foreign Affairs plays a role in international cooperation and efforts by promoting Geneva as a centre of competence, including work on strengthening recognition of Switzerland at the international level and promoting establishment in Geneva of international institutions that are active in sustainable development.
ROLE OF HEALTH STAKEHOLDERS IN THE DEVELOPMENT OF VNRS

The SDGs will most effectively be achieved with the aid of well-designed accountability mechanisms and “a robust, voluntary, effective, participatory, transparent and integrated follow-up and review framework ... operating at the national, regional and global levels” (15). At the global level, the HLPF was launched in July 2013 to provide political leadership and guidance, to work towards a global transformation for sustainable development and to play a central role in overseeing a network of different follow-up and review processes (16).

VNRS are a part of the formal follow-up and review mechanism of the 2030 Agenda; these are presented by Member States voluntarily at the annual HLPF. VNRS are a key tool for accountability for the SDGs at both the national and the global level. As the main mechanism for tracking progress on the SDGs at the national level and reporting on progress at the global level, VNRS provide an opportunity for Member States to answer to people with respect to their implementation of the SDGs and assess their results, including successes, challenges, gaps in implementation, possible solutions and emerging issues. As a tool for accountability, the VNR process can strengthen national ownership of the SDGs; promote transparency, inclusiveness and participation in reporting on the SDGs; and support more effective implementation of the 2030 Agenda. For health stakeholders, VNRS are an opportunity to promote leadership for health and well-being and to put health issues high on the development agenda.

Questions in the survey dealing with VNR development were intended to gain a better understanding of how responsibilities for implementation of the 2030 Agenda are shared in the country, as well as the participation of health stakeholders. Questions specifically explored the involvement of ministries in charge of health, public health institutes, civil society organizations related to health and parliamentarians in the development of the VNR (Box 9).

Twenty-five of the 29 participating Member States (86%) had submitted a VNR (17) at the time of taking the survey. Regarding the involvement of health stakeholders:

- 17 (68%) that indicated a high level of involvement of the Ministry of Health in the development of the VNR, where the Ministry had strong control over key decisions, led or co-led the development process for the VNR or was considered a strong partner;

- 13 (52%) indicated a moderate level of involvement from public health institutes, defined by instances where these were involved/consulted in the process of development of the VNR, such as providing data and information;

- 11 (44%) indicated a moderate level of involvement from civil society organizations (related to health), defined by instances where these groups were involved/consulted in the process of development of the VNR, such as providing data and information; and

- 16 (64%) indicated no involvement of international development organizations and/or international financing institutions, with any involvement being generally at a low level.

Four Member States reported that they had not submitted a VNR to the HLPF even though they actually had. Therefore, they did not reply to these questions and could not be included in the results.
Belgium provided an in-depth account of their VNR process and how horizontal collaboration was achieved.

In order to prepare this first Voluntary National Review (VNR), a political steering committee, chaired by the Prime Minister was set up. Through this committee, a clear division of tasks regarding data collection was established. The Inter-Ministerial Conference for Sustainable Development was responsible for collecting data regarding implementation within the country, the federal Foreign Ministry regarding external action, and the Inter-Federal Statistical Institute regarding statistical data.

Two penholders within the federal Foreign Ministry were assisted by a close-knit network of focal points, ensuring gathering of additional inputs for the report text and easy contacts with the administrations and policy units within all respective federal and federated government bodies. At various points in time, the contributing administrations as well as the political steering committee were invited to share their insights about the successive drafts of the report. The Belgian VNR report was also discussed in the federal parliament during a joint session of its Committees on Foreign Relations, Environment and Health.

Civil society involvement was ensured at different stages through the Federal Council for Sustainable Development.

**Box 9. Belgium: a collaborative process for assembling a VNR**

**MECHANISMS FOR INTERSECTORAL COLLABORATION**

Collaboration was a key theme in national development plans and in the design of monitoring and evaluation instruments (Box 10). Member States mentioned mechanisms such as national development networks as ways in which collaboration could happen or is happening across sectors and different groups of stakeholders. One Member State commented that engaging with key stakeholders was important for effective leadership.

Member States also identified common principles to allow different sectors and groups to work together (e.g. Estonia referred to the principles of the EU Sustainable Development Strategy (18)) and for the design of monitoring and evaluation instruments, such as the revisions of the indicator set in Tajikistan.

A number of formal mechanisms for intersectoral collaboration were discussed (Box 11). These mechanisms can refer to planning, monitoring and evaluation or to facilitate interministerial work, as well as for dissemination of information on the SDGs, and their promotion within government and beyond.
The example given by Tajikistan of using interviews with key actors to determine issues related to data collection shows the importance of engagement and collaboration when reviewing indicators to assess implementation of policy priorities.

After two years of implementing the National Health Strategy of the Republic of Tajikistan 2010–2020, the Ministry of Health identified a number of gaps that required a review of the package of indicators. The Ministry’s analysis of the package of indicators found that 22 out of the total 218 indicators were never collected because of lack of clarity in the definitions of indicators and their sources. Results from interviews with key participants from working groups also showed that there were several indicators that were not indicative and did not carry significant information on the implementation of the National Health Strategy.

Box 10. Tajikistan: collaboration in the design of monitoring and evaluation instruments

Several interministerial committees and coordination structures were mentioned with a variety of purposes, including general leadership related to the SDGs across government and for specific issues such as cross-departmental working groups about housing in Tajikistan or to examine planning legislation. Portugal had two intergovernmental coordination structures, one internal to the lead ministry and one external to include other ministries, plus a network of formally designated focal points. In Estonia, the Government Office Strategy Unit coordinates the implementation and monitoring of sustainable development issues.

Box 11. Examples of mechanisms for intersectoral collaboration
References to the creation of specific entities to implement the 2030 Agenda and/or for developing the VNRs were also mentioned.

- **Sustainable development commissions** (Estonia and Finland) included nongovernmental organizations (NGOs) and discussed drafts of strategic action plans related to sustainable development before they were adopted by the government and published reports with policy recommendations.

- **High Commissioner for the 2030 Agenda** was created in Spain as a “national institution whose function is to coordinate and follow up actions carried out by the State Administration”.

- **Representative for health** was included in the coordination mechanisms in Czechia to ensure health is taken into account in the country’s 2030 framework.

- **Stakeholder workshops** were one mechanism used in Ireland to engage stakeholders in the development of the VNR. These were informal working groups to collaborate in the development of the VNR. Although the presentation of a VNR itself is a formal mechanism at the international level, Ireland described the preparation of the VNR involving an informal group that extended beyond government, with participation of “social partners, ministry policy planners and other[s]”.

Other facets of collaboration were discussions regarding a centralized or distributed responsibility for coordination of the 2030 Agenda. For example, in some cases the function of SDG coordination was delegated to an individual or to an institution, such as the High Commissioner for the 2030 Agenda in Spain or the Cross Sectoral Coordination Centre under the authority of the Prime Minister in Latvia. The Latvian Coordination Centre was said to “oversee the entire central government planning process, making changes when needed and providing guidance to ministries through consultation”. In still other cases, the responsibility was delegated to a committee (Box 12) or to stakeholders from across society (Box 13). Block 3 examines intersectoral collaboration in more detail.
<table>
<thead>
<tr>
<th>Country</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>A political steering committee was chaired by the Prime Minister and received support from regional federated entities directly involved in the implementation of the 2030 Agenda and the SDGs.</td>
</tr>
<tr>
<td>Czechia</td>
<td>Both centralization and distribution of responsibility were managed via a network of focal points in each ministry for the SDGs. Czechia also provided an example of collaborating on the collection of data related to the SDGs, with a National Coordinator for the Sustainable Development Agenda at the Ministry of the Environment in charge of coordinating SDG fulfilment, operation and evaluation activities and with a network of focal points in each Ministry.</td>
</tr>
<tr>
<td>Poland</td>
<td>A special team was established to ensure coherence in the development of the strategy for sustainable development. The team operated as part of the Coordination Committee for Development Policy, which was a central platform for monitoring the country’s development management process. The team included representatives of administration at each level.</td>
</tr>
<tr>
<td>Slovenia</td>
<td>The Government Office for Development took overall responsibility for implementation and coordination of the 2030 Agenda but was supported by the permanent Interministerial Working Group on Development Policies.</td>
</tr>
</tbody>
</table>

**Box 12. Examples of committees with responsibility for coordination of the 2030 Agenda**

Poland gave the example of a review of SDG implementation and coherence of the development plan in relation to the SDGs; this involved a range of stakeholders including from local levels of government, multilateral organizations and public consultations.

[A special team was established to review coherence of the Strategy for Responsible Development with the 2030 Agenda. The team operated as part of the Coordination Committee for Development Policy, which is a central platform for monitoring the country’s development management process. It was ensured that members of the team included representatives of administration at each level. In addition to experts representing individual Ministries and Statistics Poland, the Team had representatives of regional and local levels. Socio-economic partners, including organizations of employees and employers, have been invited to cooperate within the Team. Among the participants were also representatives of academic circles, organizations belonging to the United Nations family (including WHO), and youth organizations. Public consultations were conducted in a multidimensional manner – at the national and regional level – by electronic means and by direct referring of the project to the opinions of specific communities and stakeholder groups.**

**Box 13. Poland: SDG implementation review with cross-society stakeholders**
Health inequities are differences in health status or in the distribution of health resources between different population groups arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair and could be reduced by the right mix of policies. The Roadmap proposes to leave no one behind and reduce health inequities by addressing all health determinants, taking life-course, gender-responsive and rights-based approaches to health, and acting through universally progressive policies, legislation and empowerment.

Block 2 covers responses from Member States about their actions towards reducing health inequities. It should be noted that the words inequalities and inequities were seen interchangeably in survey responses. For the purposes of this report, we refer to health inequities as the disparities in the health status of different population groups that are systematic and unfair, and inequalities as the disparities in life circumstances.

POLICIES, PLANS OR STRATEGIES ADDRESSING THE REDUCTION OF HEALTH INEQUITIES

Twenty-five of participating Member States (86%) indicated that they have a policy, plan or strategy addressing the reduction of health inequities and/or improvement of the social determinants of health either at national or subnational level. Of these, 60% of Member States had a specific policy dealing with the subject, while 40% indicated that health inequity and social determinants of health were being addressed within other policies or strategies. The majority of Member States (73%) having a strategy to reduce health inequities were within the EU grouping.

Member States illustrated their commitment to reducing inequities in various ways, such as making the case that reducing health inequities “is not only fair, but also a good investment”. Member States explicitly acknowledged the importance of reducing health inequities for population-wide improvements in health and well-being, and ultimately for sustainable development.

Although not all Member States had specific policies or strategies dealing with the reduction of health inequities, most referred to the reduction of inequalities and/or improvement of the social determinants of health as incorporated into various strategic frameworks. Czechia was an example of a Member State having both national health strategies dealing with the reduction of inequalities by ensuring access to health care for socially excluded groups or people at risk of social exclusion and also “specifically targeted strategies … addressing the issue, such as social inclusion strategies, preventing and tackling homelessness, social housing concept, action plan to promote positive ageing, strategies to protect children’s rights, plan to promote equal opportunities for people with disabilities, Roma integration strategy, gender equality strategy, prevention of violence against children etc.” Ukraine cited the Law of Ukraine on state financial guarantees of medical services for the population as an indication of the Government’s commitment to reduce inequities.
MEASURES TO REDUCE HEALTH INEQUITIES

The survey then asked which measures to address the reduction of health inequities and/or improvement of social determinants of health had been included in the country’s national/subnational policies/plans/strategies or equivalent (Fig. 9). Improving access to high-quality health and education services and protection from financial hardship for those using those services was the most frequently selected option (76% of Member States), followed by “ensuring quality conditions for early childhood development, starting in places where children and their families live, learn, play and work” (66% of Member States).

![Fig. 9. Measures to address the reduction of health inequities and/or improvement of social determinants of health in the policies of the 28 responding Member States](image-url)
Two Member States provided more information. Belgium had action plans “focused on several aspects of poverty, including health but also education, employment, social security ... in a cross-sectoral perspective” (Box 14). Monaco did not have a policy or strategy dealing with the reduction of inequalities, explaining that the issue was not relevant “given the very high level of social security already existing”.

Access to health care was a strong theme in this block, which also relates to Block 5 on UHC. Universal access to health care was described as a way of addressing health inequities in Ireland (Box 15) and Czechia. Increasing health literacy for socially excluded groups or people at risk of exclusion (related to Block 8) was one of the strategies mentioned by Czechia.

Member States referred to strategizing at the local level as a specific mechanism to ensure participation and reduce inequalities (see Box 3 for local actions in Ireland). Belgium discussed federal and regional action plans to reduce poverty and social exclusion while in Portugal, local health plans are a method to communicate health at the local level and promote community participation. These plans were described as “strategic document[s] whose actions contribute to health gains, promoting more health for the entire population and tackling inequities”. These subnational plans “fall into strategic options of the National Health Plan ... and are intended to contribute to increasing health gains through the pursuit of common goals, the integration of sustained efforts by all sectors of society, and the use of strategies based on citizenship, equity and access, quality and healthy policies”.

**Box 14. Belgium: coordinating the reduction of poverty and inequality in a federated system**

In Belgium's federated system both “federal and regional authorities have adopted action plans dedicated to the reduction of poverty and the fight against social exclusion, in which the reduction of health inequities are [sic] included”. There are number of action plans and reporting procedures related to the reduction of poverty and increasing social cohesion. For example, the federal plan to fight against poverty includes guaranteeing the right to health as one of its six strategic objectives:

- ensuring the social protection of the population
- reducing child poverty
- optimizing access to the labour market through social and professional activation
- intensifying the fight against homelessness and unsanitary housing
- guaranteeing the right to health
- making public services accessible to all.

For each strategic objective, the plan formulates operational objectives accompanied by concrete actions for their implementation. Implementation is monitored by the Federal Council of Ministers. At the regional level, health was one of 12 selected themes in the Walloon Poverty Alleviation Plan for the Wallonia Region, alongside other social and economic themes related to health such as housing and food (f19).
Healthy Ireland is a national strategy that includes measures to address the reduction of health inequities. The Healthy Ireland strategy targets the broader social determinants of health, recognizing that investment in population-level interventions that improve health outcomes is not only fair but also beneficial. Sláintecare, the 10-year health-care reform programme launched in 2017 (20), supports the key aims of the Healthy Ireland strategy and is intended to reduce health inequities through providing higher-quality, accessible and universal health care. In reference to Block 5 on UHC and Block 3 on multisectoral collaboration, the Oireachtas Committee on the Future of Healthcare was established to devise cross-party agreement on a single, long-term vision for health and social care and the direction of health policy in Ireland.
Empowerment and community participation were also themes identified to tackle health inequities by Estonia, the responses to the survey described the need for “adequate and timely intervention [to] prevent the emergence of a new generation of excluded people” with empowerment as a priority to achieve this aim.

Income and employment as fundamental conditions for creating and sustaining a healthy life were highlighted by some Member States, as was the need to promote actions that will accelerate progress across multiple goals and targets and increase life expectancy (Boxes 16 and 17).

Migration and migrant communities were mentioned by Luxembourg and Switzerland in their responses to this block, with Luxembourg citing a “solidarity approach for migrants” as an example of reducing health inequities: “the Ministry/Directorate of Health takes care of the physical and psychological health problems of migrants. People with physical and mental health problems have easily access to the health system”.

The SDGs present a major opportunity to embed activity on the social, economic, commercial, cultural and environmental determinants of health. No poverty (SDG 1), zero hunger (SDG 2), education (SDG 4), gender (SDG 5), decent work and economic growth (SDG 8), reduced inequalities (SDG 10), sustainable cities and communities (SDG 11), climate action (SDG 13), peace (SDG 16), clean water and sanitation (SDG 6), life on land (SDG 15) and affordable and clean energy (SDG 7) all impact health and well-being.

There are several overarching approaches to inter- and multisectoral action to address health determinants, including a Health in All Policies approach; developing portfolios of action on environment and health legal and regulatory frameworks; financial and fiscal incentives; and information, communication and engagement strategies. Often, several of these approaches will need to be deployed to support interventions across SDGs.

**Box 16. The importance of maximizing co-benefits for health and sustainable development**

- **Hungary**: provided examples of a public health tax on unhealthy commodities (e.g. pre-packed sugary products, soft drinks, energy drinks and savoury snacks), including a ban on sales of these listed products plus alcohol and tobacco at events targeting children and students. The 2014 Public Catering Act is another initiative of the Government, which is a measure to make public catering healthier. In 2017 Hungary allocated €1 million to the World Food Programme.

- **Luxembourg**: the example of employment was given as a way of tackling multiple causes of inequality, “government is giving the financial support to employers to facilitate access to employment and professional reclassification”.

- **Poland**: the need for countering more than one threat at the same time was discussed, in particular in areas where there is scientific evidence of relationships between threats or correlating and protective factors.
Poland’s National Health Programme includes measures to address health inequities. Its strategic goals are to increase life expectancy for people in Poland, improve health-related quality of life and reduce social inequities in health. The implementation of each strategic goal is supported by operational objectives and tasks. Both operational objectives and tasks set out in the Programme will contribute to reducing social inequities in health and are implemented concurrently to ensure coherence. Efforts are made to prioritize evidence-informed interventions with effects in more than one area.

Empowerment and community participation were also themes identified to tackle health inequities by Estonia, the responses to the survey described the need for “adequate and timely intervention [to] prevent the emergence of a new generation of excluded people” with empowerment as a priority to achieve this aim.

Income and employment as fundamentals conditions for creating and sustaining a healthy life were highlighted by some Member States, as was the need to promote actions that will accelerate progress across multiple goals and targets and increase life expectancy (Boxes 16 and 17).

Migration and migrant communities were mentioned by Luxembourg and Switzerland in their responses to this block, with Luxembourg citing a “solidarity approach for migrants” as an example of reducing health inequities: “the Ministry/Directorate of Health takes care of the physical and psychological health problems of migrants. People with physical and mental health problems have easily access to the health system”.

Box 17. Poland: reducing social inequities to increase life expectancy
The SDGs present a major opportunity to embed activity on the social, economic, commercial, cultural and environmental determinants of health. No poverty (SDG 1), zero hunger (SDG 2), education (SDG 4), gender (SDG 5), decent work and economic growth (SDG 8), reduced inequalities (SDG 10), sustainable cities and communities (SDG 11), climate action (SDG 13), peace (SDG 16), clean water and sanitation (SDG 6), life on land (SDG 15) and affordable and clean energy (SDG 7) all impact health and well-being.

There are several overarching approaches to inter- and multisectoral action to address health determinants, including a Health in All Policies approach; developing portfolios of action on environment and health legal and regulatory frameworks; financial and fiscal incentives; and information, communication and engagement strategies. Often, several of these approaches will need to be deployed to support interventions across SDGs.

The questions in this block aimed to explore the level of intersectoral collaboration between ministries in charge of health and a range of health-determining sectors and describe the key health and well-being priorities to be addressed within/by health-determining sectors.

**COLLABORATION BETWEEN A MINISTRY IN CHARGE OF HEALTH AND HEALTH-DETERMINING SECTORS**

Collaboration was defined as high when there were joint working methods and production of intersectoral plans with clear leadership, tasks, capacity and reporting obligations; moderate when there was regular dialogue through cross-consultations and/or mentions of partners in respective sector plans; and low when collaboration was based on irregular, ad hoc information sharing/gathering. Based on these definitions, Member States were asked to rate the level of collaboration between their ministry in charge of health and the health-determining sector and describe the key health and well-being priorities to be addressed within/by health-determining sectors. 27 Member States replied to this question. Most sectors were highly or moderately engaged (Fig. 10).

The following findings regarding collaboration within the 27 responding Member States stand out.

- High levels of collaboration were reported between ministries of health and the sectors of welfare and social protection (70% of Member States), followed by environment, water and sanitation (62%), education (62%) and labour and employment (59%).

- Moderate to high levels of collaboration were reported between ministries of health and the sectors of gender and women’s rights, with at least 48% of Member States reporting joint working and coproduction of intersectoral plans and/or regular dialogue with cross-consultations. Similarly, for agriculture, food and nutrition, 48% of Member States reported high levels of collaboration and 34% moderate levels of collaboration.
Fig. 10. Level of collaboration between the ministry in charge of health and the health-determining sector in the 27 responding Member States

<table>
<thead>
<tr>
<th>Sector</th>
<th>High</th>
<th>Moderate</th>
<th>Low</th>
<th>None</th>
<th>None</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welfare and social protection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labour and employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment, water and sanitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender &amp; women’s rights</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agriculture, food and nutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local government</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subnational government</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance and trade</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habitat, housing, land use and urbanization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Industry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commerce</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culture &amp; media</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Energy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Moderate to low or no collaboration was reported between ministries of health and the sectors of industry, transport, finance and trade, habitat and housing, commerce, and culture and media.

Collaboration with local and subnational government was mixed, and high levels of collaboration were mostly reported by Member States in the EU group.

Collaborations mentioned between ministries of health and other sectors included the private sector by Ireland (collaboration rated as low), road safety by Spain (medium collaboration), taxes by Spain (medium collaboration), and defence and interior by Spain (low collaboration).

A variety of modes of collaboration were described in the answers supplied by Member States. Formal modes of collaboration included trans-sectoral working groups for developing guidelines or established processes for consultation. Spain described the creation of “intersectoral tables” at the local level with participation of other sectors, including the health sector, an activity that is promoted in the prevention and health promotion strategy of Spain. Belgium described “an Inter-Ministerial Conference set up to assure collaboration between the Governments of the Federal authority, the Regions and the Communities concerning health policies”. Informal modes of collaboration were also described; for example, Finland described “informal meetings … and exchange of information … [contributing] to successful intersectoral collaboration to achieve the health-related SDGs”.
Collaboration at different levels (local and regional) was a theme that also emerged. Croatia cited a national health promotion programme based on a multisectoral approach that “required collaboration with the local government”. Spain mentioned the provision of an online course about local health. To facilitate access, the training programme was delivered online and was made available to any professional at local level. The course was designed to increase the capacity of health professionals at local levels to foster health and well-being by promoting healthy environments and lifestyles. Lithuania mentioned a governance arrangement and coordination mechanism with representation from different levels of government to ensure implementation of the state health programmes (Box 18).

Member States referred to a number of challenges to collaboration, including financial, cultural, logistical and political. For example, Cyprus mentioned that if actions resulting from collaboration with other ministries had spending implications, then these could be challenging to follow through. Armenia mentioned financial conflicts of interest between the Ministry of Health and the Ministry of Economy, where a framework for limitation of tobacco production is not supported by the Ministry of Economy because of the expected financial losses. Czechia mentioned the culture and identity of different sectors, which can lead to a “kind of blindness to the other sectors” as well as the “different political affiliation of members of the government” as a political challenge to collaboration. Latvia mentioned difficulties in reaching political agreements because of conflicting interests (health versus economy), lack of evidence-informed research, and calculations balancing economic and health benefits, referring to “massive industry interference in legislation and lobbying” regarding alcohol, tobacco and drug-related policy. Additionally, Slovenia mentioned that political stability is a prerequisite for intersectoral collaboration.

**Box 18. Lithuania: governance arrangement and coordination mechanism to ensure implementation of the state health programme**

In Lithuania different levels of government have specific responsibilities to support and ensure implementation of state health programmes.

- The Government of Lithuania is responsible for intersectoral collaboration and drafting legislation.
- The Ministry of Health is responsible for overseeing the entire health system.
- The National Health Board is subordinated to Parliament and is in charge of health policy implementation. The Board consists of representatives from municipal health boards, universities, NGOs and public health professionals. The Board has the most active role and coordinates public health policy areas, while the municipal health boards implement health policy at the local level.
Setting up coordination structures between different stakeholders for intersectoral cooperation is indeed a challenge and was highlighted by Croatia; however, it was unclear from the information given whether this challenge pertained to logistics or a lack of will and clashing sectoral identities, or both. Equally, some Member States referred to mechanisms that facilitated intersectoral collaboration (Box 19):

- merging of different functions regulated under one ministry, such as health, labour and social protection;
- using legal or other formal mechanisms, such as planning laws, conventions and protocols, to facilitate and regulate participation, empowerment and collaboration;
- identifying common principles to allow different sectors and groups to work together, such as the principles of the EU Sustainable Development Strategy (18); and
- facilitating action from the bottom-up, identified as helping to integrate health with other sectors and non-state actors.

**Box 19. Examples of mechanisms that facilitate intersectoral collaboration**

- **Belgium** stated that the participation of the chair of the Federal Public Service for Public Health as Vice President of the Interdepartmental Commission for Sustainable Development facilitated the building of bridges between the various sectors and enabled progress towards more integrated strategies and methodologies for the implementation of the SDGs.
- **The Republic of Moldova** provided an example of good collaboration through combining the regulation of three areas under one ministry, the Ministry of Health, Labour and Social Protection, thus allowing regulatory consistency “between the health sector, labour and employment and welfare and social protection”.
- **Ukraine** provided an example of a planning law that required environmental assessment when considering the implementation of new state development projects to look for consequences for the environment, including for the health of the population.
MEASURES TO PROMOTE MULTI- AND INTERSECTORAL POLICIES AND ACTION

Member States were then asked to rate the extent of measures taken to prevent disease and address health determinants by the promotion of multi- and intersectoral policies and action throughout the life-course by the health sector (Fig. 11). The strongest area of actions and measures referred to was “strengthening and implementing legal and regulatory measures in sectors outside the health sector to tackle shared risk factors”, with 66% of Member States indicating this area had been identified as a priority and actions were being taken and 24% of Member States responding that the measure was identified as a priority but with limited action being undertaken.

In their responses, Member States highlighted the actions taken and the need for Member States to consider both the contribution of the health sector on other sectors and the impacts on health from other sectors. Estonia mentioned “establishing common understanding on how the health objectives can contribute to the goals in other sectors, balancing different interests” as an example of actions taken to promote multi- and intersectoral policies. Ukraine mentioned requiring environmental assessment for considering implementation of new state development projects to assess the impact of those projects for the environment and for the health of the population. Member States gave brief examples of environmental and educational initiatives as examples of intersectoral collaboration (Boxes 20 and 21).

Box 20. Examples of collaborations and measures taken to prevent disease and address health determinants

- **AMR**: Belgium mentioned developing an action plan on AMR using the One World–One Health approach.

- **Environmental health**: Belgium, Czechia, Israel, Tajikistan and Ukraine mentioned actions related to environmental health. For example, Israel focused on air pollution and health and Belgium gave the example of an “awareness project focusing on health and environmental inequities”. Czechia mentioned a National Portfolio for Action on the Environment and Health in Czechia 2019.

- **Promotion of healthy nutrition and physical activity**: Czechia, Croatia, Finland, Hungary, Ireland, Israel, Latvia, Luxembourg, Monaco, Norway, the Republic of Moldova and Slovakia mentioned actions related to healthy nutrition and physical activity, with some citing the use of taxes on sugar and sweetened beverages.

- **Substance use and abuse**: Armenia, Croatia, Czechia, Estonia, Latvia, Lithuania, Monaco and the Republic of Moldova all mentioned efforts to reduce substance use and abuse, for example alcohol reduction programmes, tobacco control, harm reduction, and drug demand and supply reduction programmes. Tobacco control in itself was a strong theme in need of intersectoral collaboration. Armenia mentioned the elaboration of a legal framework including the introduction of a comprehensive ban on tobacco advertising, promotion and sponsorship; a total ban on smoking in indoor public places; and other measures to decrease tobacco use and consumption. The State Public Health Inspectorate in the Republic of Moldova, in coordination with local authorities and police, was ensuring the enforcement of a ban on marketing of tobacco products near to schools and medical institutions.
Box 21. Luxembourg: key health and well-being priorities to be addressed within/by different sectors

Luxembourg referred to specific topics for collaboration between the health sector and other sectors; these examples of collaboration were:

- **agriculture**: food safety;
- **media**: collaboration between the communication service of the Ministry of Health and the Government;
- **education**: close collaboration between Ministry of Education and Ministry of Health regarding children’s health; and
- **labour and employment**: close collaboration with the Directorate of Health regarding disabilities, professional reclassification and surveillance of classified industries.
Fig. 11. Action and measures taken to prevent disease and address health determinants by multi- and intersectoral policies and action

- **Promote information systems that provide integrated information to policy-makers**: High (31), Moderate (38), Moderate (10), Moderate (7), Low (14), None (7), None (7), None (7), None (7), No response (7).
- **Systematically adopt a Health in All Policies**: High (48), Moderate (24), Moderate (7), Moderate (7), Low (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), No response (7).
- **Communicate co-benefits for multiple sectors from addressing health and well-being**: High (45), Moderate (31), Moderate (3), Moderate (7), Low (14), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), No response (7).
- **Develop national portfolio of action on environment and health (Ostrava Declaration)**: High (42), Moderate (34), Moderate (3), Moderate (7), Low (14), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), No response (7).
- **Ensure consumer environments promote healthy choices through pricing policies, information or economic and fiscal measures**: High (55), Moderate (31), Moderate (0), Moderate (7), Low (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), No response (7).
- **Strengthen and implement legal and regulatory measures in sectors outside the health sector that tackle shared risk factors**: High (66), Moderate (24), Moderate (0), Moderate (3), Moderate (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), None (7), No response (7).

**Note**: High indicates that a measure has been identified as a priority and actions are being taken; moderate indicates that a measure has been identified as a priority but limited action is being taken, low indicates that a measure has been identified as a priority but no action is being taken and none indicates that the measure is not a priority.
Member States can address the challenge of achieving the SDGs through a renewed focus on the many dimensions of everyday places or settings. Both the physical and social characteristics of a place can vary markedly between locations and over time, thus underpinning inequities in health and well-being. Moreover, how people choose or are obliged to live, and to move and consume in the places they live, can directly affect the environmental processes and systems on which everyone relies for health and well-being. A key theatre and opportunity for action are those places perceived as local.

Work to achieve the SDGs has attracted new alliances and actors involved in the long-standing healthy settings approach (e.g. promoting health in schools, hospitals, workplaces and cities), such as by cities and mayors. The Shanghai Consensus for Healthy Cities 2016 (22) identified 10 priority action areas for cities to achieve SDG 3 (health and well-being) and SDG 11 (sustainable cities and communities). The Quito implementation plan for the New Urban Agenda (23), adopted at Habitat III (the United Nations Conference on Housing and Sustainable Urban Development) in 2016 creates the potential for new city-level collaboration for urban health. The Ostrava Declaration from the Sixth Ministerial Conference on Environment and Health also identified specific action points (24).

The Roadmap exemplifies a number of measures that Member States can take to establish healthy places, settings and resilient communities, included in the NDP and/or in the integrated health policy or strategy. This block reviews those measures.

Localization of the SDGs was a theme highlighted by some Member States, particularly those with decentralized governance arrangements. Localization was defined as central government, regions and municipalities adopting context-specific approaches for effective alignment and implementation. Localization also was cited as an enabler to facilitate participation, empowerment, enforcement of laws and regulations and collaboration. Benefits of collaboration with local levels included facilitating integrating health with other sectors and non-state actors; implementing measures for UHC, such as allowing for local contexts to be considered when planning health services; and allowing successful monitoring of the SDGs.

High collaboration with local levels was mostly reported by EU Member States. Increasing capacities and creating appropriate coordination arrangements (e.g. community or municipal health boards) were some of the solutions mentioned by Member States to enhance localization of SDG policies and plans. Raising awareness about legal obligations or the requirements of statutory guidance, assessing existing capacity to deliver and understanding how best to build new capacity, and knowing what is being done well and what needs improving were all considered crucial for provision of support for implementation at local levels.

The engagement of public agencies, spatial planners, voluntary bodies, business, industry and other actors in taking action to implement the common SDG priorities was the measure most frequently indicated by Member States (72%) to establish healthy settings. Other measures are summarized in Fig. 12.
Of note, only 45% of Member States reported that they were “increasing resilience of households and communities so as to improve capacities to prevent, prepare, withstand, respond to and recover from climate risks and natural and man-made disasters”. This is in contrast to the selection of measures and priorities for health-related emergency preparedness seen in Block 1 and financing for health emergencies seen in Block 6.

The United Kingdom referred to establishing healthy settings as a responsibility at the regional rather than national level: “health services ... are devolved. Each of the four nations takes its own approach under its respective government; while most of these measures are in place, they are set out in diverse frameworks and policies”.
Achieving UHC has been stated as the top priority for WHO. When a country decides to move towards UHC, it makes a political choice to ensure that all people receive quality health services where and when they need them and without suffering financial hardship. Acting on that choice requires robust policies and political will, backed up by strong government capacity.

There were a variety of ways in which Member States illustrated their commitment to the pursuit of UHC in their responses. These commitments ranged from a vision of universally accessible care to commitments focused on reducing barriers to access and/or improving quality of service provision, plus ensuring good use of services from the demand side. Member States also referred to different mechanisms used to express their commitment to UHC:

- **Belgium**: different levels of Government express the commitment to UHC, for example at the Federal level through agreements and political statements and at the regional level, through policy documents;
- **Czechia, Estonia and Hungary**: commitment to UHC is expressed in their NHPs;
- **Luxembourg**: Government programme contains the expression of commitment;
- **Republic of Moldova**: commitment to UHC is expressed in its NDP;
- **Portugal**: UHC is enshrined in the Constitution of the Portuguese Republic; and
- **Sweden**: laws and regulations have roles in implementing and achieving UHC;

In summary, 26 Member States (90%), including all 19 EU Member States, reported the pursuit of UHC was expressed in a national/subnational policy strategy or statement, with the majority of Member States being able to identify actions or measures being taken for improvements in all dimensions of UHC (population access, services covered and proportion of costs covered).

**POLICIES AND ACTION FOR THE PURSUIT OF UHC**

The pursuit of UHC was expressed in a thematic national/subnational policy/strategy or a statement focused on the pursuit of UHC in 42% of Member States; 35% of Member States referred to the pursuit of UHC being expressed in another policy/strategy focused on health or health systems strengthening, and 23% of Member States referred to expressing the pursuit of UHC in other ways (Box 22).
Regarding the body or agency responsible for the pursuit of UHC, most Member States (72%) indicated that the ministry in charge of health was the body or agency responsible for the pursuit/achievement of UHC in their country. Two Member States commented that the pursuit of UHC was a shared responsibility between national and local levels of government (Box 23).

**Box 22. Examples of how Member States express the commitment to the pursuit of UHC**

- **Finland** highlighted that the Government directs the policy on social and health-care client fees through legislation and that responsibility for organizing services lies with local government, the municipalities.
- **Israel** stated that they had “achieved UHC” and so efforts were focused on improving services in the National Health Basket.
- **Poland** and the **Republic of Moldova** had UHC commitments expressed in their NDPs.
- **The United Kingdom** linked its response to the constitution of its National Health Service, which enshrines free access at the point of care.

**Box 23. Body or agency responsible for the pursuit of UHC**

- **Estonia**: responsibility lies with the Ministry of Social Affairs.
- **Finland**: in reference to regional or local level bodies, it was noted that “part of the responsibility lies with local government, the municipalities…”.
- **Luxembourg**: the Social Security Ministry was involved.
- **Norway**: “the responsibility to provide services rests with municipalities (primary health care) and Regional Health Authorities (specialized care)”.  
- **Sweden**: the “National Board of Health and Welfare, the Swedish Social Security Agency, all the 21 regions were responsible for health and medical care, [and] all 290 municipalities responsible for elderly and disability care”.
Member States reported the aim of prioritizing improvements in all dimensions of UHC by implementing a number of specific actions or measures (Fig. 13), with at least 65% of Member States having defined monitoring and evaluation activities to ensure progress (Box 24). For example, in Ireland “the Health Service Executive’s national service plan and the deliverables in the Sláintecare 2019 action plan detail targets and milestones to be achieved in 2019. Ireland is currently in the process of developing a framework to assess the overall performance of its health service, with the support of the EC Structural Reform Support Service.” In Sweden, progress towards UHC is regulated by law or a decree and is assessed with statistics that are available to the general public.

**Fig. 13. Specific actions or measures being taken by the 29 Member States to improve the dimensions of UHC**

- **Equitable access to comprehensive, people-centred health services (in terms of access, this includes physical, social, financial, etc.)**
  - EU: 83%
  - CIS: 80%
  - All Member States: 89%

- **The quality of covered services, including ensuring the availability of an appropriately skilled workforce**
  - EU: 89%
  - CIS: 83%
  - All Member States: 89%

- **The scope of health services covered under a national basket of reimbursed services**
  - EU: 80%
  - CIS: 76%
  - All Member States: 76%

- **The reorientation of primary health care**
  - EU: 80%
  - CIS: 79%
  - All Member States: 80%

- **Efficient and equitable health financing policies to reduce out-of-pocket payments for core services**
  - EU: 80%
  - CIS: 69%
  - All Member States: 74%

- **Increased public financing for health**
  - EU: 80%
  - CIS: 66%
  - All Member States: 74%
Estonia referred to an analysis on health insurance coverage conducted in 2018 that mapped current gaps in health insurance coverage and the reasons behind lack of, or disruption in, coverage among certain population groups. The following were the key findings:

- the health insurance coverage of the Estonian population is low compared with that in the Organisation for Economic Co-operation and Development (OECD) or EU Member States, with 86% of those of working age (19–65 years) covered;
- lack of health insurance is unequally distributed between different groups: men, people of ideal working age, the non-Estonian speaking population and people with lower levels of education;
- health insurance is lacking for two main reasons: (i) insufficient employment and income, and (ii) insufficient coverage of social protection and its take-up by the population through limited awareness of the preconditions for extension of coverage and/or lack of desire or motivation to request access to other benefits of the social system that would also qualify them for insurance (e.g. registering as unemployed or applying for an incapacity for work);
- many grounds exist for receiving health insurance cover, some of which are ambiguous, making it difficult for the state to manage and for people to understand;
- health insurance could be given to a further 1% of the population by adjusting the present system; and
- to achieve UHC, attention must also be paid to waiting lists and cost-sharing, which are more challenging in Estonia than in other EU Member States.

The following recommendations were presented as possible options to increase insurance coverage:

- change the employment and contribution parameters in the present system so that health insurance was expanded to people whose employment and earned income is unstable;
- improve the take-up of health insurance by raising people’s awareness and influencing their behaviour; and/or
- replace the present system with UHC that applies to all residents of Estonia.

In spring 2019, a national UHC working group was established to prepare proposals to the Government for achieving UHC. It includes representatives from the Ministry of Social Affairs, Ministry of Finance and the Estonian Health Insurance Fund.
To improve financing for health, Tajikistan shared the example of introducing financing reforms that included performance-based funding within primary health care (Box 25). The reforms are intended to improve funding of primary health care, in particular the level of per capita funding in all cities and regions, and to initiate performance-based funding (initially in 10 pilot regions, in collaboration with the World Bank). Reforming insurance to reduce financial barriers and increase coverage for people and services was also referred to by Czechia, discussing the “optimization of the reimbursement system in health care” and Latvia prioritizing measures to increase the number of groups covered by the state health budget and setting voluntary insurance for certain services that are not covered by the state budget.

Box 25. Tajikistan: UHC Partnership

In 2016, Tajikistan joined the UHC Partnership, supported and funded by WHO and the EU among others; at the time the Tajik health system was structured around input-based financing and generated significant out-of-pocket payments. To date, important targeted measures have been taken to determine the position of key stakeholders in order to advance key reforms in integrating and acquiring services, assessing the status of preconditions for introducing compulsory health insurance and improving financial protection, and assessing the effectiveness of the health-care system. The benefit package for the poor has been defined as well as a list of priority services, which will be included in the programme for 2020–2023; the major criterion to design the benefit package was universal access to services.
To improve service quality, Estonia referenced taking into account sociodemographic and local specificities when planning and organizing health services, as well as developing remote services and a supportive e-health infrastructure. Israel mentioned a focus on improving services in the national health basket as a priority. Service integration was mentioned with reference to areas such as social services, community care, child and family services and mental health/psychiatric care. Finland commented that “the objective is to transform the services into an integrated system that responds to the needs of children and families”. Slovenia mentioned the creation of health promotion centres within primary health centres, which would act as centres of health in local communities and would deliver preventive services in partnership with social services, the education sector, local administration and civil society. Czechia and Estonia both mentioned integrating digital health into service delivery to improve access to services. Ireland highlighted the need to have timely access to affordable care (Box 26).

Core values to pursue for UHC included collaboration, transparency and efficiency. Slovenia mentioned “universality, solidarity, equality, equity financing, accessibility, quality and safety of health care” as core values of their health-care system related to the achievement of UHC. Tajikistan mentioned that collaboration was required to complete the planned UHC-related reforms, particularly with the Ministry of Finance. Outside of government, Ireland, Luxembourg and Portugal gave examples of collaboration between government sectors, NGOs and the private sector in delivering a stronger health system; regulation of that collaboration was carried out through protocols and conventions. Czechia reported that the Ministry of Health communicates and cooperates in formulating strategies and in their implementation with all key stakeholders both horizontally (i.e. with representatives of other ministries) and vertically (i.e. with representatives of regions, cities and municipalities; with professional societies; and with representatives of patient organizations). Improving transparency as a goal was also mentioned by Switzerland in the context of their comprehensive health-care strategy.

The roles of local and regional levels were emphasized by some Member States, mentioning that local specificities need to be taken into account when planning health services. The local and regional dimension was also mentioned in the way responsibilities are shared between central and local levels of government. For example, in Finland, Norway and Sweden, the local level is responsible for organizing and delivering services.

**Box 26. Ireland: improving timely access to affordable care**

Ireland’s Sláintecare programme implemented an Action Plan in 2019 that directly addressed an identified need within the country for “significant improvement in many areas, particularly in relation to timely access to affordable care” (20). One of the four workstreams examined service redesign with a focus on reducing waiting lists and improving timely access. This workstream included “modelling various entitlement and eligibility scenarios and examining costs and benefits” for universal access, which would then be proposed to the Government for consideration. It should be noted that Sláintecare was devised after the establishment of a cross-parliamentary party committee to agree on a single, long-term vision for health and social care.
BARRIERS AND OBSTACLES TO STRENGTHENING HEALTH SYSTEMS IN PURSUIT OF UHC

Regarding barriers or obstacles to strengthening health systems in pursuit of UHC, the most frequently selected option was an “ageing population” (72% of Member States) (Fig. 14). This finding was further elaborated by Finland, which did not select an ageing population as a barrier or obstacle to strengthening health systems in pursuit of UHC but identified the challenge of ensuring continuous development to reflect demographic change. This finding is also consistent with health priorities in NHPs and intervention areas, with transforming health services to meet the current and future health challenges as one of the priority areas most frequently referenced. Other barriers or obstacles most frequently selected were “increased public demands for access to and use of new technologies, new medications and new models of care” (59% Member States). Some Member States added limited funding of the health-care system and coordination of care (Box 27). Of note, 80% of CIS Member States selected “inefficient public spending on health” and “fragmentation in health services delivery”.

Box 27. Lithuania: financial challenges for better health-care services

Lithuania outlined a number of priorities that were currently underfunded.

Priority investment needs, to improve the affordability, quality, effectiveness and resilience of health care and long-term care services, have been identified, including for example, improvements in infrastructure. Priorities are in particular to: improve equal access to affordable and good quality health care and long term care; move health services to the stronger primary care and more person-centred model; complete the transition from institutional care to independent living community-based services; support re-skilling, upskilling and retention of the health-care, long-term and social care workforce.
Fig. 14. Barriers or obstacles to strengthening health systems in pursuit of UHC in the 29 Member States

- Ageing populations
- Increased public demands for access to and use of new technologies, new medications and new models of care
- Shortages, imbalances, mismatches between education models and health needs, and/or productivity concerns in health workforce
- Higher expectations of quality and safe care
- Fragmentation in health services delivery
- Inefficient public spending on health
- Challenges in access to and affordability of essential medicines and health technologies
- Weaknesses in the design of population entitlement, benefit package and user charges
- Large gaps in health coverage
- Weaknesses in health system governance to define, lead and implement policies in the health sector
- Emerging and remerging diseases

EU
CIS
All Member States

Percentage

0 20 40 60 80
Better health and well-being can improve economic productivity, strengthen social capital and improve social protection while contributing to macroeconomic progress and inclusive sustainable growth. Investing in upstream health-promoting policies and interventions brings economic, social and environmental benefits that contribute to sustainable development and equity.

Current investment policies and practices are unsustainable, and proceeding with business as usual will undoubtedly result in high human, social, economic and environmental costs (25). Only 10% of global GDP was spent on health in 2015, and only around 3% of health-care expenditure is allocated to public health and preventive action (26,27). If no measures are taken, total health-care costs across the OECD countries will double by 2050 (28).

The Roadmap contains a number of measures to promote investment for health in order to achieve the most effective mix of investments across health promotion and disease prevention, treatment and care. The questions in this block explored Member States’ activities to promote investment for health and well-being, to maximize co-benefits for health and sustainable development and to achieve the highest attainable standard of health for all at all ages.

Member States were asked about which measures they were taking to ensure adequate investments in health and well-being and its determinants. Generally, results show an even spread on all the examples of measures provided (Fig. 15). The most frequently selected measure was “prioritizing and increasing public funding for health at national and subnational levels by setting appropriate investment targets for providing essential public services for all (health, education, food, housing, employment, energy, water and sanitation) that are consistent with national development strategies”, which was selected by 62% of Member States, including 80% of the CIS Member States. The next most frequently selected measure was “ensuring adequate funding for pandemic and emergency response”, which was selected by 55% of Member States and would agree with 59% of Member States reporting to include an “all-hazard, multisectoral preparedness and response to health emergencies” as a health priority in their NDP.

The two least selected options were “assessing systematically public- and private-sector investments for their health and health and equity impact and applying incentives and disincentives to redirect them accordingly”, selected by only six Member States, and “applying social and environmental criteria for all purchases and ensuring financial integrity in the health sector”, selected by eight Member States. Of note, only eight EU Member States referred to the measure “applying social and environmental criteria for all purchases, and ensuring financial integrity in the health sector” (Croatia, Czechia, Finland, Latvia, Luxembourg, Norway, Slovakia and Turkey).

The international Blue Flag programme (29) and the Spanish Healthy Cities Network (Box 28) were examples of public investment initiatives cited in the responses from Spain.
Spain described two initiatives to promote healthy actions by sectors beyond the health sector. Blue Flag is a “public investment initiative … to support … sustainable development of coastal areas by adopting the highest standards of sanitary conditions, health and safety, lifeguard provision and accessibility”. The Spanish Federation of Municipalities and Provinces also supports the Spanish Healthy Cities Network and establishes annual collaboration agreements with the Ministry of Health and Consumption to reinforce the Network.
Challenges for public health and development are often large in scale, with numerous and complex roots. Addressing these challenges lies beyond the capability and authority of any single actor and requires a whole-of-government and whole-of-society approach to engage and actively commit to the SDGs. Making progress towards the SDGs requires collaboration among multiple stakeholders, including the public and private sectors, civil society organizations, other regional and international organizations within and outside the United Nations system and individuals with the knowledge, resources and opportunity to become agents for change.

Questions in this block explored Member States’ collaboration with non-state actors, partners and stakeholders to assess their efforts towards strengthening that collaboration. Member States were asked if they have a strategy/plan/framework (or similar) that enables better coordination or enhances engagement with non-state actors; 69% of Member States reported having a framework for better coordination, while 24% explicitly replied that there was no strategy/plan/framework.

NON-STATE ACTOR ORGANIZATIONS AND COLLABORATION WITH THE HEALTH SECTOR

The non-state actors most frequently engaged by the health sector were professional organizations (e.g. medical associations and professional chambers), followed by groups representing specific or general interests (ranging from the most specific interest to the broadest issues of global welfare such as climate change) and academic institutions (Fig. 16). These three groups of non-state actors were engaged in a range of activities, but most frequently in “participating in formal structures such as consultative groups, public consultations, and lobbying”. Other types of collaboration most frequently reported were for the generation of evidence, particularly with academic institutions (reported by 66% of Member States).

Faith-based community organizations were the grouping least frequently engaged by the ministries in charge of health; the strongest engagement was in “advocating, addressing the public to instigate social change or creating pressure on the political system to shape policy” (reported by 34% of Member States).

The types of collaboration reported for non-state actors were as follows.

- “Participation in formal structures such as consultative groups, public consultations, and lobbying”: this was the most frequent engagement with non-state actors reported.
- “Advocating, addressing the public to instigate social change or create pressure on the political system to shape policy” was the second most frequent collaboration and was reported for almost all groups of non-state actors.
- “Generating evidence” was most frequently a collaboration activity with academic institutions (69% of Member States) or professional organizations (55% of Member States).
“Consensus-building” was reported as a collaboration activity most frequently engaging professional organizations (62% of Member States), groups representing specific or general interest (51% of Member States) and health-condition-related community organizations (48% of Member States).

“Mobilizing people to act through petitions, demonstrations, membership drives and social media actions” was reported as a collaboration activity most frequently undertaken for groups representing specific or general interest plus health-condition-related community organizations (both reported by 45% of Member States), as well as identity-based community organizations and local community organizations (both reported by 38% of Member States).

“Providing services to public (e.g. disaster relief, needle exchange, free medical care)” was reported as a collaboration activity most frequently for groups representing specific or general interest and professional organizations (both by 41% of Member States) as well as for private sector entities and health-condition-related community organizations (both by 34% of Member States).

“Watchdog (monitoring public and private compliance with policy and ethics)” was most frequently linked to professional organizations (45% of Member States), groups representing specific or general interest and health-condition-related community organizations (both by 41% of Member States).
"Technical standard-setting" was a collaboration activity almost exclusively engaging professional organizations and academic institutions (both by 55% of Member States).

“Social partnership (with a social role in issues such as wage-setting, working conditions and workforce training)” was reported as a collaboration activity almost exclusively for groups representing specific or general interests and professional organizations (both by 38% and 45% of Member States, respectively).

Formal mechanisms were mentioned in terms of engaging with non-state actors, such as the creation of advisory councils to ensure participation of civil society by law in Belgium (Box 29), a procedure for consultation in planning discussed by Latvia (Box 30), and the creation of intersectoral committees to regulate and oversee strategy implementation in Tajikistan.

Box 29. Belgium: engaging with non-state actors in a Federal Council for Sustainable Development

Belgium has "a long tradition of involvement and consultation with civil society". Interactions with advisory councils are strong in both federal and federated entities (e.g. the Federal Council for Sustainable Development). These structures bring together different societal groups, including social partners (trade unions and employers’ organizations) as well as environmental, development cooperation-related groups, consumers, women, youth and academic organizations. The advisory councils are often created by law and are responsible for:

- advising public authorities on various sustainable development policy measures and taking part in political dialogues with members of the Government;
- establishing a forum for the exchange of views on sustainable development, including the organization of stakeholder dialogues in preparation for sessions of statutory bodies, working groups and fora;
- informing and raising awareness with citizens, the private sector and public bodies on the subject of sustainable development; and
- proposing research activities in all fields related to sustainable development.

Close collaboration with civil society also exists in terms of raising public awareness of the SDGs.
Some Member States mentioned collaboration with informal groups. In Latvia public participation in development planning processes involved both formal and informal groups (unregistered initiative groups, interest associations), groups of citizens and individual people (public representatives); although these are considered informal groups, participation is regulated by the Cabinet of Minister under defined procedures. Lithuania discussed the role of individuals as well as groups in the implementation of the health strategy, in terms of taking ownership of individual’s own health and that of family members.

A range of outputs and outcomes of collaboration were mentioned, from raising awareness of the SDGs to specific inputs into strategies for health or more widely for sustainable development. Training was also mentioned by Hungary, who cited their “Strategic Partnership Agreement … to ensure more effective cooperation between the Chamber of Healthcare Workers Hungary and the Ministry of Human Capacities especially in the field of health-care workers trainings and working conditions”. Ireland cited an SDG Champions Programme to raise awareness of the SDGs and to demonstrate, through the example of the Champions’ engagement with sustainable development, that everyone in society can make a contribution to achieving the 17 SDGs.

The regional and local dimensions of collaboration were also highlighted. Czechia used the example of their Strategic Framework, which also serves as a guide for development of the strategies in regions and municipalities. Lithuania cited communities as key to implementation of the country’s health strategy.

MEASURES TO STRENGTHEN COLLABORATION WITH NON-STATE ACTORS

The most frequently reported measures being taken to strengthen collaboration were “creating accessible forums for civil society organizations to participate in decision-making” and “strengthening information sharing and health literacy” both reported by 72% of Member States. All other measures were reported by at least 62% of Member States, with no strong differences across CIS and EU Member States (Fig. 17).
Fig. 17. Measures taken to strengthen collaboration with non-state actors by the 29 Member States

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening information sharing and health literacy</td>
<td>77</td>
</tr>
<tr>
<td>Creating accessible forums for civil society organizations to participate in decision-making</td>
<td>72</td>
</tr>
<tr>
<td>Developing mechanisms/platforms to promote cooperation between various groups and cooperative initiatives in civil society, academic settings and other sectors</td>
<td>66</td>
</tr>
<tr>
<td>Raising awareness activities to mobilize political will and investment in health and well-being, and implementation of the 2030 Agenda</td>
<td>62</td>
</tr>
</tbody>
</table>
Within their responses, Member States also identified common principles to allow different sectors and groups to work together (e.g. the principles of the EU Sustainable Development Strategy (18) referred to by Estonia), and in the design of monitoring and evaluation instruments, such as the revisions of the indicator set in Tajikistan.

Increasing health literacy through health education and various forms of communication, as well as actions taken through health systems and other policies, has the potential to support the achievement of targets related to SDG 3 on health while advancing a wide range of other SDGs (31).

Research and innovation are essential for achieving the SDGs. In this context, research and innovation refer not only to creating new knowledge and evidence or new technologies but also to finding novel means of implementation, including legal and financial instruments to ensure more effective and equitable health systems.

The questions in this block were aimed at exploring Member States’ efforts to strengthen health literacy in their population and to promote international and regional research and health innovation. The results for this block, including themes from the analysis of qualitative data, are split into two to better reflect both topics of health literacy and research/innovation.

**STRENGTHENING HEALTH LITERACY**

Health literacy is an important pillar of health promotion and a critical determinant of health (32). Health literacy refers, broadly, to the ability of individuals to “gain access to, understand and use information in ways which promote and maintain good health” for themselves, their families and their communities (33). In the Roadmap, Member States are advised to take measures to strengthen health literacy, including integrating health literacy into policies and strategic planning at national, regional and local levels; investing in health-literate organizations, services and systems; and embracing new technology and innovations that enhance health literacy at individual as well as societal levels.

In the survey, Member States were asked about the availability of national plans or strategies to strengthen the health literacy of their population; 59% of Member States had national plans or strategies in place, and of these, 35% referred to a specific plan or strategy for strengthening health literacy (Czechia, Israel, Norway, Portugal, Spain and the United Kingdom). Almost half of the responding Member States (41%) referred to generalized health plans, agreements or strategies that address health literacy (Belgium, Estonia, Latvia, Lithuania, Poland, Tajikistan and Turkey) and 12% of Member States referred to general health promotion plans (Armenia and Croatia). In Israel, the “healthy possibility” programme focuses on strengthening health literacy, specifically relating to nutrition. Tajikistan illustrated the importance of community participation in priority setting with the pilot project the Public Health Handbook.
Fig. 18 summarizes the actions to strengthen health literacy reported by Member States. The highest ranked actions were “providing easy access to health information and services and navigation assistance” and “actions implemented through media and digital health” (both reported by 69% of Member States). These actions were followed by actions in specific settings, with 55% of Member States reporting actions implemented at the workplace; 51% Member States reporting actions at the individual, community, organization and systems level; and 48% of Member States reporting actions to improve the living environment. The least frequently reported action was “to support intersectoral work, political leadership and strategies to overcome cultural barriers into health literacy policy” (24% of Member States). This finding is at odds with the wider general commitment to support intersectoral working and multipartner cooperation (Block 7).
Individual health literacy levels among users, as well as providers, influencers and decision-makers, is a precondition for successful implementation of any health initiative involving the exchange of information. Member States gave a number of different examples to increasing capacity-building within health literacy. The United Kingdom gave an example related to making library and knowledge services accessible to health professionals to increase the awareness of health literacy issues, as well as to support members of the public in improving their health literacy, including their digital health literacy. This was done through partnerships between health librarians in the National Health Service and public librarians in local authorities. Portugal also deemed it important to “promote the training of health professionals in the development of interaction and communication strategies with people” (Box 31) (34). Health literate settings was a theme observed in examples from the United Kingdom and Spain, where schools and prisons were also targeted sites for health literacy programmes (Box 32).

Health Literacy Action Plan

The Health Literacy Action Plan targets the Portuguese population to continuously and consciously improve health literacy levels in the population in a sustainable way (34). It has the following objectives:

- adopting healthy lifestyles in the daily context
- training for a proper use of the health system
- promoting well-being
- promoting knowledge and research.

The Action Plan includes measures to facilitate the navigation of the National Health Service and the health system in general. It uses a life-cycle approach and frames its implementation by setting, context and strategic objectives, in line with the framework of the National Health Plan.

Health Literacy Good Practices Manual

The Health Literacy Good Practices Manual targeted health professionals for training in health literacy (34).

This manual is presented as a working tool available to health professionals in order to stimulate their reflection and action for promoting health literacy of the population. Its main objective is to promote the training of health professionals in the development of interaction and communication strategies with people and transform the existing paradigm, focused mainly on the cure of the disease towards a focus on disease prevention and health promotion.
In Spain, the Network of Citizen’s Schools for Health is an online resource created with the purpose of empowering patients, families and carers by making knowledge, tools and the best available information accessible through the website. The information available is based on best evidence and is presented in a way that is understandable for citizens as well as applicable within each person’s reality, values and beliefs (35).

**PROMOTING HEALTH INNOVATION AND RESEARCH**

The SDGs provide opportunities for innovation in areas such as information and communication technologies and their use, improved service provision and system performance and monitoring of both population health and the impact of health policies. These opportunities also include new approaches to health information analysis, which have the potential to improve and contextualize the meaning of information and ensure its use as the basis for making effective health policy. The Roadmap advises Member States to:

- develop, implement and monitor intersectoral national and local strategies to strengthen information technology for use by individuals and in education; and

- widely share evidence and promote regional cooperation in science, technology and innovation to enhance knowledge sharing and translation.

In the survey, Member States were asked about the availability of a national strategy/plan to promote innovation, research and development to create new knowledge and evidence or technologies, as well as to find novel means of implementation, including legal and financial instruments for alignment and acceleration of SDG attainment. Only 44% of Member States indicated that they had a national strategy/plan to promote innovation, research and development; 77% of these were EU Member States. Some Member States gave examples of roadmaps, strategies and policies specifically related to research and innovation for health and sustainable development.

A variety of initiatives to promote research and innovation were referred to in Member States’ answers. Belgium mentioned a federal research programme to meet the needs for scientific knowledge among Belgian federal departments and to support the scientific potential in the federal scientific institutions. The programme has three pillars, the third one focused on “Federal societal challenges, including sustainability and health”. Sweden mentioned the creation in 2015 of the National Innovation Council to strengthen their innovation power; the Council was intended to strengthen cooperation in the community between important actors, such as academia, business and the public sector, and to promote good cooperation within the Government and its ministries for a developed innovation policy. Portugal mentioned GovTech, a Government initiative that aims to reward and support innovative start-up products and services that meet one of the 17 SDGs.

---

**Box 32. Spain: health literacy schools**

In Spain, the Network of Citizen’s Schools for Health is an online resource created with the purpose of empowering patients, families and carers by making knowledge, tools and the best available information accessible through the website. The information available is based on best evidence and is presented in a way that is understandable for citizens as well as applicable within each person’s reality, values and beliefs (35).
Effective coordination of institutions and organizations across society to foster improvements in research and innovation was also emphasized, with Latvia characterizing the groups involved under the concept of an innovation system, emphasizing the need to optimize “science, technology and innovation governance by ensuring effective coordination and increasing investment [in] research and development”. Coordination at a ministerial level was also cited as important. Finland referred to their Health Sector Growth Strategy for Research and Innovation Activities Roadmap for 2016–2018, which was jointly developed by the Ministry of Education and Culture, the Ministry of Employment and the Economy, the Ministry of Social Affairs and Health, research and innovation funding providers (Finnish Funding Agency for Innovation, Academy of Finland) and health sector players. Cyprus cited centres such as universities and research centres that were working towards innovation, research and development for new knowledge, evidence or technologies. Israel has a Government Innovation Authority working in partnership with the Ministry of Health on health-related research, development and new technologies.

Motivation to invest in health innovation and research included improving a country’s position as an internationally renowned forerunner in health sector research and innovation (Finland) and promoting the international competitiveness of the country’s scientific sector (Latvia). Latvia also emphasized its principle of subnational development and concentrating research within fewer and stronger institutions spread throughout the country. Latvia also had specific targets related to improvements in innovation and research, such as increasing the number of scientific articles published in recognized international databases to 1500 articles and the number of inventions to around 50 intellectual property units per year.
The 2030 Agenda places the generation and use of equity-sensitive evidence-based information at the core of the Member States’ ability to make policies and measure their impacts. New ways of generating, measuring, analysing, coordinating and promoting the use of data and information for policies to improve health and well-being and reduce inequalities are needed for improved policymaking and to effectively engage other sectors and promote investment for health.

Questions in this block explored actions taken by Member States to strengthen national health information systems, inform and evaluate policies for health and well-being and support reporting on the SDGs.

The first question explored whether Member States had already completed a SDG baseline analysis. Only 69% of Member States referred to having performed an SDG baseline analysis, although we know that 25 participating Member States (86%) had submitted a VNR (17) at the time of taking this survey (Block 1). Two Member States supported their answer by attaching their VNR (Ireland and Israel); a further 11 Member States uploaded other baseline documents.

Regarding processes carried out to support data and statistical development to monitor the health-related SDGs, 72% of Member States had begun the initial work of collecting and ordering data to support SDG monitoring (Fig. 19), but fewer Member States (45%) had carried out activities related to increase coordination, partnership and innovation across the broader data ecosystem and making this information available and accessible to the public. Box 33 outlines the data production and review for the SDGs in Tajikistan.
Fig. 19. Processes carried out to support data and statistical development to monitor health-related SDGs in the 29 Member States

- **Assessment of existing data production instruments across the entire national statistical system**
- **Strengthen the role of national statistical offices**
- **Prioritization of SDG indicators for data production based on country’s needs and gaps**
- **Coordination, partnership and innovation across the broader ecosystem**
- **Creation of platforms, portals and/or scorecards to inform on SDG progress**

**Box 33. Tajikistan: reviewing data production**

Tajikistan presented its process of reviewing indicators, which illustrates the importance of revising data production instruments, including data sources, their comparability and frequencies, and how these support monitoring progress on the country’s health goals and the SDGs.

After the second year of implementation of the strategy [Republic of Tajikistan National Health Strategy 2010–2020 (RTNHS)], the Ministry of Health identified a number of gaps that required a review of this package of indicators. In this regard, the Ministry of Health conducted an analysis of the package of indicators with a view to its use as the main M&E [monitoring and evaluation] tool to assess annual progress in the implementation of the RTNHS. In 2013, the review of the indicator package revealed that although the data had been collected for two years, 22 out of the total 218 indicators were never collected due to a lack of clarity in definitions of indicators and their sources. Additionally, results from interviews with key participants from working groups showed that there were several indicators that were not indicative and did not carry significant information on the implementation of the RTNHS.

The use of interviews with key actors to determine issues related to data collection is notable, and possibly something other Member States could consider when reviewing the indicators they use to assess implementation of policy priorities.
Latvia gave an example of assessing the impact of development policy and how this has been used for planning and budgeting. In order to achieve more efficiency, the Ministry of Finance in 2016 introduced a new budget expenditure review procedure for the National Development Plan of Latvia for 2014–2020 (NDP2020):

The government financing decisions made in previous years are periodically re-evaluated. This process refocuses budget expenditures on relevant performance indicators. The [SDG] Cross Sectoral Coordination Centres perform bi-annual impact assessments of the NDP [NDP2020] assessing the contribution of investments in achieving progress on the desired policy outcomes, and provide recommendations to the Government and Parliament.

In 2017, a midterm impact assessment was carried out for the NDP2020. Progress was qualified based on the SDGs where a score of 1 indicated significant progress/the trend fully complies with the SDG, 0 showed insignificant positive or negative changes/the trend does not move towards the achievement of the SDG and −1 meant significant negative changes/the trend moves against the achievement of the SDG. A key finding of the midterm impact assessment was that “although income inequality has fallen in recent years, the NDP2020 target will not be achieved. The GINI index, the inequality measure used in Latvia 2030, has also not changed significantly – it still remains one of the highest in the EU”. The assessment highlighted two areas of focus: (i) ensuring an innovative and eco-efficient economy, and (ii) reducing income and opportunity inequality.

Building on this assessment, in 2019 “a series of midterm impact assessments will be carried out on several important Latvian sectoral policies, including public health, inclusive education, inclusive employment and other areas. These will provide additional detail needed to plan future policy.”

Member States highlighted the international dimension considered when collecting data on SDGs targets nationally. Czechia used data collected on international megatrends to shape its sustainable development strategies, including the possible impact on the effectiveness of meeting the objectives of the country’s sustainable development strategy.

Monaco outlined a particular issue in obtaining data for their population: “given the specificities of the Member State and the overlapping of populations and health systems with neighbouring France, it is sometimes difficult to obtain exploitable statistics”.

Latvia recognized that “our sustainability agenda has both a domestic and an international dimension”. To adapt the SDG indicator framework, development planners compared the SDG targets and global indicators with existing policy goals and target indicators. Such comparison was enabled by using international indicator sets such as official United Nations, Eurostat, Sustainable Development Solution Network and OECD pilot project indicators (Box 34).
A number of methods for developing a baseline analysis on SDGs were presented. Both Switzerland and the United Kingdom used open data platforms (Box 35). Latvia had a participatory process involving stakeholders in putting together the country’s baseline for all SDGs, which was then approved by the Cabinet of Ministers. Hungary gave the example of their national e-health platform, the Electronic Health Service Space, as an answer to a process carried out to support data and statistical development to monitor the health-related SDGs.

Digitalization for improving data collection and communication, and sharing these results, was a final theme. Member States were in the process of improving the digital processes in collecting monitoring data (e.g. Latvia), and in piloting a platform to verify the system of data collection and interpretation and publishing indicators and results online (e.g. Switzerland).

Box 35. Open data platforms in Switzerland and the United Kingdom

Switzerland: the MONET system

Switzerland’s MONET system uses qualitative objectives to group key development indicators designed to measure progress towards sustainable development (37). The platform is intended for the use by both the public and policy-makers, MONET provides data on approximately 100 indicators, which are regularly updated. The system is based on three principles: social solidarity, economic efficiency and ecological responsibility. These principles ultimately constitute the framework with which observed developments can be rated with regard to their sustainability. Consequently, each indicator must be related to at least one principle. The assessment of each indicator is presented in a simplified manner in the form of a tile with colours and symbols to facilitate its understanding.

United Kingdom: the Office for National Statistics National Reporting Platform

In the United Kingdom, data for the global indicators is reported to the United Nations by the Office for National Statistics. These data are open, transparent and accessible via the National Reporting Platform (38). The Platform sets out the global indicators for which data are available, the source, disaggregation where available and any other relevant information.
Participants in a design laboratory to co-create tasks, products or initiatives at the third Meeting of the Coalition of Partners to Strengthen Public Health Services in the European Region.
Discussion

Responses by Member States showed diverse, innovative and transformative elements to implementation of the 2030 Agenda (39,40). The E4A approach (engage, assess, align, accelerate and account; Fig. 20) was used to facilitate analysis and discussion of results (40). This approach can be used to identify common patterns in the way Member States are approaching achievement of the SDGs.

![Fig. 20. The E4A approach to achieve the SDGs](image)

**Assess**
- Assess the distance to achieving the health-related goals by 2030
- Assess the readiness, opportunities and challenges for achieving sustainable development
- Assess how health, well-being and health systems contribute to sustainable development
- Use the results from the assessment to set priorities

**Align**
- Create a joint vision, set priorities, and catalyse coordinated actions
- Optimize financing and budgeting
- Ensure policy coherence across governments and sectors for sustainable development and health and well-being
- Work towards the integration of Health in All Policies
- Ensure the interests of future generations are considered

**Engage**
- Include
- Commit
- Transform

**Account**
- Accurately measure progress and prevent backsliding on commitments
- Measure process and outcome indicators
- Ensure sufficient participatory civic space in all countries and contacts
- Guarantee timely, relevant and transparent communication to stakeholders, communities and people

**Accelerate**
- Identify the most effective accelerators and interventions
- Invest in these accelerators and interventions to trigger multiplier effects across SDGs
- Communicate the co-benefits of acceleration to build political, institutional and public support

*Source: Menne et al., 2020 (40).*
Engagement with key stakeholders was recognized as important for effective leadership by Member States participating in the survey. Phrases such as "concerted action", "the need for sustained engagement with stakeholders" and "sustained momentum for long-term impact" were used by Member States. Commitment to the SDGs was reflected through actions within Member States to adapt and integrate them within their planning frameworks and mechanisms, rather than by broad commitments to the SDGs without specific policy paths. Member States also referred in their responses to a number of mechanisms for engagement and intersectoral collaboration.

Assessments to understand how much progress was needed for achieving the health-related SDG targets, as well as the context, opportunities and challenges for this had been undertaken by most of the responding Member States. Most of these assessments occurred as part of the development of VNRs, which are part of the formal follow-up and review mechanism for the 2030 Agenda and the main mechanism for tracking progress on the SDGs at the national level and reporting at the global level. The development and presentation of VNRs provide opportunities for Member States to assess progress; to present successes, challenges and gaps in implementation; and to consider possible solutions and emerging issues. Their development requires engagement across government departments and non-state actors. For health stakeholders specifically, VNRs are an opportunity to promote leadership for health and well-being and to put health issues high on the development agenda.

Alignment of policies and processes within and between sectors and levels of governance with the vision, objectives and outcomes of sustainable development is key for a coherent approach. Alignment includes a joint vision for health and well-being that maximizes co-benefits across the SDGs, minimizes the sustainability trade-offs generated by activities within the health sector and harmonizes financial, legal and regulatory mechanisms. Member States had taken actions to align, adapt and integrate the SDGs within their own planning frameworks and mechanisms rather than making a commitment to them in general without any specific policy.

NDPs, often presented as the umbrella for the alignment of processes and support-shared values, were available in 76% of participating Member States. A high to moderate level of alignment between priorities in development frameworks and health and well-being priorities was indicated. Most of the health priorities mentioned by Member States were related to aspects of promoting healthier populations and advancing UHC, while the wider spectrum of equity, environment and protecting people from health emergencies was less prominent in the reports from Member States.

Some Member States referred to other mechanisms to support a coordinated approach, such as ensuring integration of the SDGs in various sectoral frameworks, strategies or action plans through setting up coordination structures between different stakeholders for intersectoral cooperation.

Mechanisms that facilitated intersectoral collaboration included:

- merging different functions for regulation under one ministry, such as health, labour and social protection;
- using legal or other formal mechanisms, such as planning laws, conventions and protocols, to facilitate and regulate participation, empowerment and collaboration;
- identifying common principles to allow different sectors and groups to work together, such as the principles of the EU Sustainable Development Strategy (18);
- encouraging action from the bottom-up (localization) to facilitate integrating health with other sectors and non-state actors; and

- promoting the use of incentives to encourage investments by non-health sectors and private sector in actions for health and well-being;

For these mechanisms to succeed, policy-makers need to be equipped with the skills and capacities to generate sufficient common ground and to produce mutually agreed, realistic, context-specific and achievable targets.

**Accelerators or catalysts** for progress were also mentioned. Member States highlighted the importance of advocating for the co-benefits of health and well-being to the achievement of other sustainable development priorities.

Localization was identified to facilitate participation, empowerment, enforcement of laws and regulations and collaboration. Increasing capacities and setting the appropriate coordination arrangements (e.g. community or municipal health boards) were some of the solutions Member States mentioned to enhance localization of the SDGs.

Digital innovation and e-health were particularly highlighted as accelerators for achieving UHC, strengthening health literacy and reducing inequalities. Some Member States received international development assistance to enhance digital and e-health infrastructure. Other Member States indicated that they were increasing investment for research and building infrastructure for digital health service delivery and e-health. Digital innovation was also seen as a way of engaging other sectors and partners in the achievement of the SDGs. Incentives to strengthen innovation power in the community between important actors and support innovative start-up products and services that meet one of the 17 SDGs were also mentioned by some Member States. Digitalization also featured in the process of collecting and monitoring data.

**Accountability** mechanisms that are well designed and “a robust, voluntary, effective, participatory, transparent and integrated follow-up and review framework” are required for the effective implementation of the 2030 Agenda. Effective review and follow-up are crucial activities in the policy cycle that help to monitor and evaluate the extent to which – by predefined targets – policy objectives have been met. This includes understanding if gaps were correctly identified, if policy expectations have been fulfilled and what lessons have been learned. Review and follow-up also cover the extent to which an intervention has helped to secure policy legitimacy; develop stakeholder support; exhibit clarity of purpose; demonstrate a comprehension of complexity; and contribute to the wider attainment of policy objectives (41). Member States reported the implementation of a range of activities to strengthen monitoring and reporting. However, this was one of the blocks where challenges for coordinated action were observed, requiring more efforts to increase coordination, partnership and innovation across the broader data ecosystem and making this information available and accessible to the public.

Despite the common patterns identified and the positive results, more efforts to advance governance and leadership for health are needed. Health and well-being as a development priority may benefit from being seen from a more holistic lens that encompasses a life-course approach, considers the determinants of health and invests in health promotion, protection, preparedness, prevention and resilience. While more than 90% of Member States reported health and well-being as a development priority, more focus could be placed on promoting and enabling healthy lifestyles, healthy ageing, education and life-long learning; promoting healthier settings; and promoting the co-benefits of
reducing environmental pollution and degradation. The new forms of leadership, governance arrangements, policy measures and actions Member States mentioned as being taken to advance implementation of the 2030 Agenda have the potential to become avenues to be leveraged by health stakeholders in support of achieving the health and well-being goals and ultimately the SDGs.

Results also confirmed that progress depends upon the process of implementation and that more needs to be done to ensure intentions are turned into results. Although it is difficult to make judgements on implementation based on the survey data, it was observed that, while the frameworks for governmental intervention have adequate coverage of issues pertaining to health and the SDGs, fewer Member States appear to be using evidence-informed approaches when implementing measures to address the listed priorities, particularly those that required collaboration and adaptability. A mismatch was also observed between the health sector priorities and the measures/interventions reported to be included in NHPs, particularly in areas of emergencies and migration.

Other challenges for effective implementation identified include financial, cultural, logistical and political challenges. One of the most frequent mentioned group of challenges was financial, such as budget constraints and funding conflicts, gaps in access to information on the availability of international funds, gaps in budgetary requirements for implementation of the health priorities, or gaps in the use of public financial management instruments to support more effective implementation and increased accountability. For example, only 52% of Member States referred to having budget estimated in their NHP; only 62% referred to efforts to increase coordination, partnership and innovation across all sectors by making better use of incentives; only 45% referred to efforts to improve coordination of the broader data ecosystem; and only 38% to make data available and accessible to the public.

Even where governance is concentrated rather than dispersed, implementation was still highly dependent on the local context. All Member States have a shared responsibility to achieve the SDGs, with the engagement of governments and a range of stakeholders locally, nationally and globally. Indeed, investment in increasing capacities and initiation of appropriate coordination arrangements (e.g. community or municipal health boards) are needed, and these are solutions highlighted by some Member States participating in this survey.
Policy-makers, academics and representatives of United Nations agencies and civil society met at the WHO Regional Office for Europe to discuss methods and tools to facilitate implementation of the 2030 Agenda for Sustainable Development.
Conclusions

Implementation of the 2030 Agenda is advancing in all Member States of the WHO European Region, but current projections indicate that no Member State is fully on track to achieve the health-related targets and goals, and that there is room for an increase in pace for further strengthening and advancing implementation: there are only nine years left before 2030. Added to this, the challenges of 2020 may set progress back in some areas. To achieve the SDGs, a new pluralistic approach is required, with the engagement of actors and sectors who do not traditionally share mutual objectives in policy development and implementation.

Indeed, results of this survey show that most Member States have put new governance mechanisms in place, and most report engagement by civil society and local authorities, illustrating this pluralistic approach. However, interministerial and/or intersectoral oversight, monitoring and/or coordination continue to be a challenge.

For follow-up on the findings of this survey, we recommend a closer look at how some of the processes mentioned by Member States work in practice, such as the delegation of authority, the enablers of intersectoral collaboration and the accelerators such as financing for health and accountability mechanisms. Further information will need to be gathered on implementation pathways through qualitative interviews with key actors, focus groups or ethnographic studies.

This survey did not focus on international cooperation or collaboration, although of course this is vital to underpin the SDGs and their implementation. Further research could examine how Member States work together to achieve health-related and other SDGs.

This survey was initiated in response to a Member States’ request to the Regional Director in resolution EUR/RC67/R3 to report on progress on the implementation of health-related SDGs in the WHO European Region. It is intended that the findings from the completed survey will enable mutual learning for policy-makers in Member States and other actors involved in working towards integration of the SDGs and their achievement. This survey should also inform future monitoring processes and serve as a baseline for upcoming surveys, as well as informing the work of WHO, other United Nations agencies and partners. Findings also contribute to inform the implementation of the WHO Thirteenth General Programme of Work, the European Programme of Work and the Global Action Plan for Healthy Lives and Well-being for All. Aspects identified through this survey can also help to build back better after COVID-19.
References


Annex 1.
Survey strategy and analysis

SURVEY DESIGN

The survey was designed during the first half of 2019; it followed closely the structure of the Roadmap strategic directions and enabling measures and was structured around nine blocks relating to these.

**Block 1:** advancing governance and leadership for health and well-being

**Block 2:** leaving no one behind

**Block 3:** preventing diseases and addressing health determinants by promoting multi- and intersectoral policies and action throughout the life-course

**Block 4:** establishing healthy places, settings and resilient communities

**Block 5:** strengthening health systems for UHC

**Block 6:** investing for health and well-being

**Block 7:** supporting multipartner cooperation

**Block 8:** promoting health literacy, research and innovation

**Block 9:** monitoring and evaluation.

The survey was designed to utilize quantitative and qualitative approaches in order to capture progress, challenges and lessons learned from Member States in setting priorities, aligning their NDPs and NHPs with the SDGs, and setting effective multi- and intersectoral mechanisms to advance SDG policy implementation. Additionally, it aimed to capture the measures/activities included by Member States in their national and/or subnational policies that address the areas outlined in Blocks 1–9.

LIMITATIONS

The data and analysis are limited by several factors.

- Although there was a reasonable geographical spread of participating Member States across the Region, the analysis is not representative of the whole Region. It also will not identify all the challenges and activities relevant to Member States’ efforts to implement the 2030 Agenda and to achieve the health-related SDGs.

- The analysis is based on information provided by Member States and relevant information or examples may not have been included in the responses or be contained in documents attached. There may be extra information, programmes, activities or initiatives that may not have been captured by the way questions were designed or the space allowed by the
The analysis team also recognized the risk of bias given that most case studies were paraphrased to facilitate presentation of the data and readability of the report. This potential risk of bias was mitigated by consultation with national counterparts once the report was finalized.

DATA COLLECTION

The survey had a total of 75 variables. A set of conditions was defined to facilitate answering the survey, resulting in 33 independent variables. Variables were mostly multiple-choice questions with qualitative categories. Where relevant, the survey allowed reference to choices other than those offered in the preset options, as well as free space to explain certain responses. This gave Member States the opportunity to provide more context and nuance in conjunction with preset options, as well as to explain the reasons behind a negative response. In relevant cases, respondents were asked to attach documents and web links as proof of evidence.

The survey was uploaded to the LimeSurvey platform. Each Member State was assigned a specific identifiable token for accessing the platform. Tokens were distributed to all 53 Member States of the Region through an e-mail sent to the officially designated WHO national counterpart. They were invited to participate in the survey in July 2019. The survey was made available in English and Russian. Member States filled out the survey between July 2019 and February 2020.

Twenty-nine Member States responded, a total of 55% of all WHO European Region Member States; 21 Member States completed the survey using the LimeSurvey platform, and eight sent their responses by e-mail in a Microsoft Word document. The latter responses were later uploaded onto the platform by the analysis team. In some cases, Member States who completed the questionnaire using a Word version provided additional information that was not allowed in the LimeSurvey platform because of its pre-set limits and conditions. This additional information was considered by the analysis team and decisions on how to treat the data were made by consensus. Responses from Belarus (Russian), Tajikistan (Russian) and Monaco (French) were translated into English. As the survey was distributed to WHO national counterparts, the person or team filling out the survey was based in the ministry of health or equivalent. Consequently, the responses are considered official submissions on behalf of the Member State.

DATA ANALYSIS

The data analysed in this report are mostly based on the 29 submitted responses by Member States. In some cases, the analysis extended to the uploaded documents and other relevant information (e.g. websites). One exception relates to the questions concerning the NDP and VNRs (questions 1a–1f) where answers were crossed-checked from data gathered for the VNR analysis and/or followed-up with focal points in Member States.
Responses were analysed by a team made up of content experts and a qualitative methods expert and used a mixed methods approach. For both qualitative and quantitative data, initially data were checked for any duplicate entries, errors and missing data. When considered necessary by the analysis team, Member States’ focal points were contacted to clarify some responses.

To summarize responses, Member States were grouped into commonly used regions, with similar geographical, historical, political and economic characteristics:

- **EU (19 Member States):** Bulgaria, Belgium, Estonia, Croatia, Cyprus, Czechia, Finland, Hungary, Ireland, Latvia, Lithuania, Luxembourg, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden and the United Kingdom
- **CIS and Ukraine (five Member States):** Armenia, Belarus, Republic of Moldova, Tajikistan and Ukraine
- **an unassigned group (five Member States):** Monaco, Norway, Switzerland and Turkey.

**Quantitative analysis methodology**

For the quantitative analysis, results were aggregated and percentages calculated. Conditional percentages were calculated for conditional questions. Some questions allowed Member States to select more than one option and so total percentages could not always be calculated.

**Qualitative analysis methodology**

For the qualitative analysis, a novel qualitative interpretive thematic approach was used. The full free text answers were uploaded into NVivo software programme ensuring the country and text were kept connected and creating one analysis file per block of questions. The use of NVivo enabled the management of large amounts of data of different types (e.g. free text answers, website text and policy documents) and allowed for ease of coding the data to produce themes.

Key steps of the interpretive thematic approach were:

- initial immersion in the data to identify initial codes emerging in relation to the survey;
- application of the interpretive frame; and
- refinement of codes in theme production through sharing with the SDG programme team and expert judgement.

Coding and theme generation was carried out mainly by one analyst but cross-checked and discussed with the wider analysis team to reduce errors and minimize bias. An example is provided in Table A1.1 to show this process leading to theme generation. To maintain a coherent narrative flow to this document and to keep this analysis at a manageable length, a full list of codes is not included but the full list and examples of codes are available on request.
Table A1.1. Example of code and theme generation

<table>
<thead>
<tr>
<th>Theme</th>
<th>Examples of codes within this theme</th>
<th>Explanation</th>
<th>What it is not</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action</td>
<td>Concerted action</td>
<td>Joint or collaborative action</td>
<td>Solely commitment to action, some joint working should be present in the example</td>
<td>Estonia: “Willingness for concerted action. Driven by the sense of danger on the one hand and a relatively high level of pretensions on the other hand, an expectation for concerted action to strengthen the society and state and thereby increase our sustainability has developed in the Estonian society”</td>
</tr>
<tr>
<td>Stakeholder engagement</td>
<td>Broad term for any actions or activities regarding outreach to or engagement with stakeholders from government, including civil society, NGOs</td>
<td>Not collaboration, a separate theme which relates more to joint activities undertaken with stakeholders</td>
<td></td>
<td>Ireland: “Core components of implementation of the SDGs; deep and sustained engagement with stakeholders”</td>
</tr>
<tr>
<td>Sustaining momentum</td>
<td>References to the continuation of existing activities now oriented to SDG-related goals</td>
<td>Indication of actions</td>
<td></td>
<td>Ireland: “the wider health and social care system to work together over the long-term, sustaining momentum, and with a clear focus on the desired outcomes of reform”</td>
</tr>
</tbody>
</table>

Following initial coding, the text was recoded using an interpretive frame based on the objectives for each block (Table A1.2). Documents uploaded by Member States for that block were also added to NVivo, read for relevance to the interpretive frame and coded where relevant. These codes were further analysed and collapsed into themes. The interpretive frame was also used to assess examples provided by Member States. The analysis team highlighted those examples that particularly represented the themes of that block, were a strong outlier or a point of difference. Some examples were augmented with online research of publicly available information to clarify or provide extra information.

**Case studies**

To facilitate presentation of the data and readability of the report, case studies and phrases referred to by Member States were in most case paraphrased. Focal points were invited to revise the report to check for accuracy.
Table A1.2. Interpretive frame for coding and theme generation stages of the qualitative analysis

<table>
<thead>
<tr>
<th>Block</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| 1     | ■ To assess the national development strategy and the level of leadership and commitment expressed on the health and well-being; secondarily assessing the level alignment and quality of those policies  
■ To assess where the leadership for SDGs comes from, the institutional mechanisms and the role of health stakeholders  
■ To assess the national health strategy and its alignment to the SDGs and quality of those policies, as well as the level of commitment to the SDGs using budget as a proxy indicator for the commitment |
| 2     | ■ To assess reduction of health inequities by addressing all health determinants, taking life-course, gender-responsive and rights-based approaches to health, and action on universally progressive policies, legislation and empowerment |
| 3     | ■ To assess the health sector's cooperation with other sectors to integrate action to achieve multiple SDGs, and to optimize the co-benefits for health-related policies and measures taken in other sectors to address the determinants of health  
■ To use co benefits as a filter for example  
■ Table as an indirect indicator |
| 4     | No qualitative data |
| 5     | ■ To assess actions and measures taken to improve access without experiencing financial hardship to needed health promotion; disease prevention; and curative, rehabilitative and palliative services  
■ To assess obstacles and barriers to access |
| 6     | No qualitative data |
| 7     | ■ To increase institutional capacity, build and engage effective, accountable and transparent institutions, and strengthen collaboration with partners and stakeholders |
| 8     | ■ To assess the development and implementation of intersectoral national and local strategies to strengthen health literacy and information technology for use by individuals and in education  
■ To assess international and regional research to support and promote the implementation of the health and well-being aspects of the SDGs |
| 9     | ■ To assess what is being done to strengthen national health information systems to inform and evaluate policies for health and well-being  
■ To assess actions to support reporting on the SDGs to improve governance and comparability of information and the application of e-health standards across the WHO European Region |
Annex 2.
Survey sent to Member States

Survey to assess Member States’ progress in implementing the 2030 Agenda for Sustainable Development based on the WHO European Region Roadmap to implement the 2030 Agenda for Sustainable Development for better Health and Well-being

At the 67th session of the Regional Committee for Europe in 2017, Member States of the WHO European Region adopted the Roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy for health and well-being (EUR/RC67/9, hereafter referred to as “the roadmap”). The roadmap aims to assist Member States of the WHO European Region strengthen their capacities to achieve better, more equitable, sustainable health and well-being for all at all ages. To advance the implementation of both the 2030 Agenda and Health 2020. The roadmap proposes 5 interdependent strategic directions and 4 enabling measures:

**Strategic directions**

- Advancing governance and leadership
- Leaving no one behind
- Preventing disease and addressing health determinants
- Establishing healthy places, settings and resilient communities
- Strengthening health systems for universal health coverage.

**Enablers**

- Investment for health
- Multi-partner cooperation
- Health literacy, research and innovation
- Monitoring and evaluation

This questionnaire aims to assess progress in alignment and implementation of the Sustainable Development Goals (SDGs) based on the application of the roadmap strategic
directions and enabler measures. Accordingly, the questionnaire is structured in 9 blocks to facilitate the collection of information.

**Completing the survey**

Click **Next** to begin the survey. You can either go through each section/block in chronological order by clicking **Next**, or switch between them using the **Question Index** dropdown menu in the top right corner. The survey can be saved and returned to at any time by clicking **Resume later**, also in the top right corner. Closing the window tab without clicking **Resume later** will result in some responses being lost. Previously saved answers and comments can be adjusted at any time until the survey is finalized by clicking **Submit**. In an effort to reduce the response time, the survey has automatic skips, which means that certain questions are hidden depending on your previous answers. You are encouraged to select the answer that is most representative for your country; this may require contact with other relevant stakeholders/bodies. You may also be required to upload and/or indicate web-links if available. Before you begin, it is advisable to have the following documentation (or similar) at hand for referencing.

- National development planning frameworks (policy, strategy or equivalent)
- National health planning frameworks (plan, policy, strategy or equivalent)
- Public health plan/policy/strategy or equivalent
- Voluntary national report
- Institutional mechanism for SDG implementation.

You will not be able to use Internet Explorer (IE) to complete this survey. Please use one of the following browsers: Chrome, Firefox or Opera. If you do not have access to any of these browsers, please fill in the Word version of the survey and return with any relevant supporting documents/evidence to the email provided below.

**Submission of the survey**

After you have submitted the survey, we will notify you that it has been received and we will review your responses to ensure the survey is valid and complete. We may then follow-up with you for further information or clarification. We thank you for your valuable time and input.

**Helpdesk**

If you require any support while completing the survey or have any questions on how to complete it, please contact Emilia Aragon, Technical Officer, Health and Sustainable Development at aragondeleonm@who.int.

**Contact information**

Name and Surname______________________________

Job title______________________________________

Institution/Organization_________________________
Country______________________________________________________

Email Address_________________________________________________

Phone Number__(+______)________________________________________

Block 1. Advancing governance and leadership

Objective: to strengthen leadership, governance and investment for health to maximize co-benefits for health and sustainable development and to achieve the highest attainable standard of health and well-being for all at all ages and for future generations

1.A Does your country have an overarching national sustainable development framework, strategy or action plan?

Overarching national planning frameworks refer to national sustainable development strategies, visioning documents, or roadmaps that integrate economic, social and environmental objectives into one strategically focused blueprint for action at the national level.

- [ ] Yes
- [ ] No. Please, explain the strategic approach used in your country to achieve the Sustainable Development Goals. Focus on providing information regarding the domestic priorities for health and sustainable development of your country as well as the coordination mechanisms set to addressing the priorities, financing and monitoring progress (limit 2000 characters):

__________________________________________________________________

If you answered yes for question 1.A, please move to question 1.A.1
If you answered no for question 1.A, please move to question 1.B

1.A.1 Specify the year in which the national sustainable development planning framework was approved by a relevant government authority and the expiration date  __ (mm/yy) __ – __ (mm/yy) ___.

1.A.2 Has the national sustainable development planning framework been modified since its adoption?

- [ ] Yes
- [ ] No

If you answered yes for question 1.A.2, please move to question 1.A.2.A.
If you answered no for question 1.A.2, please move to question 1.A.3

1.A.2.A Please explain your response and indicate the key reason(s) for the modification and date(s) if available:

Limit 1750 characters (e.g. change of national priorities/agenda, adoption of international commitments like the 2030 Agenda for Sustainable Development, among others).

[ ] Date (mm/yy)

1.A.3 Does the national sustainable development planning framework include health and wellbeing as a development priority?

Health and wellbeing as a development priority, including measures to improve population health and well-being by considering health in all policies and reducing health inequalities.

- [ ] Yes
- [ ] No

1.A.4 From the following priority areas, please select those that are included in the national sustainable development planning frameworks (please select as many options as applicable):

Life-course approach

- [ ] Child and adolescent health (SDG targets 3.2, 4.2). (Examples of measures include: ending preventable deaths of mothers, newborns and children; ensuring health and wellbeing of
mothers and children by reducing malnutrition, improving access to sexual and reproductive health; ensuring access to good-quality early childhood development; expanding enabling environments for children and adolescents’ health and wellbeing.)

- **Healthy ageing (SDG 3, 5, 10).** (Examples of measures include: prevention of falls; promotion of physical activity; vaccination of older people and prevention of infectious disease in health-care settings; public support for informal care giving with a focus on home care, including self-care; building capacity in geriatrics and gerontology among the health and social care workforce; prevention of social isolation and social exclusion; strategies to ensure the quality of care for older people, with a focus on dementia care and palliative care for long-term patients; prevention of elder maltreatment.)

- **Improve women’s and men’s health (SDG 5 and 3).** (Examples of measures include: strengthening governance for the health and wellbeing of women and men; eliminating discriminatory values, norms and practices that affect the health and well-being of girls and women; making gender equality a priority; tackling the impact of gender and social, economic, cultural and environmental determinants on women’s and men’s health and well-being; making health systems gender responsive; improving health promotion with gender-transformative approaches.)

- **Sexual and reproductive health (SDG targets 3.1, 3.7 and SDG 5).** (Examples of measures include: guaranteeing universal access to sexual and reproductive health and eliminating inequities; enabling all people to make informed choices about their sexual and reproductive health; ensuring sexual and reproductive human rights are respected, protected and fulfilled.)

### Noncommunicable diseases and risk factors

- **Healthy lifestyles:** healthy eating, reformulation of food products, increasing physical activity, reducing tobacco use, reducing the harmful use of alcohol and/or improving air quality (SDG targets 2.2, 3.4, 3.5, 3a, 3.9). (Examples of measures include: promoting healthy consumption via fiscal and marketing policies; reformulating and improving product: salt, fats and sugars; reducing salt consumption; promoting active living and mobility; promoting clean air.)

- **Noncommunicable diseases, i.e. cardiovascular diseases, cancer, chronic respiratory diseases and/or diabetes (SDG target 3.4).** (Examples of measures include: providing access to early detection and effective treatment; providing access to cardio-metabolic risk assessment and management; providing access to vaccinations and relevant communicable disease control.)

### Communicable diseases

- **Antimicrobial resistance (SDG 3).** (Examples of measures include: improving awareness and understanding of antimicrobial resistance; strengthening knowledge and evidence base through surveillance and research; reducing the incidence of infection through effective sanitation, hygiene and infection-prevention; optimizing the use of antimicrobial medicines in human and animal health; increasing investment in new medicines and technologies.)

- **Communicable diseases:** HIV/AIDS, tuberculosis, viral hepatitis and/or vector borne diseases (SDG target 3.3). (Examples of measures include: strengthening programmes for the control of infectious diseases; providing adequate access to services, including access to safe and affordable medications and vaccines; integrating patient-centred care and prevention services; focusing prevention strategies for vulnerable populations.)

- **Immunizations (SDG targets 3.8, 3b).** (Examples of measures include: strengthening and achieving financial sustainability of national immunizations programmes; eliminating measles and rubella; addressing vaccine hesitancy; tailoring immunization programmes to reach underserved groups; investing in research and development.)

### Health system strengthening for universal health coverage

- **Financial protection (SDG target 3.8).** (Examples of measures include: promoting policies to reduce out-of-pocket payments; ensuring adequate public financing for health systems; reducing fragmentation in health system funding channels; adopting strategic purchasing mechanisms; ensuring effective and equitable coverage decisions based on systematics, evidence-based and transparent processes.)

- **Fostering environmental sustainability of health systems (SDG 3, 6, 12, 13, 14 and 15).** (Examples of measures include: minimizing and adequately managing waste and hazardous chemicals; promoting an efficient management of resources; promoting sustainable
procurement; reducing health systems’ emissions of greenhouse gases and air pollution; prioritizing disease prevention, health promotion and public health services; engaging the health workforce as an agent of sustainability; increasing community resilience and promoting local assets; creating innovative models of care.)

- **Health information and health information systems (SDG targets 17.7 and 17.8).** (Examples of measures include: generating, measuring, analysing, coordinating and promoting the use of data and information for policies to improve health and well-being and reduce inequalities.)

- **Quality-assured, affordable medicines, vaccines and health products (SDG target 3b).** (Examples of measures include: improving access to essential medicines and medical devices; supporting the appropriate use of medical products; improving efficiency of procurement systems; promoting effective regulations and quality control; promoting responsible use of medicines and medical devices; promoting research and development.)

- **Sustainable and resilient health workforce (SDG target 3c).** (Examples of measures include: rethinking the roles of health workers and optimizing the skill mix; investing in and transforming health workforce education and training; improving the performance of health workers; establishing policies to ensure a sufficient and sustainable health workforce; ensuring the availability of the health workforce to quickly respond to emergencies or pandemics.)

- **Transforming health services to meet the current and emergent health challenges (SDG target 3.8).** (Examples of measures include: strengthening the integration of primary health care and public health services, hospitals and social care; strengthening key processes of designing care, organizing providers and settings, managing services and improving quality.)

### Emergencies

- **All-hazard, multisectoral preparedness and response to health emergencies (SDG targets 1.5, 3d, 11.5).**

- **Building strong public health-oriented and people-centred health systems, institutions and networks based on the essential public health functions and core capacities under the International Health Regulations (2005) (SDG target 3d).**

- **Strengthening adaptive capacity and resilience to health risks related to climate change (SDG 13) and/or supporting measures to mitigate climate change and achieve health co-benefits in line with the Paris Agreement.**

### Health determinants

- **Addressing and preventing interpersonal violence, including the negative consequences of interpersonal violence (SDG targets 5.2, 16.1 and 16.2).** (Examples of measures include: prevention of child maltreatment, elderly maltreatment, violence against women, among others.)

- **Addressing education and life-long learning (SDG 4).** (Examples of measures include: improving access to high quality education services and protection from financial hardship in using those services; ensuring quality conditions for early childhood development.)

- **Addressing employment, income and living conditions (SDG 1, 2, 8, 10 and 16).** (Examples of measures include: fostering a healthy workforce and tackling the health risks of being unemployed or insecurely employed; developing universal social protection and policy priorities and strategies in order to reduce inequities and remove barriers to protecting households from deprivation and poverty; implementing a basket of coordinated social, economic and environmental policy measures; targeting groups that are being left behind or excluded.)

- **Enabling cities and regions to become healthier, more inclusive, safer, more resilient and more sustainable (SDG 3 and 11).** (Examples of measures include: engaging with local and city levels; adopting healthy urban planning; providing access to active transport and green spaces; tackling air pollution and improving road safety; tackling inequalities in health; ensuring coherence in municipal policies for better health outcomes; working with other levels of governance to create and enabling system for better health outcomes.)

- **Improving road safety (SDG target 3.6 and 11.2).** (Examples of measures include: enhancing leadership on road safety; implementing measures for speed management, infrastructure design and improvement; vehicle safety standards; enforcement of traffic laws; improving survival after a road accident.)
1.A.4.D.1 What is the level of monitoring of the health-related indicators?
- **High** (more than 75% health-related indicators are monitored and reviewed at least once every two years to make decisions or change the course of action)
- **Moderate** (50-75% of the key health-related indicators are monitored, reviews take place every two to five years and are used often to make decisions or change the course of action)
- **Low** (less than 50% indicators are monitored and are not regularly used to make decisions or change the course of action)
- **None** (no monitoring activity)
- **Other. Please specify (Limit 100 characters)** ____________________________

If any of the priority areas in question 1.A.4 are selected, please move to question 1.A.4.A
If no priority areas in question 1.A.4 are selected, please move to question 1.A.5.

1.A.4.A Please indicate the level of implementation of the health and wellbeing priority areas included in your country's national sustainable development planning framework:
- **High** (action is being taken on more than 75% of health and wellbeing priorities)
- **Moderate** (action is being taken on 50-75% of health and wellbeing priorities)
- **Low** (action is being taken on less than 50% of health and wellbeing priorities)
- **None** (no action is being taken)

1.A.4.B What is the level of alignment of the health priorities identified in the national sustainable development planning framework compared to the priorities stated in the national health planning framework?
- **High** (more than 75% of health priorities are aligned)
- **Moderate** (50-75% of health priorities are aligned)
- **Low** (less than 50% of priorities are aligned)
- **None** (no alignment)

1.A.4.C Does the national sustainable development planning framework include targets on the health priorities identified?
- **Yes**
- **No**

1.A.4.D Does the national sustainable development framework include indicators on the health priorities identified?
- **Yes**
- **No**

If you answered yes to question 1.A.4.D, please move to question 1.A.4.D.1
If you answered no to question 1.A.4.D, please move to question 1.A.5
1.A.5 Please upload the national sustainable development planning framework and other relevant documents and provide URL if available:

Upload up to 3 documents /drafts __________
Provide web link____________________________

1.B Within the administrative structure of government of your country, where is the leadership for implementation of the 2030 Agenda? Please explain briefly and specify the name of the ministry, body, unit or institutional arrangement in charge of implementation of the 2030 Agenda within the administrative structure of government:

(Limit 700 characters)

1.C What are the functions assigned to the institutional and coordination arrangement of your country?

☐ Promote horizontal coherence across ministries
☐ Promote vertical coherence across national and subnational government levels
☐ Develop national sustainable development planning frameworks
☐ Oversee the monitoring and evaluation of the sustainable development planning frameworks
☐ Monitor sustainable development issues and provide policy advice
☐ Other. Please specify (limit 200 characters) ________________________.

Please attach evidence, if available:

(attach up to 3 files)

1.D Please select the level of participation of the sectors involved in the coordination and institutional arrangement for implementation of the 2030 Agenda of your country (please select as many sectors as applicable)

<table>
<thead>
<tr>
<th>Sector</th>
<th>High (has strong control over key decisions; acts as a partner in the development of alternatives and identification of preferred solutions)</th>
<th>Moderate (is involved/consulted in the process of development of alternatives and identification of preferred solutions)</th>
<th>Low (is informed of key decisions).</th>
<th>None (no participation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment and natural resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance and economy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender equality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and wellbeing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labour, employment and social affairs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
infrastructure
Rural development
Others. Please specify only those you consider relevant sharing (limit 5 sectors) ______________

Other sector 1 (limit 100 characters)
Other sector 2 (limit 100 characters)
Other sector 3 (limit 100 characters)
Other sector 4 (limit 100 characters)
Other sector 5 (limit 100 characters)

Optional: Please explain your response, providing more detail on the participation and role of the different sectors:

(Limit 500 characters)

1.E Is there a body or person assigned as the SDG focal point in the Ministry of health?

☐ Yes
☐ No

If you answered yes, please provide contact details below.
If you answered no, please move to question 1.F

Please provide contact details:

(Limit 200 characters)

1.F Has your country submitted a voluntary national review (VNR) to the High-Level Political Forum (HLPF) meeting under the auspices of United Nations Economic and Social Council (ECOSOC)?

☐ Yes
☐ No

If you answered yes to question 1.F, please move to question 1.F.1
If you answered no to question 1.F, please move to question 1.G

1.F.1 Please indicate the extent of involvement from the Ministry of Health, public health institutions or other health stakeholders in the development of the VNR.

<table>
<thead>
<tr>
<th>Stakeholder involvement</th>
<th>High (had strong control over key decisions - Lead or co-lead the process of development of the VNR or)</th>
<th>Moderate (was involved/consulted in the process of development of the VNR, e.g. providing data and information)</th>
<th>Low (was informed of key decisions in the process of development of the VNR)</th>
<th>None (no involvement)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public health institute</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil society organizations (related to health)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parliamentarians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>International development organizations and/or international financing institutions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others. Please specify (up to 5 health stakeholders, limit 100 characters per stakeholder)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other stakeholder 1 (limit 100 characters)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other stakeholder 2 (limit 100 characters)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other stakeholder 3 (limit 100 characters)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other stakeholder 4 (limit 100 characters)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other stakeholder 5 (limit 100 characters)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Optional: Please explain your response, providing more detail on the extent of involvement of the different stakeholders:

(Limit 1500 characters)

1.G Please list the national health and wellbeing priorities of your country (as in the main health and wellbeing planning frameworks) (up to 10 priorities, limit 150 characters per priority):

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.  
10.  

1.H What is the level of alignment of your country’s health and wellbeing priorities with the SDGs? *Alignment refers to the correspondence of the issues covered by the SDG targets to the health-related targets set in the national long-term, medium-term, and thematic or disease-specific plans.* *Alignment in scope refers to the level of correspondence of the subthemes identified in the SDG target, or specific groups identified in the SDG target (sex disaggregation, rural and urban population, population...*
1.1 Please select the approach used in your country to address the national health and wellbeing priorities (please select all applicable options):

- Implementing an overarching health policy or strategy covering the vision, policy directions, strategy and/or plans
- Implementing thematic or disease-specific strategies or plans
- Implementing sub-national and decentralized planning frameworks
- Other. Please specify (limit 700 characters):

1.1.1 Specify the year in which the integrated health policy or strategy was approved by the relevant government authority and the expiration date (please provide the year that the integrated health policy or strategy was initially approved even if subsequent modifications have been made):

____ (mm/yy) - ____ (mm/yy)

1.1.2 Has the approved integrated health policy or strategy been updated or modified since its original adoption:

- Yes
- No.

If you answered yes to question 1.1.2 please move to question 1.1.2 A
If you answered no to question 1.1.2, please move to question 1.1.3

1.1.2 A. Please explain your response, providing key reason(s) for modification and provide the most recent year in which modifications have taken place:

(e.g. national priorities/agenda changed, international commitments, resulting from monitoring and evaluation activities, etc). Limit 700 characters

____ (mm/yy)

1.1.3 Please specify if your current integrated health policy or strategy includes measures about (please select as many options as applicable):

**Life-course approach**

- Child and adolescent health (SDG targets 3.2, 4.2). (Examples of measures include: ending preventable deaths of mothers, newborns and children; ensuring health and wellbeing of mothers and children by reducing malnutrition, improving access to sexual and reproductive health; ensuring access to good-quality early childhood development; expanding enabling environments for children and adolescents’ health and wellbeing.)

- Healthy aging (SDG 3, 5 and 10). (Examples of measures include: prevention of falls; promotion of physical activity; vaccination of older people and prevention of infectious disease in health-care settings; public support for informal care giving with a focus on home care, including self-care; building capacity in geriatrics and gerontology among the health
and social care workforce; prevention of social isolation and social exclusion; strategies to ensure the quality of care for older people, with a focus on dementia care and palliative care for long-term patients; prevention of elder maltreatment.)

- **Improve women’s and men’s health (SDG 5 and 3).** (Examples of measures include: strengthening governance for the health and wellbeing of women and men; eliminating discriminatory values, norms and practices that affect the health and well-being of girls and women; making gender equality a priority; tackling the impact of gender and social, economic, cultural and environmental determinants on women’s and men’s health and well-being; making health systems gender responsive; improving health promotion with gender-transformative approaches.)

- **Sexual and reproductive health (SDG targets 3.1, 3.7 and SDG 5).** (Examples of measures include: guaranteeing universal access to sexual and reproductive health and eliminating inequities; enabling all people to make informed choices about their sexual and reproductive health; ensuring sexual and reproductive human rights are respected, protected and fulfilled.)

**Noncommunicable diseases and risk factors**

- **Healthy lifestyles: healthy eating, reformulation of food products, increasing physical activity, reducing tobacco use, reducing the harmful use of alcohol and/or improving air quality (SDG targets 2.2, 3.4, 3.5, 3a, 3.9).** (Examples of measures include: promoting healthy consumption via fiscal and marketing policies; reformulating and improving product: salt, fats and sugars; reducing salt consumption; promoting active living and mobility; promoting clean air.)

- **Noncommunicable diseases: i.e. cardiovascular diseases, cancer, chronic respiratory diseases and/or diabetes (SDG target 3.4).** (Examples of measures include: providing access to early detection and effective treatment; providing access to cardio-metabolic risk assessment and management; providing access to vaccinations and relevant communicable disease control.)

**Communicable diseases**

- **Antimicrobial resistance (SDG 3).** (Examples of measures include: improving awareness and understanding of antimicrobial resistance; strengthening knowledge and evidence base through surveillance and research; reducing the incidence of infection through effective sanitation, hygiene and infection-prevention; optimizing the use of antimicrobial medicines in human and animal health; increasing investment in new medicines and technologies.)

- **Communicable diseases: HIV/AIDS, tuberculosis, viral hepatitis and/or vector-borne diseases (SDG target 3.3).** (Examples of measures include: strengthening programmes for the control of infectious diseases; providing adequate access to services, including access to safe and affordable medications and vaccines; integrating patient-centred care and prevention services; focusing prevention strategies for vulnerable populations.)

- **Immunizations (SDG targets 3.8, 3b).** (Examples of measures include: strengthening and achieving financial sustainability of national immunizations programmes; eliminating measles and rubella; addressing vaccine hesitancy; tailoring immunization programmes to reach underserved groups; investing in research and development.)

**Health system strengthening for universal health coverage**

- **Financial protection (SDG target 3.8).** (Examples of measures include: promoting policies to reduce out-of-pocket payments; ensuring adequate public financing for health systems; reducing fragmentation in health system funding channels; adopting strategic purchasing mechanisms; ensuring effective and equitable coverage decisions based on systematics, evidence-based and transparent processes.)

- **Fostering environmental sustainability of health systems (SDG 3, 6, 12, 13, 14 and 15).** (Examples of measures include: minimizing and adequately managing waste and hazardous chemicals; promoting an efficient management of resources; promoting sustainable procurement; reducing health systems’ emissions of greenhouse gases and air pollution; prioritizing disease prevention, health promotion and public health services; engaging the health workforce as an agent of sustainability; increasing community resilience and promoting local assets; creating innovative models of care.)

- **Health information and health information systems (SDG target 17.7 and 17.8).** (Examples of measures include: generating, measuring, analysing, coordinating and promoting the use of data and information for policies to improve health and well-being and reduce inequalities.)
Quality-assured, affordable medicines, vaccines and health products (SDG target 3b). (Examples of measures include: improving access to essential medicines and medical devices; supporting the appropriate use of medical products; improving efficiency of procurement systems; promoting effective regulations and quality control; promoting responsible use of medicines and medical devices; promoting research and development.)

Sustainable and resilient health workforce (SDG target 3c). (Examples of measures include: rethinking the roles of health workers and optimizing the skill mix; investing in and transforming health workforce education and training; improving the performance of health workers; establishing policies to ensure a sufficient and sustainable health workforce; ensuring the availability of the health workforce to quickly respond to emergencies or pandemics.)

Transforming health services to meet the current and emergent health challenges (SDG target 3.8). (Examples of measures include: strengthening the integration of primary health care and public health services, hospitals and social care; strengthening key processes of designing care, organizing providers and settings, managing services and improving quality.)

Emergencies

All-hazard, multisectoral preparedness and response to health emergencies (SDG targets 1.5, 3d, 11.5).

Building strong public health-oriented and people-centred health systems, institutions and networks based on the essential public health functions and core capacities under the International Health Regulations (2005) (SDG target 3d).

Strengthening adaptive capacity and resilience to health risks related to climate change (SDG target 13) and/or supporting measures to mitigate climate change and achieve health co-benefits in line with the Paris Agreement.

Health determinants

Addressing and preventing interpersonal violence, including the negative consequences of interpersonal violence (SDG targets 5.2, 16.1 and 16.2). (Examples of measures include: prevention of child maltreatment, elderly maltreatment, violence against women, among others.)

Addressing education and lifelong learning (SDG 4). (Examples of measures include: improving access to high quality education services and protection from financial hardship in using those services; ensuring quality conditions for early childhood development.)

Addressing employment, income and living conditions (SDG targets 1, 2, 8, 10 and 16). (Examples of measures include: fostering a healthy workforce and tackling the health risks of being unemployed or insecurely employed; developing universal social protection and policy priorities and strategies in order to reduce inequities and remove barriers to protecting households from deprivation and poverty; implementing a basket of coordinated social, economic and environmental policy measures that target groups that are being left behind or excluded.)

Improving road safety (SDG targets 3.6, 11.2). (Examples of measures include: enhancing leadership on road safety; implementing measures for speed management, infrastructure design and improvement; vehicle safety standards; enforcement of traffic laws; improving survival after a road accident.)

Migration and health (SDG 10). (Examples of measures include: establishing a framework for collaborative action; advocating for the right to health of refugees; addressing the social determinants of health; achieving public health preparedness and ensuring an effective response; strengthening health systems and their resilience; preventing communicable diseases; preventing and reducing risks posed by noncommunicable diseases; ensuring ethical and effective health screening.)

Promotion of social inclusion, gender equality and human rights (SDG 1, 5, 10 and 16) (Examples of measures include: strengthening governance for health and well-being; eliminating discriminatory values, norms and practices that affect health and wellbeing; tackling the impact of gender and social, economic, cultural and environmental determinants of health and wellbeing; improving health system responses to women’s and men’s health and wellbeing.)

Reduction of environmental pollution and degradation and health-related risks (SDG target 3.9 and SDG 7, 9, 11, 12, 13, 14 and 15). (Examples of measures include: improving indoor
1.1.4 Please describe the level of implementation of the integrated health policy or strategy:

- High (action is being taken on more than 75% of health and wellbeing priorities)
- Moderate (action is being taken on 50–75% of health and wellbeing priorities)
- Low (action is being taken on less than 50% of health and wellbeing priorities)
- None (no action is being taken).

1.1.5 Please select the challenges/barriers encountered when implementing the integrated health policy or strategy (please select as many options as applicable):

- Insufficient budget to meet the priorities
- Limited partnership opportunities
- Frequent changes of key staff
- Ineffective mechanisms (e.g. legal, regulatory, financial) for ensuring coordination and cooperation
- Poor quality of statistical information
- Low level of intersectoral cooperation and interaction
- Other. Please specify (limit 200 characters) _________________________________

Please, briefly explain your response:

Limit 700 characters.

1.1.6 Does the integrated health policy or strategy outline budgetary requirements for its implementation?

- Yes
- No

If you answered yes to question 1.1.6, please move to question 1.1.6.A
If you answered no to question 1.1.6, please move to question 1.1.7

1.1.6.A Please indicate the degree the estimated costs of implementing the integrated health policy or strategy are covered by the current domestic resources.

- High (more than 75% of all costs to implement priority actions are covered by the current domestic resources)
- Moderate (50–75% of all costs to implement priority actions are covered by the current domestic resources)
- Low (less than 50% of all costs to implement priority actions are covered by the current domestic resources and/or funds are insufficient to implement any of the main priorities)
- None (covered costs by current domestic resources are insufficient to implement priority actions)

1.1.7 What priorities, objectives or activities, if any, of the integrated health policy or strategy are currently underfunded or insufficiently funded?
1.1.8 Is your government currently receiving international funds/official development assistance to support implementation of the national health priorities?

☐ Yes
☐ No

If you answered yes to question 1.1.8, please move to question 1.1.8.A
If you answered no to question 1.1.8, please move to question 1.1.9

1.1.8.A Please describe the health and development priorities for which you are currently receiving international funds/official development assistance for and the share of international funds used to finance these activities if available (percentage) (up to 5 priorities limit 200 characters per priority):

<table>
<thead>
<tr>
<th>Priority</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health priority 1</td>
<td>%</td>
</tr>
<tr>
<td>Priority 2</td>
<td>%</td>
</tr>
<tr>
<td>Priority 3</td>
<td>%</td>
</tr>
<tr>
<td>Priority 4</td>
<td>%</td>
</tr>
<tr>
<td>Priority 5</td>
<td>%</td>
</tr>
</tbody>
</table>

1.1.9 What are the greatest challenges (if any) in accessing international funds/official development assistance for development and health and wellbeing? (please select as many options as applicable)

☐ Lack of information on the opportunities
☐ Lack of country eligibility
☐ Lack of connection by health actors to the development processes
☐ Lack of capacity to prepare country proposals
☐ Lack of success in submitted previous applications
☐ None (no challenges/challenges were minimal)
☐ Not applicable
☐ Other. Please specify (limit 700 characters) __________________________________________________________________________________________

1.1.10 Has your country assessed how the national budget contributes to financing the health-related SDGs?

☐ Yes
☐ No

If you answered yes to question 1.1.10, please move to question 1.1.10.A
If you answered no to question 1.1.10, please move to question 1.1.11

1.1.10.A What is the share of the national budget that can be attributed to achievement of the health-related SDGs in your country?

Percentage ____________________________

1.1.11 Please upload relevant documents related to the integrated health policy or strategy and provide URL if available:

Upload up to 5 relevant documents/drafts __________
Provide link____________________________________

Block 2. Leaving no one behind

Objective: to reduce health inequities by addressing all health determinants, taking life-course, gender-responsive and rights-based approaches to health, and action on universally progressive policies, legislation and empowerment
2.A Is there a national/subnational health policy/plan/strategy addressing the reduction of health inequalities (HI) and/or improvement of the social determinants of health (SDH)?

☐ Yes
☐ No
☐ Other (reducing health inequalities and/or improvement of the SDH is part of another national/subnational policy/strategy)

Please explain your response and specify the title of the policies/strategies addressing the reduction of inequalities:

(Limit 700 characters)

If you answered ‘yes’ or ‘other’ to question 2.A, please move to question 2.A.1
If you answered no to question 2.A, please move to question 2.B

2.A.1 Please upload the national/subnational health policy/plan/strategy addressing the reduction of HI and/or improvement of the SDH and provide URL if available:

Upload relevant documents /drafts __________
Provide link____________________________

Attach up to 3 files, policies/strategies

2.B Please specify which of the following measures to address the reduction of health inequalities and/or improvement of the SDH have been included in your country’s national/subnational policies/plans/strategies or equivalent (please select as many options as applicable):

☐ Improving access to high-quality health and education services and protection from financial hardships in using those services
☐ Ensuring quality conditions for early childhood development, starting in places where children and their families live, learn, play and work
☐ Fostering a healthy workforce and tackling the health risks of being unemployed or insecurely employed through active labour market policies
☐ Developing universal social protection and policy priorities and strategies to reduce inequities and remove barriers to protecting households from deprivation and poverty
☐ Implementing a basket of coordinated social, economic and environmental policy measures, targeting groups that are being left behind or excluded
☐ Addressing the structural causes of discrimination; ensuring policies and measures to reduce gender-based violence and to eliminate child and forced labour, trafficking and sexual exploitation
☐ Others. Please specify (limit 1400 characters) ________________________________

Block 3. Preventing disease and addressing health determinants by promoting multi- and intersectoral policies and action throughout the life-course

Objective: to foster the health sector’s cooperation with other sectors to integrate action to achieve multiple SDGs, and to optimize the co-benefits for health of policies and measures taken in other sectors to address the determinants of health

3.A For the following health determining sectors, please indicate the level of collaboration between the Ministry of Health and the health-determining sector and describe the key health and wellbeing priorities to be addressed within/by the sector.
intersectoral plans with clear leadership, tasks, capacity and reporting obligations) | with cross consultation s and/or mentioned as partners in respective sector’s plans) | information sharing/gathering)

| Agriculture, food and nutrition | | |
| Commerce | | |
| Culture & media | | |
| Education | | |
| Energy | | |
| Environment, water and sanitation | | |
| Finance and trade | | |
| Gender & women’s rights | | |
| Habitat, housing, land use and urbanization | | |
| Industry | | |
| Labour and employment | | |
| Welfare and social protection | | |
| Transportation | | |
| Local government | | |
| Subnational government | | |
| Other. Please specify (up to 5 sectors) | | |
| Other sector 1 (limit 100 character) | | |
| Other sector 2 (limit 100 character) | | |
| Other sector 3 (limit 100 character) | | |
| Other sector 4 (limit 100 character) | | |
| Other sector 5 (limit 100 character) | | |

Optional: Please explain your response, providing more detail on the level of collaboration and describe the key health and well-being priorities to be addressed within/by the different sectors.

(Optional 1500 characters)

Optional: Please attach relevant documentation (action plans, joint memorandums of understanding, other agreements and/or other relevant evidence) that describes the main priorities for cooperation between the Ministry of Health and the health determining sectors.

Attach up to 5 files

3.B Please indicate the extent of actions taken for the following measures to prevent disease and address health determinants by promoting multi- and intersectoral policies and action throughout the life-course by the health sector:
<table>
<thead>
<tr>
<th>Action and measures</th>
<th>High (measure has been identified as a priority and actions are being taken)</th>
<th>Moderate (measure has been identified as a priority, but limited action is being taken)</th>
<th>Low (measure has been identified as a priority, but no action is being taken)</th>
<th>None (measure is not a priority)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate co-benefits for multiple sectors from addressing health and wellbeing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systematically adopting a Health in All Policies approach in policy-making processes through normative frameworks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengthen and implement legal and regulatory measures in sectors outside the health sector that tackle shared risk factors (e.g. air pollution) or unhealthy commodities (e.g. alcohol, drug, tobacco) to help control and manage noncommunicable diseases</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure consumer environments promote healthy choices through pricing policies, information or economic and fiscal measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promote information systems that provide integrated information to policy-makers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop national portfolio of action on environment and health (Ostrava Declaration)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you selected the extent of actions for any of the measures as ‘high’ or ‘moderate’ for question 3.B, please answer question 3.B.1
If you selected the extent of actions for any of the measures as ‘low’ or ‘none’ for question 3.B, please answer question 3.B.2
3.B.1. Could you list one or two examples of the actions and measures selected in the previous question?

**Up to 2 examples, limit 300 characters per example**

3.B.2 What are the main challenges to promote multi- and intersectoral policies and action?

**Limit 300 characters**

---

**Block 4. Establishing healthy places, settings and resilient communities**

**Objective:** to engage local communities and stakeholders in designing and managing places, settings and communities consistent with the needs of their people throughout the life-course

4.A Please indicate which of the following measures, to establish healthy places, settings and resilient communities, are included in the national development planning framework and/or in the integrated health policy or strategy of your country (please select as many options as applicable):

- ☐ Engagement with local communities and stakeholders in designing and managing places, settings and communities consistent with the needs of the people throughout the life-course with defined vertical accountability mechanisms
- ☐ Create spaces that are supportive to groups of all ages and levels of ability, including access to natural resources and green and blue spaces
- ☐ Engage communities in identifying the physical, social and cultural characteristics of places that are most supportive of the health and wellbeing of the inhabitants
- ☐ Engage public agencies, spatial planners, voluntary bodies, business, industry and all other actors in taking action to implement the common priorities
- ☐ Develop partnerships among communities, individuals, patients and their family members and carers in order to empower populations to develop health-promoting behaviour
- ☐ Increase resilience of households and communities so as to improve capacities to prevent, prepare, withstand, respond to and recover from climate risks and natural and man-made disasters
- ☐ Other. Please specify (limit 700 characters) __________________________________

---

**Block 5. Strengthening health systems for universal health coverage (UHC)**

**Objective:** to ensure all people obtain the high-quality health promotion, disease prevention, curative, rehabilitative and palliative services they need without experiencing financial hardship

5.A Is the pursuit of UHC expressed in a national / subnational policy strategy or statement?

- ☐ Yes
- ☐ No

*If you answered yes to question 5.A, please move to question 5.A.1
If you answered no to question 5.A, please move to question 5.B*

5.A.1 How is the pursuit of UHC expressed in your country:

- ☐ The pursuit of UHC is expressed in a thematic national/subnational policy/strategy or statement focused in the pursuit on UHC
- ☐ The pursuit of UHC is expressed in another policy/strategy focused on health or health systems strengthening
- ☐ Other. Please specify (limit 100 characters) ______________________________

---
Please, explain your response briefly, indicating the name of the policy, strategy or statement and the approach proposed. Upload relevant document and if available, provide URL: 

Limit 700 characters.

Upload 1 document

Provide URL

5.A.2 Which body or agency is responsible for the pursuit/achievement of UHC in your country?

Limit 700 characters

5.B Within the context of your health system, are you able to identify specific actions or measures being taken to improve (please select as many options as applicable):

- Equitable access to comprehensive, people-centred health services (in terms of access, this includes physical, social, financial etc)
- Increased public financing for health
- Efficient and equitable health financing policies to reduce out-of-pocket payments for core services
- The scope of health services covered under a national basket of reimbursed services
- The quality of covered services, including ensuring the availability of an appropriately skilled workforce
- The re-orientation of primary health care (e.g. to serve the goals of bringing care closer to the individual, reducing costs and waste in the system, promoting continuity of care, etc.)

If any options in question 5.B are selected, please move to question 5.B.1
If no options in question 5.B are selected, please move to question 5.C

5.B.1 For the above are there dedicated targets set with a monitoring and evaluation strategy?

- Yes
- No
- Partially. Please explain your response (limit 700 characters)

5.C Indicate what are the obstacles or barriers, if any, to strengthening your health system in pursuit of UHC? (Please select as many options as applicable)

- Shortages, imbalances, mismatches between education models and health needs, and/or productivity concerns in health workforce
- Challenges in access to and affordability of essential medicines and health technologies
- Large gaps in health coverage
- Weaknesses in the design of population entitlement, benefit package and user charges
- Inefficient public spending on health
- Fragmentation in health services delivery
- Weaknesses in health system governance to define, lead and implement policies in health sector
- Increased public demands for access to and use of new technologies, new medications and new models of care
- Higher expectations of quality and safe care
- Ageing populations
- Emerging and re-emerging diseases
- Others. Please specify (up to 5 challenges, 100 characters per challenge): ____________________

5.D Please upload the most relevant document(s) where the approach proposed to the pursuit of UHC is expressed and if available, provide URL:

Attach up to 3 documents

Provide URL

5.E Health system strengthening and the pursuit of UHC requires collaboration between and across levels of government and society. Can you describe national examples of collaboration between governmental, non-governmental and private sectors in delivering stronger health systems for UHC? Please focus on
describing the issue and the plan for action, methods of collaboration, context and stakeholders involved, challenges and results of collaboration (optional).

Limit 2500 characters

If you responded to question 5.E, please move to question 5.E.1
If you did not respond to question 5.E, please move to question 6.A

5.E.1 Would you agree to be contacted so you can elaborate on your example:

☐ Yes
☐ No

Block 6. Investment for health and wellbeing

Objective: To promote investment for health and wellbeing, to maximize co-benefits for health and sustainable development and to achieve the highest attainable standard of health for all at all ages

6.A Indicate which of the following measures are used in your country to ensure adequate investments in health and wellbeing and its determinants (please select as many options as applicable):

☐ Using evidence-informed and innovative mechanisms to incentivize non-health sectors to invest in actions for health and wellbeing
☐ Prioritizing and increasing public funding for health at national and subnational levels by setting appropriate investment targets for providing essential public services for all (health, education, food, housing, employment, energy, water and sanitation) that are consistent with national development strategies
☐ Harmonizing development assistance and international funds for health with the county’s national priorities
☐ Improving efficiency and equity on health spending by, for example, prioritizing investment in evidence-informed health and other policies and interventions that have demonstrated co-benefits for health and sustainable development (accelerators)
☐ Ensuring adequate funding for pandemic and emergency response
☐ Assessing systematically public- and private-sector investments for their health and health equity impact and applying incentives and disincentives to redirect them accordingly
☐ Applying social and environmental criteria for all purchases and ensuring financial integrity in the health sector
☐ Other. Please specify (limit 350 characters) __________________________________________________________________

Block 7. Multi-partner cooperation

Objective: to increase institutional capacity, build and engage effective, accountable and transparent institutions, and strengthen collaboration with partners and stakeholders

7.A Is there a strategy/plan/framework (or similar) with the purpose to enable better coordination/enhance engagement with non-state actors in your country?

☐ Yes
☐ No

7.A.1 If the answer to 7.A is yes, please specify the name of the policy and objectives and upload relevant documentation. If available, provide URL:

Name of policy and objectives (Limit 1750 characters)

Upload 1 document

URL
7.8 For the following groups of non-state actors, please indicate the type of collaboration between them and your Ministry of Health:

<table>
<thead>
<tr>
<th>Non-state actor</th>
<th>Non-state actor participates in meetings, consultation and hearings for decision-making and public policy</th>
<th>Non-state actor plays an explicit role in governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groups united by shared interests and goals:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Groups representing specific or general interests (ranging from the most specific interest to the broadest issues of global welfare such as climate change)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizations of professionals (e.g. medical associations and professional chambers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community organizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faith-based community organizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identity-based community organizations (i.e. ethnic-based or another group)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local community organizations (e.g. neighbourhood or rural district organizations)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health-condition related community organizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private sector entities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>International NGOs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic institutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, Please specify (up to 5 non-state actors)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other non-state actor 1 (limit 100 characters)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other non-state actor 2 (limit 100 characters)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other non-state actor 3 (limit 100 characters)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other non-state actor 4 (limit 100 characters)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other non-state actor 5 (limit 100 characters)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.C Indicate which of the following measures are being used in your country to strengthen collaboration of the health sector with partners and stakeholders (please select as many options as applicable):

☐ Raising awareness activities to mobilize political will and investment in health and wellbeing, and implementation of the 2030 Agenda for Sustainable Development
☐ Developing mechanisms/platforms to promote cooperation between various groups and cooperative initiatives in civil society, academia, settings and sectors
☐ Creating accessible forums for civil society organizations to participate in decision-making
☐ Strengthening information sharing and health literacy
☐ Other. Please specify (limit 200 characters) ____________________________

---

Block 8. Health literacy, research and innovation

Objective: to promote international and regional research to support and promote the implementation of the health and well-being aspects of the 2030 Agenda and the SDGs

8.A Are there national plans or strategies addressing strengthening health literacy of the population?

WHO defines health literacy “as the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health ... Health Literacy goes beyond a narrow concept of health education and individual behavior-oriented communication, and addresses the environmental, political and social factors that determine health.”

☐ Yes
☐ No

8.A.1 If the answer to 8.A is yes, please specify the name of the policy and objectives and upload relevant documentation. If available, provide URL:

Name of policy and objectives (Limit 1750 characters)

Upload 1 document

URL

If you answered yes to question 8.A, please move to question 8.A.1
If you answered no to question 8.A, please move to question 8.B

8.B Which of the following actions or measures to strengthen health literacy are you able to identify being implemented in your country (please select as many options as applicable):

☐ Allocating fiscal and human resources for strengthening health literacy of the population
☐ Building supportive environments for consumers (e.g. clear labelling, a traffic light system to indicate healthier and less healthier choices, consumer design strategies, among others)
☐ Providing easy access to health information and services and navigation assistance (e.g. using e-health and other digital technologies as appropriate)
☐ Acknowledging a wide variety of learning styles and using multiples approaches to promote health literacy
☐ Actions to improve the living environment
☐ Actions implemented at the workplace
☐ Actions implemented through media and digital/e-health
☐ Actions at the individual, community, organization and system levels
☐ Actions to support intersectoral work, political leadership and strategies to overcome cultural barriers into health literacy policy
☐ Promoting health literacy in high risk situations, including outbreaks and emergencies
☐ Other. Please specify (limit 200 characters) ____________________________

8.C Is there a national strategy/plan to promote innovation, research and development to create new knowledge and evidence or technologies, as well as to find novel means of implementation, including legal and financial instruments for alignment and acceleration of SDG attainment?

☐ Yes
☐ No
8.C.1 If answer to 8.C is yes, please specify the name of the policy and objectives and upload relevant documentation. If available, provide URL:

Name of policy and objectives (Limit 1750 characters)

Upload 1 document

URL

Block 9. Monitoring and evaluation

Objective: to strengthen national health information systems to inform and evaluate policies for health and well-being and support reporting on the SDGs to improve governance and comparability of information and the application of e-health standards across the WHO European Region

9.A Has your country performed a SDG baseline analysis?
SDG baseline analysis refers to an assessment of the current status of the SDG indicators. It could be specifically for the health-related SDG indicators, or a general SDG baseline analysis (list of health-related indicators attached).

☐ Yes
☐ No

9.A.1 If answer to 9.A is yes, please attach SDG baseline analysis:

Upload 1 document

9.B Indicate which of the following processes have been done in your country to support data and statistical development to monitor health-related SDGs² (select as many options as applicable)

☐ Assessment of existing data production instruments across the entire national statistical system, including data sources, their comparability and frequencies to support monitoring health-related SDGs
☐ Prioritization of SDG indicators for data production based on country’s needs and gaps (e.g. national development plans priorities), critical data for SDG acceleration and leaving no one behind
☐ Strengthening the role of national statistical offices and data ecosystems, including official as well as non-official stakeholders’ data
☐ Coordination, partnership and innovation across the broader ecosystem of data stakeholders, to leverage technological innovations and new data sources, ensure interoperability of data systems, minimize duplication of efforts, and improve coherence of development implementation and reporting initiatives
☐ Creation of platforms, portals and/or scorecards to inform on SDG progress
☐ Other. Please specify (limit 200 characters) ________________________________

Thank you for taking the time to complete this survey. This message indicates that you have now completed the questionnaire. Please click the Submit button if you are satisfied with your replies. We are very appreciative of the time you have taken to assist in our analysis, and we commit to utilizing the information gained to contemplate and implement improvements in our work. We will share these results in a report at the next Regional Committee for the WHO European Region.

## Annex 3. Country profiles

The following table outlines the profile data for the 29 Member States who responded to the survey.

<table>
<thead>
<tr>
<th>Member State</th>
<th>Health-related SDG index¹</th>
<th>National development plan</th>
<th>National health plan</th>
<th>Voluntary national review</th>
<th>Health priorities</th>
</tr>
</thead>
</table>
| Armenia      | 68                       | Yes                      | No                  | 2018 and 2020            | • Strengthen prevention of diseases through immunization, early diagnosis and treatment, with special emphasis on NCDs  
• Create a strong primary health-care system, including increased accessibility for deprived populations, guaranteed availability of medicines  
• Develop and implement better standards in health-care services  
• Ensure specialized inpatient medical care for vulnerable groups; improved maternal and child care, provision of reproductive and adolescent health care  
• Provide capacity-building and professional development for medical providers  
• Introduce health insurance to enhance the financial sustainability of the overall health-care system |
| Belarus      | 55                       | Yes                      | Yes                 | 2017                     | • Increase life expectancy and health promotion  
• Focus on mother and child health  
• Prevent and control NCDs (including cardiovascular diseases, cancer, alcoholism)  
• Prevent communicable diseases (TB, HIV)  
• Modernize the health system (quality of care and e-health) |
| Belgium      | 77                       | Yes                      | No                  | 2017                     | • Ensure access to health for all  
• Ensure adequate care supply in line with the needs of the population  
• Implement both an encompassing and modern organizational health system structure  
• Correct pricing  
• Improve efficiency of the health system  
• Monitor environmental health |
| Bulgaria     | 61                       | Yes                      | Yes                 | 2020                     | • Create conditions ensuring lifelong health for all  
• Develop a fair, sustainable and effective health-care system  
• Be quality and result-oriented  
• Strengthen public health capacity |

¹ The Health-related SDG index is a measure of the overall level of progress towards the health-related SDGs in each country.
<table>
<thead>
<tr>
<th>Member State</th>
<th>Health-related SDG index&lt;sup&gt;a&lt;/sup&gt;</th>
<th>National development plan</th>
<th>National health plan</th>
<th>Voluntary national review</th>
<th>Health priorities</th>
</tr>
</thead>
</table>
| Croatia          | 67                                 | Yes                       | Yes                  | 2019                     | • Prevent NCDs (cardiovascular diseases, cancer, chronic respiratory disease and diabetes)  
|                  |                                    |                           |                      |                          | • Focus on child and adolescent health                                                |
|                  |                                    |                           |                      |                          | • Promote healthy ageing                                                              |
| Cyprus           | 76                                 | No                        | No                   | 2017                     | • N/A                                                                              |
|                  |                                    |                           |                      |                          |                                                                                     |
| Czech Republic   | 69                                 | Yes                       | Yes                  | 2017                     | • Achievements within health care include                                              |
|                  |                                    |                           |                      |                          | • healthy life expectancy increasing for all population groups                         |
|                  |                                    |                           |                      |                          | • effects of health inequalities decreasing                                            |
|                  |                                    |                           |                      |                          | • public health-care system stable and the corresponding professional structure is developing with lower average age, higher remuneration |
|                  |                                    |                           |                      |                          | • consumption of addictive substances being reduced                                   |
|                  |                                    |                           |                      |                          | • burden of health-endangering substances and noise being reduced through better environmental quality |
|                  |                                    |                           |                      |                          | • Support healthy lifestyles, with an emphasis on primary disease prevention and health promotion throughout life |
|                  |                                    |                           |                      |                          | • Reduce the consumption of addictive substances                                      |
|                  |                                    |                           |                      |                          | • Reduce the burden of health-endangering substances and noise through better environmental quality |
| Estonia          | 68                                 | Yes                       | Yes                  | 2016 and 2020             | • Maintain and support health throughout the life-course and health and well-being through the living environment and health system development |
|                  |                                    |                           |                      |                          | • Increase life expectancy and healthy life years                                     |
|                  |                                    |                           |                      |                          | • Reduce inequality in health (based on gender, region, education, etc.)              |
|                  |                                    |                           |                      |                          | • Support healthy choices                                                            |
|                  |                                    |                           |                      |                          | • Promote person-centred health care                                                  |
|                  |                                    |                           |                      |                          | • Create environments conducive to health                                              |

<sup>a</sup> National health plan: Yes or No
<table>
<thead>
<tr>
<th>Member State</th>
<th>Health-related SDG index&lt;sup&gt;a&lt;/sup&gt;</th>
<th>National development plan</th>
<th>National health plan</th>
<th>Voluntary national review</th>
<th>Health priorities</th>
</tr>
</thead>
</table>
| Finland      | 79                               | Yes (1)                  | Yes (1)             | 2016 and 2020            | • Overarching strategy of the Ministry of Social Affairs and Health reflects priority areas in the health and welfare including:  
  - active inclusion of people  
  - integrated services and benefits  
  - safe and healthy living and working environments  
  - financial sustainability  
  - well-being amid the ongoing transformation of work |
| Hungary      | 67                               | Yes (1)                  | Yes (1)             | 2018                     | • Promote health-conscious behaviour and transmission to future generations  
  • Reduce stress in the workplace and improve working conditions  
  • Launch and support prevention and screening programmes  
  • Propagate health-conscious behaviour patterns  
  • Support health-conscious behaviour transmission programmes through education  
  • Provide information about products that are harmful for health and prohibit or tax them  
  • Modernize the health-care system |
| Ireland      | 76                               | Yes (1)                  | Yes (1)             | 2018                     | • Increase proportion of people who are healthy at all stages of life  
  • Reduce health inequalities  
  • Protect the public from threats to health and well-being  
  • Create an environment where every sector of society can play their part |

<sup>a</sup> Includes both income and non-income dimensions.
<table>
<thead>
<tr>
<th>Member State</th>
<th>Health-related SDG index $^a$</th>
<th>National development plan</th>
<th>National health plan</th>
<th>Voluntary national review</th>
<th>Health priorities</th>
</tr>
</thead>
</table>
| Israel       | 82                            | Yes                      | Yes                 | 2019                     | • Use digital health as a tool to advance accessibility, quality and efficiency in health-care services  
• Impart positive nutrition across all ages to combat NCDs and encourage healthy living  
• Improve long-term care in advanced community programmes  
• Care for the ageing population and support community-based programming to handle issues that arise within that context  
• Improve access to dental care across all sectors  
• Enhance vaccination programming  
• Improve programming for transition from hospital to community health  
• Reduce the effects and prevalence of AMR and other hospital-acquired infections |
| Latvia       | 64                            | Yes                      | Yes                 | 2018                     | • Prevent inequality in the field of health by taking measures to ensure equal health promotion and health-care opportunities for inhabitants  
• Reduce premature mortality from NCDs by reducing the negative impact of risk factors on health  
• Improve the health of mother, father and child to reduce infant mortality  
• Promote healthy and safe life and working environments to reduce injuries and mortality from external causes of death  
• Reduce morbidity from communicable diseases  
• Ensure efficient management of the health-care system and rational utilization of resources  
• Improve access to health services and medicinal products  
• Provide sufficient human resources |
| Lithuania    | 58                            | Yes                      | Yes                 | 2018                     | • Improve population health and life expectancy, reduced health inequities  
• Create safer social environments, reduce health inequities and social exclusion  
• Create health-promoting working and living environments  
• Foster healthy lifestyle and its culture |

$^a$ Health-related SDG index refers to the index representing the health-related Sustainable Development Goals (SDGs) for each member state.
## Health-related SDG Index

<table>
<thead>
<tr>
<th>Member State</th>
<th>Health-related SDG Index</th>
<th>National development plan</th>
<th>National health plan</th>
<th>Voluntary national review</th>
<th>Health priorities</th>
</tr>
</thead>
</table>
| Luxembourg   | 69                       | Yes                       | No                   | 2017                     | • Promote eating healthily, moving more  
|              |                          |                           |                      |                           | • Promote healthy nutrition at school using products from the agriculture sector  
|              |                          |                           |                      |                           | • Improve access to high-quality health care  
|              |                          |                           |                      |                           | • Reduce the number of road deaths  
|              |                          |                           |                      |                           | • Implement the national plans  
|              |                          |                           |                      |                           | • National Cancer Plan  
|              |                          |                           |                      |                           | • National HIV Plan 2018–2022  
|              |                          |                           |                      |                           | • National Hepatitis Plan 2018–2022  
|              |                          |                           |                      |                           | • national plan against drugs and associated addictions  
|              |                          |                           |                      |                           | • National Tobacco Plan  
|              |                          |                           |                      |                           | • national plan for promotion of emotional and sexual health  
| Monaco       | N/A                      | No                        | No                   | 2017                     | • Prevent NCDs  
|              |                          |                           |                      |                           | • Promote mental health and well-being  
|              |                          |                           |                      |                           | • Prevent and reduce addiction  
|              |                          |                           |                      |                           | • Raise awareness of good sexual and reproductive health practices  
|              |                          |                           |                      |                           | • Use medicines rationally  
|              |                          |                           |                      |                           | • Strengthen rapid detection and risk assessment for potential health emergencies  
|              |                          |                           |                      |                           | • Ensure regulatory preparedness for public health emergencies  
|              |                          |                           |                      |                           | • Enhance policies for risk reductions  
|              |                          |                           |                      |                           | • Assess health system governance  
|              |                          |                           |                      |                           | • Conduct impact analysis for health  
| Norway       | 84                       | Yes                       | Yes                  | 2016                     | • Reduce communicable diseases  
|              |                          |                           |                      |                           | • Reduce NCDs  
|              |                          |                           |                      |                           | • Reduce substance abuse  
|              |                          |                           |                      |                           | • Reduce pollution  
|              |                          |                           |                      |                           | • Implement guidelines in the WHO Framework Convention on Tobacco Control  

---

Annex 3 Table contd.
<table>
<thead>
<tr>
<th>Member State</th>
<th>Health-related SDG index*</th>
<th>National development plan</th>
<th>National health plan</th>
<th>Voluntary national review</th>
<th>Health priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poland</td>
<td>69</td>
<td>Yes</td>
<td>Yes</td>
<td>2018</td>
<td>• Improve diet, nutritional status and physical activity of the population</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Prevent and resolve problems related to the use of psychoactive substances, behavioural addictions and other hazardous behaviours</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Prevent mental health problems and improve mental well-being of society</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Limit health risks resulting from physical, chemical and biological hazards in all environments: external, workplace, residence, recreation and education</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Promote healthy and active ageing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Improve reproductive health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Reduce incidence and premature mortality linked to NCDs (cardiovascular diseases, cancer, chronic respiratory disease, diabetes)</td>
</tr>
<tr>
<td>Portugal</td>
<td>71</td>
<td>No</td>
<td>Yes</td>
<td>2017</td>
<td>• Reduce premature mortality</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Increase healthy life expectancy at 65 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Reduce the prevalence of smoking in the population aged 15 years and over and eliminate exposure to environmental tobacco smoke</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Control the incidence and prevalence of overweight and obesity in children and the school population in order to limit its growth by 2020</td>
</tr>
<tr>
<td>Member State</td>
<td>Health-related SDG index</td>
<td>National development plan</td>
<td>National health plan</td>
<td>Voluntary national review</td>
<td>Health priorities</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------</td>
<td>---------------------------</td>
<td>----------------------</td>
<td>---------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Republic of Moldova   | 59                       | Yes                       | No                   | 2020                      | • Strengthen health education programmes  
• Improve efficiency of the health-care system with an element of individual safety provisions  
• Provide UHC, including developing an efficient health system with elements of individual insurance and incentives  
• Protect against financial hardship  
• Bolster health policies in all areas to reduce NCDs  
• Increase medical knowledge of beneficiaries of services and patients so they can apply acquired knowledge and skills to their benefit  
• Strengthen primary health care  
• Reduce premature mortality caused by communicable diseases and NCDs through prevention, including both screening and vaccination  
• Provide individual universal access to sexual and reproductive health services  
• Prevent and treat abusive drug use, alcohol consumption and smoking  
• Stage health interventions to meet the needs of disadvantaged and marginalized people (including access to services), especially for those with physical disabilities |
| Slovakia              | 73                       | Yes                       | Yes                  | 2018                      | • Implement an integrated health-care model prioritizing first-contact physicians (general practitioners for adults/children, gynaecologists)  
• Ensure that the health-care system is complemented by general practitioners and specialists through a resident programme  
• Implement medical prevention programmes aiding the prevention of communicable diseases and NCDs in cooperation with other health-care services  
• Redefine hospital types and the scope of health care they provide, catchment areas and types and structures of health-care facilities  
• Reassess the number and structure of acute beds and strengthen the number of beds available for aftercare, rehabilitation and nursing  
• Achieve functional reception and transmission of information between hospitals and other health-care facilities in institutional and outpatient health care  
• Implement public health programmes (nonmedical prevention, promotion of health awareness) and increase pandemic and bio-risk preparedness  
• Raise the level of public health among socially disadvantaged communities  
• Promote health awareness and prevention among citizens using modern communication tools and technologies  
• Improve the level of nonmedical determinants of health through multisectoral cooperation (particularly in living, work and social environment) |
<table>
<thead>
<tr>
<th>Member State</th>
<th>Health-related SDG index</th>
<th>National development plan</th>
<th>National health plan</th>
<th>Voluntary national review</th>
<th>Health priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slovenia</td>
<td>78</td>
<td>Yes</td>
<td>Yes</td>
<td>2017 and 2020</td>
<td>• Reduce the burden of NCDs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Reduce health inequalities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Reduce health threats</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Improve financial sustainability of health-care system</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Focus on patient mobility</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Achieve satisfied patients and health-care providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Increase the contribution of the health sector towards economic and social development</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Promote health protection and disease prevention</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Strengthen primary health care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Enhance mental health</td>
</tr>
<tr>
<td>Spain</td>
<td>74</td>
<td>No</td>
<td>No</td>
<td>2018</td>
<td>• Improve health through actions in</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• primary and community care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• equity in health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• environment and health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• climate change, ecological transition and health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• oral health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• strategies against chronicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Strengthen the national health system and improve cohesion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Increase health and development of the knowledge-driven economy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Support innovation in health-care and health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Support the health workforce with financing, human resources policies and health training</td>
</tr>
<tr>
<td>Sweden</td>
<td>83</td>
<td>Yes</td>
<td>Yes</td>
<td>2017</td>
<td>• Create conditions for good and equitable health in the population and close avoidable health gaps within a generation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Improve conditions in early life</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Provide knowledge, skills and education/training</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Improve work, working conditions and work environment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Increase incomes and opportunities to earn a living</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Improve accommodation and neighbourhoods</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Support good living habits</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Provide equitable and health-promoting health and medical services</td>
</tr>
<tr>
<td>Member State</td>
<td>Health-related SDG index</td>
<td>National development plan</td>
<td>National health plan</td>
<td>Voluntary national review</td>
<td>Health priorities</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------</td>
<td>---------------------------</td>
<td>----------------------</td>
<td>--------------------------</td>
<td>------------------</td>
</tr>
</tbody>
</table>
| Switzerland  | 79                       | Yes                       | Yes                  | 2016 and 2018             | • Increase quality of life  
• Ensure equality of opportunity  
• Create transparency in service provision  
• Increase quality of health-care provision |
| Tajikistan   | 57                       | Yes                       | Yes                  | 2017                     | • Priorities are:  
  • maternal, newborn and child health  
  • funding of health care  
  • NCDs  
  • local departments of health |
| Turkey       | 66                       | Yes                       | Yes                  | 2016 and 2019             | • Promote and extend healthy life  
• Strengthen primary care and increase effectiveness within the health-care system  
• Ensure accessible, effective, efficient and quality provision of health services  
• Implement integrated health-care services model  
• Improve satisfaction of citizens and health workers and ensure sustainability of the health-care system  
• Contribute to socioeconomic development of country and global health, develop national technology and improve domestic production in health industries |

---

Annex 3 Table contd.
<table>
<thead>
<tr>
<th>Member State</th>
<th>Health-related SDG index&lt;sup&gt;a&lt;/sup&gt;</th>
<th>National development plan</th>
<th>National health plan</th>
<th>Voluntary national review</th>
<th>Health priorities</th>
</tr>
</thead>
</table>
| Ukraine      | 48                                | Yes                       | No                   | 2020                     | • Reduce maternal mortality  
• Minimize avoidable mortality among children under-5 years of age  
• Stop the HIV/AIDS epidemic and TB, including through the use of innovative practices and treatments  
• Reduce premature mortality from NCDs  
• Reduce premature mortality by a quarter, including through the introduction of innovative approaches to disease diagnosis  
• Reduce the level of serious injuries from road accidents, including through the use of innovative resuscitation, treatment and rehabilitation  
• Ensure overall quality immunization of the population with the use of innovative drugs  
• Reduce the prevalence of smoking among the population by using innovative means of communicating the negative effects of smoking  
• Reform the financing of the health-care system |
| United Kingdom | 80                               | Yes                       | No                   | 2019                     | • Lead the health and care system to help people live more independent, healthier lives for longer |

Source: "GBD 2017 SDG Collaborators, 2018 (1)."

Reference

The WHO Regional Office for Europe

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

Member States

Albania  
Andorra  
Armenia  
Austria  
Azerbaijan  
Belarus  
Belgium  
Bosnia and Herzegovina  
Bulgaria  
Croatia  
Cyprus  
Czechia  
Denmark  
Estonia  
Finland  
France  
Georgia  
Germany  
Greece  
Hungary  
Iceland  
Ireland  
Israel  
Italy  
Kazakhstan  
Kyrgyzstan  
Latvia  
Lithuania  
Luxembourg  
North Macedonia  
Malta  
Monaco  
Montenegro  
Netherlands  
Norway  
Poland  
Portugal  
Republic of Moldova  
Romania  
Russian Federation  
San Marino  
Serbia  
Slovakia  
Slovenia  
Spain  
Sweden  
Switzerland  
Tajikistan  
Turkey  
Turkmenistan  
Ukraine  
United Kingdom  
Uzbekistan