



Healthcare programs in the eight European nations members of the World Health Organization Small Countries Initiative for health: Andorra, Cyprus, Iceland, Luxembourg, Malta, Monaco, Montenegro, and San Marino

Andrea Gualtieri¹, Antonella Antonelli², Nicola Romeo³

¹Institute for Social Security (ISS), Città di San Marino, Republic of San Marino

²Federazione Italiana Medici Pediatri (FIMP), Roma, Italy

³Department of General Pediatrics, Institute for Social Security (ISS), Borgo Maggiore, Republic of San Marino

Abstract

It is described as the eight small European Countries Initiative. The initiative developed during the 63rd session of the World Health Organization Regional Committee for Europe, held in 2013 in Istanbul, Turkey. Eight European countries counting a population of less than 1 million, gathered together under the auspices of the World Health Organization, to form the European Small Countries Initiative for Health. The eight countries include Andorra, Cyprus, Iceland, Luxembourg, Malta, Monaco, Montenegro, and San Marino. The main aim of the small countries network is to foster a common political commitment, useful to develop locally good health practices. A specific goal was the implementation of the Health 2020 European policy framework and strategy for the 21st century, in the context of countries with small populations. The rationale is in fact, that countries with smaller populations have a significant advantage to promote and implement policies and strategies for health and well-being that draw on the contribution of many sectors. The eight small European Countries Initiative particularly aims at amplifying the voice of small countries in European and global health contexts, reaching out to local and international legislators and rulers. It further aims at sharing existing resources among members, with the intent to maximize assets, and innovating and applying solutions to increase capacity to improve health. The founding principle of the eight countries initiative network, is that the experiences of small countries can provide useful learning opportunities, particularly in the healthcare area, that can then be used at regional level in more populous nations.

Keywords: Healthcare, network, small

Introduction

On the occasion of the 63rd session of the World Health Organization (WHO) Regional Committee for Europe, held in 2013 in Istanbul, Turkey, eight European countries counting a population of less than 1 million, gathered together under the auspices of the WHO, to form the European Small Countries Initiative for Health. The eight countries included Andorra, Cyprus, Iceland, Luxembourg, Malta, Monaco, Montenegro, and San Marino.

The initiative developed further and in July 2014, the eight countries organized the first official meeting of

the newly constituted European network for health in San Marino, which was convened by the WHO Regional Office for Europe.

The small countries network and its related projects were initiated with the main aim to foster a common political commitment, useful to developing good local health practices. A specific goal was the implementation of the Health 2020 European policy framework and strategy for the 21st century (1), in the context of countries with small populations. The rationale is in fact, that countries with smaller populations have a significant advantage to

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Corresponding Author: Nicola Romeo E-mail: nicola.romeo@iss.sm

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Table 1. Commitments listed in the “San Marino Manifesto” by the network of the Eight European Small Countries initiative**Commitments for Implementing the Health 2020 vision in countries with small populations**

- Aligning national health policies to Health 2020;
- Strengthening technical capacity on core Health 2020 aspects, with an emphasis on all determinants of health including the social determinants
- Using an intersectoral approach and sustainable actions to address the four priorities of Health 2020:
 - Investing in health through a life-course approach and empowering people;
 - Tackling the Region’s major health challenges of non-communicable and communicable diseases;
 - Strengthening people-centered health systems, public health capacity and emergency preparedness, surveillance and response;
 - Creating resilient communities and supportive environments;
- Creating a platform for sharing experiences and mutual learning about Health 2020 implementation and beyond.

promote and implement policies and strategies for health and well-being that draw on the contribution of many sectors.

According to the international manifesto, which was issued in 2014 in San Marino (2), the eight small European Countries Initiative particularly aims at amplifying the voice of small countries in European and global health contexts, reaching out local and international legislators and rulers. It further aims at sharing existing resources among members, with the intent to maximize assets, and innovating and applying solutions to increase capacity to improve health (Table 1). The founding principle of the eight countries initiative network is that the experiences of small countries can provide useful learning opportunities, particularly in the healthcare area, that can then be used at a regional level in more populous nations.

Health is a fundamental right, which the eight countries intend to strongly implement through their solid health network, as a central element for their sustainable national progress and prosperity. To such a regard, the group recognizes the importance of promoting health for all, with particular focus on disadvantaged groups, fostering equitable and sustainable development and reducing health inequities.

The governments of the eight participating countries are committed to implementing health and healthcare as a part of their whole-government responsibility. They regard the Health 2020 as the key strategy tool, which implementation would enable the eight countries to properly align their national policies with modern evidence-based, 21st century concepts, principles and approaches.

The eight countries accept and share the notion that protection and promotion of health and the tackling of the

health challenges cannot be solved by the health sector alone. They believe that actions in all government sectors and in all of society, at any level – personal, institutional, community, municipal or national – are needed to nurture and improve the health and well-being of the population.

The governments of the Small European Countries initiative for health actively support the collective effort of the member nations, in order to better addressing the social determinants of health and health inequalities, strengthening leadership and participatory management for health. Their collective effort also include improving health throughout the life-course, tackling the burden of non-communicable diseases, strengthening people-centred healthcare and public health systems, and creating resilient communities that can withstand social and economic transitions.

The main tool for achieving these goals is the development of specific projects and programs addressing areas of health and health care, which are jointly identified to be of particular impact and benefit for the population.

The small countries initiative project

In order to pursue the common willingness to strengthen their role and visibility in the context of the European health programs, the eight small countries agreed to develop a common unifying project finalized at implementing Health 2020 (3). The Health 2020 framework recognizes the differences between and within countries in the region, and it can thus be adapted to their different circumstances. Countries may in fact have different starting points; however, they can be equally effective, in aligning their health policies and strategies with Health 2020. This is the case of the eight small European countries, which root their consortium on the needs they share

Table 2. Common Intersectoral actions for health: projects identified to be of strategic importance for public health by the eight nations members of the WHO Small European Countries Initiative

- Tackling child obesity and sedentary lifestyles
- Fighting sexual abuse, exploitation of children and child pornography
- Improving school approaches to healthy lifestyle. Nutritional education and physical activity
- Setting efficient alert systems for prevention of highly infectious diseases
- Reducing salt intake
- Promoting sustainable agriculture in school settings

in the area of health, and healthcare, due to the existing similarities in their geographic and population size and economic potentials. The particular aim of the project is to include equity and the social determinants of health into the national agendas developed by the small countries participating to this WHO-supported initiative.

In exploring the best ways to expand political and institutional arrangements, and to accomplish their common goals, the small nations use their available resources and consolidated experiences to work together on projects identified to be of strategic importance for public health (Table 2). One resource is the cooperative agreements established with the Regional Office, through its WHO European Office for Investment for Health and Development. These agreements provide excellent bases to rapidly advance the general common project.

The eight countries consider the participation to the WHO Regional Committee activities, a key event that provides an opportunity for small countries to speak with one voice on common, shared small country experiences that could help Health 2020 implementation.

The Small Countries Initiative follows the positive existing experience of other similar initiatives such as the Southeastern Europe Health Network (4). After the creation of the initiative for health, the small countries also expanded their active participation to existing networks, such as the WHO European Healthy Cities Network and the Regions for Health Network, and WHO collaborating centers.

Compared with nations with larger and often socially complex populations, small countries have advantages, such as a general strong social cohesion, as well as disadvantages such as facing challenges similar to those experienced by large countries, but with less capacity.

The approach established by the Small Countries Initiative is to work on specific projects within the frame of specific action lines, grouped under the Health 2020's two strategic objectives: (a) working to improve health for all

and reducing the health divide and improving leadership, and (b) participatory governance for health.

a) Working to improve health for all and reducing the health divide

Creating conditions beneficial for health, development, and well-being are closely related to the reduction of the health divide. The Small Countries initiative is actively engaged in implementing the operational synergy between health and other sectors, pursuing politics for innovative thinking; dynamic and new governance and health authority capacity to take up new roles promoting health and well-being.

Health services targeting users and focusing on health promotion and disease prevention are also implemented by the Small Countries Initiative, also pursuing the availability of a sufficient number and proper mix of professionals within and outside the health sector.

This important intersectoral collaborative work is obtained by several concurring approaches in different areas of intervention. For instance, the health sector can play an instrumental role in helping other ministries to identify goals and targets that are mutually beneficial. Further possible areas of intersectoral work where the issue of health inequalities could be integrated and maintained are migration and health. In fact, many ministries with different competences are typically involved in migration and health. In this regard, in some of the eight member countries, reforms have taken place with the concurring efforts of the institutions ruling the health systems and other ministries, such as social security, which is an example of another possible area of action. Such positive examples may motivate other ministries and state institutions to establish or participate to existing projects when they see that a common effort is feasible and visibly contribute to improvements in health. An additional factor promoting collaboration among different areas of competence is the inclusion of health as a priority in national strategies for sustainable development, which actively promotes synergies and partnerships that align actions across sectors for better health outcomes.

Effective health information systems have been developed successfully within the small countries as an important tool able to identify and uncover inequities. This factor is of particular importance to small countries due to their size, fast population changes, and particular needs. Health information systems are in fact intersectoral, with data stored in different ministries and registries, and collected by means of numerous surveys. Effective mechanisms are able to integrate information and store data, which are made available at all times to anyone, and allow the timely identification of problems to be rapidly addressed by proper interventions.

Accordingly, small nations do not suffer from the typical challenges related to health information systems faced by larger European countries, which range from regulatory to legislative aspects and include inadequate infrastructure for data collection. These challenges include the difficulties to identify proper mechanisms for regular integration of information, improvement of human resource capacity, and other barriers such as excessive data collection with little analysis, insufficient incentives for reporting and multiple demands from United Nations agencies.

This favorable condition avoids biases caused by the reporting of data, not infrequently adjusted to answer a specific data request, and resulting in incoherence that might often affect the correct development and application of health strategies of intervention on a large scale.

An important risk faced by small countries is, however, the common mismatch between data size and the required levels to reach significance, which is frequently caused by a lack of data from epidemiologic surveys. Precision in international surveys is also often too high for small countries where sample size is inadequate despite adjustments. This is the reason for the particular care and attention put by the local governments of the small countries in developing a reliable and closely controlled health information system and data collection and storage centers. This practice will contribute to reduce the risks and challenges represented by the requests of providing data to international organizations, which are frequent and often requested with short deadlines. An efficient data collection and the possibility to provide reliable and comparable data, allows a more efficient identification of country-specific needs, the identification of good practice that can be used or adapted for countries not meeting reporting needs, and an effective transversal cooperative approach among countries.

b) Improving leadership and participatory governance for health

The inclusion of equity and the social determinants of health in the development of their working agenda has

been a key factor for the development of effective common health politics within the Small Countries Initiative group. Although it could have been challenging for the small countries to distinguish health development from general development, due to the size of their small-population, such risks of inefficiency have been overcome by creating an effective common operational structure for working jointly. The key element is the opportunity to work in cross-sectoral teams, which meet periodically to share their policies and experiences; to methodically, and systematically re-examine the efficiency and quality of their health managing systems; and to decide improvement objectives and plans.

Small countries mainstream equity into WHO programs and networks, in order to help advance work on this issue. Contributing to this collaborative effort is the network of centers of excellence that are active in the majority of the eight small countries.

Implementing health in the eight small countries through developing an efficient Health Information System (HIS)

For small countries, the availability of valid, comparable health system indicators is essential. During the past few years, European countries have developed an efficient Health Information System (HIS) with the purpose to better deal with and monitor health issues of general and specific interest, which are becoming progressively complex. However, not in all nations is HIS progressing uniformly, as in the case of small countries where the building of HIS seems to be slower (3).

Small countries face peculiar issues in the organization and establishing an efficient HIS, which seems to be mainly related to difficulties in the cooperation among key players involved in the management of HIS and its implementation. By contrast, this is generally considered by many to be easier for small countries. In reality, in small countries there is a lack of health researchers in comparison with the potential availability in larger countries, due to the small human resource pool from which to recruit efficient and experienced administrators. In this regard, it is not infrequent that experts active in small countries decide to emigrate to countries offering better job opportunities. This is also true for trainees from small countries who prefer to remain in the larger countries where they performed their training, instead of facing the possibility that their services will not be needed on their return to their country of origin. Such circumstances emphasize the scarcity of personnel dedicated to HIS, which cannot efficiently provide the same volume of health information as larger countries.

Table 3. Availability of health information systems in members of the Small Countries Health Information Network-2016

	Cancer register	Cardiovascular	Causes of death	Cerebrovascular disease	Communicable diseases	Congenital anomalies	Dementia	Diabetes	Finance and administration	Health behavior in School	Children survey	Health examination survey	Health interview survey	Hospital discharges	Injuries/accidents	Maternity and birth	Medicines	Primary care	Rare diseases	Screening	Transplants	Vaccination		
Andorra	•		•	•					•				•	•		•					•		•	
Cyprus	•		•		•			•	•				•	•		•					•	•		•
Iceland	•	•	•		•					•	•		•	•	•	•	•	•			•			•
Luxembourg	•		•		•				•				•	•	•	•					•			•
Malta	•		•		•	•	•			•	•		•	•	•	•			•		•	•		•
Monaco			•						•					•		•								
Montenegro	•	•	•	•	•			•	•			•	•	•	•	•		•			•	•		•
San Marino	•		•	•	•	•	•	•	•	•	•		•	•	•	•	•	•	•	•	•			•

A recent study recently indicated that missing data in the WHO “Health for All” database unveiled an inverse relation between population size (small countries) and data availability of statistical significance for several health indicators. Particularly those related to less common diseases or relatively rare health circumstances, as opposed to indicators related to common occurrences and highly prevalent diseases, which were satisfactorily reported and available in the database. Such insufficient data reporting has a negative impact on several areas of healthcare due to the consequent difficulty by the national institutions to efficiently evaluate performances and effectively plan for setting and/or improving adequate health services.

In 2016, in order to better implement an efficient HIS, the small countries have developed and established, in collaboration the WHO European Region, the “Small Countries Health Information Network” (SCHIN). The main objective of SCHIN is working together and sharing experiences, expertise and good practice in a common effort finalized at strengthening and further improving their HIS.

As shown in Table 3, most of the small countries have independently well-developed separate informative HIS, collecting the single nations data from registers, surveys, and databases regularly implemented by local programs. Although data information are not available consistently for all health determinants in the database of the various nations, this network may provide an opportunity for sharing knowledge and competence among the eight small countries, facilitating the building of more compre-

hensive databases, benefiting from a reciprocal cultural and technical support.

There is a strong link between health information and health policy development in the eight countries. To this regard, the collaboration and support by National governments is a further key factor in the development of efficient HISs by the SCHIN, as it helps to properly address all legal issues related to international legislations and rules, including privacy and data protection.

Strengths and weaknesses in developing an efficient HIS

A strength in developing efficient HIS in small countries is the close collaboration between national statistical offices and other sectors, which is facilitated by personal contacts and easy access to health information brokers or data owners, including clinical service leaders. These advantages show the key opportunity represented by the close relationship and short distance between health information offices and policy-makers.

Weaknesses may be due to the possibility of conflicting interests among people working in close collaborating sectors such as health research and health policy, which may be further enhanced by the absence of an autonomous public health institute in small countries.

In addition, further negative factors may be represented by the lack of technical and administrative capacity, and insufficient legal and strategic frameworks, which could be a direct result of specific social characteristics, and

structural determinants, including the small population size and geography.

Particularly in very small countries, an insufficient technical and administrative capacity may lead to dependence on institutions based in other larger countries, and a possible consequential underreporting and underutilization of the data collected.

Finally, small countries are affected by a disproportionate reporting burden, especially if under pressure for reporting to international organizations, which represent and further factor of weakness. In fact, multiple data and questionnaires that repeat similar requests and require a separate data submission are frequently requested and expected by different organizations.

Major health issues and programs in the eight members of the WHO Small Countries Initiative

The eight European nation members of the WHO Small Countries Initiative face health issues that may be considered similar in relation to their geographic and population dimensions. However, Table 4 reports a selection of major health indicators characterizing the eight small countries, which show that differences exist among these countries. The initiative supported by WHO allows the eight member countries to share experiences and expertise that enable the single governments to properly and efficiently tackle health issues that are identified to be of significant importance for the single nations.

Different countries face different health issues, which can be however confronted with a shared vision and strategy and a common approach. Below is reported a selection of case stories, which describe health programs performed in the single countries using an intersectoral approach, which may represent an effective model for larger countries.

Andorra

A selection of major health indicators recommended by WHO programs are remote in Table 4. In Andorra, among 11 to 12-year-old children, 8% were overweight and 5.5% were obese. Such evidence stimulated action to stop this trend, which may cause an increase of overweight and obesity in future generations facilitating a significant increase of noncommunicable diseases (NCDs).

Prompted by the 2004 data from the country's first national nutritional survey, which showed increased levels of overweight and obesity, the Nereu Association, a local non-governmental organization (NGO), promoted a health program called the Nereu program.

The aim of the program was to reduce significantly the prevalence of obesity in line with the Andorran Health 2020 goals, by reaching 60% of overweight or obese children in the country. The program's strategy is based on promoting a change towards or maintenance of healthy eating habits in primary school-age children who are overweight or obese and have sedentary lifestyles. Changes were planned to be accomplished by engaging children in regular physical activity and healthy eating involving their families. The program started in 2015 with a pilot project for overweight and obese children with sedentary lifestyles in seven schools in Andorra where children attended three weekly extracurricular physical activity lessons. Through this program, children practiced new skills involving different sports, and received information on healthy eating and lifestyles. Families were involved in a bi-monthly behavioral counselling sessions held by dieticians who instructed families on healthy eating and physically active lifestyles. The program follows an intersectoral collaborative approach. The Ministry of Health leads the Nereu program, promoting it in partnership with the Ministry of Education and the Ministry of Culture, Youth and Sports. These ministries have a history of working together on an education for health program and in implementing activities in the national strategy for nutrition, sport, and health. The Ministry of Health is also responsible for managing user data, and monitoring and evaluating the pilot phase. The Nereu Association, coordinates, monitors, and supervises the program's implementation. The Ministry of Education manages the extracurricular sports activities and reports progress to all involved sectors. The State Sport Secretariat stimulates the involvement and participation of sports clubs. The Andorran School for Training Sport and Mountain Professions also participates in the program by providing sports counsellors for extracurricular activities. The media supports the program by media information activities including the Andorran television.

The intersectoral work included the establishment of a committee including the Ministry of Health, the Ministry of Education, and the Nereu Association, which meet regularly. The Ministry of Education made available its intranet to keep internal stakeholders informed, and a web-based platform was set up for coordination.

The Ministry of Health's budget provides primary funds for the program, and the Ministry of Education funds physical activity sessions.

Among the main challenges faced by the program is often the work schedule of families, which in many cases are employed in the tourism industry and therefore may

Table 4. Selection of major health indicators of the eight European nations members of the WHO Small Countries Initiative for health

Indicator	Andorra	Cyprus	Iceland	Luxembourg	Malta	Monaco	Montenegro	San Marino
Population (year World Bank Report)	76.951 (2018)	849.800 (2016)	337.780 (2018)	590.321 (2018)	432.089 (2018)	38.695 (2018)	629.219 (2018)	33.328 (2018)
% of population aged 0–14 years (year WHO report)	15 (2014)	16 (2014)	21 (2009)	17 (2014)	14 (2014)	10 (2016)	15 (2017)	13.4 (2017)
WHO Estimated infant mortality x 1000 live births (year WHO report)(2016 EU average 4.0)	2 (2015)	3 (2015)	1.9 (2015)	2 (2015)	5 (2015)	3 (2015)	4 (2015)	2.18 (2017)
Estimated life expectancy (year WHO report)	83 (2013)	80 (2015)	83 (2015)	82 (2015)	82 (2015)	82 (2013)	76 (2015)	85.2 (2017)
Hospital beds / acute care pediatric beds, group specialties x 100 000 (year WHO report)	254/18 (2009)(2010)	341/32 (2014)(2018)	314/NA (2015)	484/NA (2015)	488/21 (2015)(2015)	2113/NA (2014)	393/44 (2014)	358/28 (2014)(2018)
Acute care hospital beds, pediatric group of specialties (year WHO report)	15 (2007)	277 (2018)	NA	NA	88 (2015)	NA	278 (2016)	9 (2018)
Incidence of tuberculosis x 100 000 (year WHO report)	8 (2014)	5 (2014)	2 (2014)	4 (2014)	11 (2014)	0 (2014)	18 (2014)	0 (2017)
Infant deaths x 1000 live births (year WHO report)	6 (1999)	2 (2013)	2 (2015)	2 (2014)	5 (2014)	5 (1999)	6 (2009)	2.18 (2017)
Life expectancy at birth (years) (year National census)	82 (2006)	83 (2013)	82 (2009)	83 (2014)	82 (2014)	89.4 (2017)	76 (2009)	85.2 (2017)
Life expectancy at birth (years), males (year National census)	77 (2006)	80 (2013)	84 (2009)	80 (2014)	80 (2014)	85.6 (2017)	73 (2009)	82.6 (2017)
Life expectancy at birth (years), females (year National census)	84 (2006)	85 (2013)	80 (2009)	86 (2014)	84 (2014)	93.5 (2017)	78 (2009)	86.8 (2017)
Live births x 1000 population (year WHO report)	8 (2015)	11.1 (2014)	13 (2014)	11 (2015)	10 (2014)	26 (2015)	12 (2014)	8 (2017)
Physicians/*Pediatricians x 100,000 (year WHO report)	316/22 (2009/07)	338/32 (2014/18)	378/5 (2015/14)	292/15 (2015/14)	391/15 (2015/14)	664/28 (2014/12)	234/27 (2015/14)	150/8 (2017)
Fecundity rate (2014 European average 1.58) (year WHO/ World bank data reports)	1.4 (2017)	1.37 (2017)	1.8 (2016)	1.62 (2017)	1.45 (2016)	1.53 (2017)	1.7 (2016)	1.19 (2017)
Total health expenditure as % of GDP (year WHO estimates)	8 (2014)	7 (2014)	9 (2014)	7 (2014)	10 (2014)	4 (2014)	6 (2014)	8 (2017)

*Data are for General Pediatricians, including: Pediatricians, Neonatologists, Medical interns or residents specializing in pediatrics. The following exclusion criteria applied: pediatric specialties (e.g. child/pediatric surgery, gynecology, cardiology, neurology others).

have shift work schedules that create difficulties to attend family counselling sessions.

A key factor for the success of the program is represented by the involvement of primary care professionals. They are the first line of contact in the community, which allows the health care system to identify families with children who might benefit from the Nereu program.

After the one-year pilot programme held in 2015, a full implementation of the Nereu program began 2016 and will last five years. At the end of this period, a final evaluation will be conducted to see if children have acquired and incorporated healthy habits into their everyday lifestyles.

Cyprus

A selection of major health indicators recommended by WHO programs are reported in Table 4. An important health issue, with important social implications, is for child sexual abuse and children's exploitation and pornography in Cyprus. This is a phenomenon of large magnitude (its estimated worldwide prevalence is 9.6%), which persistently affects Cyprus within the context of European children's health. Cyprus has developed a national strategy and action plan aimed at fighting this phenomenon, also establishing a dedicated an intersectoral ministerial task force including the ministers of education, health, justice and labor to coordinate preparation of a national strategy and action plan to protect children from all forms of sexual abuse and exploitation and pornography. The health of all children and their physical and psychological well-being, is the foundation for this plan and for the achievement of its strategic goals. Sex was considered, also ensuring that education initiatives would address boys and girls.

A particular focus was put on enforcing the existing legislation (issued in 2014), which is based on the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse. An important factor in this intersectoral approach is the coordinated support of the media, which helped raising the awareness of the population on this issue, which is considered of significant importance for the health of the Nation.

Due to its competence in these matters, the Ministry of Labor, Welfare, and Social Insurance is in charge of leading the taskforce, while the Ministry of Health provides technical expertise and assumes an advisory role providing scientific evidence. The existing WHO documentation and guidelines on violence and injury prevention helped in developing both the strategy and action plan.

As part of the intersectoral taskforce, the Ministry of Justice and Public Order established a specialized police group able to efficiently investigate sexual violence offenses against children, according to rural or urban location and the Ministry of Education and Culture offered seminars in schools for teachers on sex education, prevention of sexual abuse, sexual and reproductive health of adolescents, anti-racist policies and actions, diversity in school, and other similar key topics.

The private sector, including NGOs, psychologists, and social workers provided a useful support to fill the possible gap and insufficient human resources in the public sector.

The government provided an important further assistance by directly financing the initiative and putting an effort to significantly reduce bureaucracy and promoting open communication, which facilitate the intersectoral working group's interactions. An additional key factor was the frequent meeting of the task force.

Small country size and proximity facilitated the easy dissemination of the program, which has led to better links and collaboration among the governmental institutions and other sectors, offering a model to larger nations at European level. The outcomes are expected to be measured over a period of 5 to 10 years.

Iceland

A selection of major health indicators recommended by WHO programs are reported in Table 4. Due to recent significant demographic changes and economic challenges, Iceland has focused on developing effective strategies and programs aimed at preserving and improving health and wellbeing in all stages of life. An important part of these strategies is to finalize the development of a platform aimed at ensuring equality for all citizens by means of public health and disease prevention measures.

A key role in this strategy was to establish the Ministerial Council on Public Health. The main role of the Council being to promote dialogue and cooperation between ministers and ministries, to harmonize overlapping topics and areas of intervention and developing a comprehensive public health policy and action plan that could be possibly endorsed and adopted by the Government. The Prime Minister chairs the Ministerial Council, which include the Ministry of Health, the Ministry of Education, Science and Culture, the Ministry of Social Affairs and Housing, and other key ministries, such as the Ministry for the Environment. The Council also involves a wide range of public a private sector stakeholders, such as representatives of unions, public health centers, universi-

ties, and associations. Through its intersectoral work, the Council aims to improve health, wellbeing, and equity in all stages of life with a special emphasis on children and adolescents.

The health-promoting community project is implemented throughout Iceland and supported by its inclusion in the state annual budget. It assists communities at a local level to work across sectors, and creates favorable environments that promote the health and well-being of all inhabitants, emphasizing health in all policies. These participatory mechanisms have brought together stakeholders from different sectors, which has facilitated communication, joint understanding, and a sense of ownership among those involved. An important lesson learned was the importance of using language and concepts to which everyone could relate. Showing other sectors how best promoting public health and well-being and reducing health inequalities helped them to reach their goals and facilitated the accomplishment of immediate public health goals, as well as to improving public health in all age groups in general.

Luxembourg

A selection of major health indicators recommended by WHO programs are reported in Table 4. Obesity in childhood is considered one of the main health issues in Luxembourg, due to its implications in the development of chronic diseases in adult life, including diabetes, metabolic syndrome, and cardiovascular complications, which have a significant economic impact for the country. Official data show that in 2014, 26% of boys and 14% of girls aged 11 years were overweight or obese. In particular, data from the national medical school surveillance system showed that 14.1% of boys and 14.3% of girls in primary schools are overweight or obese.

Such alarming data prompted governmental action to raise awareness among the population and to provide information on the importance of healthy lifestyles for physical, mental, and social health; promote balanced nutrition; and increase the quantity and quality of physical activity in the population, particularly among children and adolescents.

The current programs of intervention are based on the 2006 national project “Get moving and eat Healthier,” which was developed in Luxembourg with the aim of increasing physical activity and promoting balanced diets for the entire population. This project is currently adopted by approximately 1000 communities, which offer sports opportunities for all ages, sexes, and interests. The key factor for its success was the intersectoral approach tak-

en by the Ministry of Health, which could not have been successfully developed alone. The proposal of the health project usefully stimulated a national debate in Parliament on obesity, and four ministries, including Health, Sport, Family Affairs Integration, and Education, Children and Youth, planned to work together. An additional contributing factor is the involvement of the private sector, such as sports clubs and school canteen suppliers, in local communities. Within the frame of the project, school catering services also started offering healthier foods in canteens and the media played an important role by promoting sport and balanced diets. The decision taken by the Prime Minister to support the project facilitated the engagement of public and private sectors. The four ministries formed an interministerial group, coordinated by a staff member in the Health Directorate, to jointly plan and monitor the project and the effectiveness of its strategy, with a special focus on increasing physical activity and promoting a balanced diet. Most importantly, funding for this project is shared between cities and ministries.

Small country size was certainly a great advantage, facilitating the ability to reach the population in an equitable manner. Although initially sports federations or fitness clubs, were not inclined to promote low-priced fitness options, they understood that promoting sport for all would benefit the whole population, won over any resistance and ultimately they provided their full support to the project. This has led to an increase in demand for trained professionals who can teach sports. The project has stopped the further increase of the prevalence of obesity in Luxembourg. A constant monitoring of its results will provide further indications on the possible reduction of this pathologic condition and on the benefits for the population, with particular reference to a better control of chronic diseases.

Malta

The publicly funded healthcare system is the key provider of health services in Malta. The Ministry for Finance is generally responsible for Malta’s economic policy, including healthcare and public health in general, preparing the government budget as it collects and allocates taxes and revenue. The Ministry for Health is responsible for the provision of health services, health services regulation and standards, and the provision of occupational health and safety. The health system in Malta is publicly financed and it provides a comprehensive basket of health services to people residing in Malta, who are covered by the social security legislation.

The Ministry for the Family and Social Solidarity is responsible of issues related to social policy and the policy

related to children, families and persons with disability, elderly and community care, social housing, social security, pensions and solidarity services. Other players include other government ministries, the Foundation of Medical Services, government commissions, agencies, boards and committees, professional regulatory bodies and professional groups, private, religious and voluntary sectors. The private sector complements the provision of health services, in particular in the area of primary health care. Services related to long-term and chronic care are in large part provided by the private sector, including religious and voluntary organizations.

The gross domestic product (GDP) in Malta was worth 15.10 billion US dollars in 2019, according to official data from the World Bank and projections from Trading Economics. The GDP value of Malta represents 0.01% of the world economy. Total health expenditure as a percentage of gross domestic product was nearly 10%. When compared with the same period of 2018, Malta's GDP increased by a significant 4.8% in the first three months of this year. Such an increase surpassed the growth of all countries within the Euro area. Of this, a third was private spending, public spending was below 7% of GDP. Lately the increase in private spending has outpaced public health expenditure growth.

General tax revenues fund the public system in Malta. All tax incomes feed into the Consolidated Fund from which all public budgets are drawn on an annual basis; the health sector competes with other public sectors for funding. Out-of-pocket payments and voluntary health insurance are the main private sources of health financing. The out-of-pocket payments account for basically all private healthcare expenditures and include a comparatively high percentage of total spending in comparison with other European countries. However, some external financing has contributed to infrastructure investment, including the EU structural funds. Healthcare centers in Malta include five public hospitals, of which two are acute and three are specialized, and two private hospitals. A loan from the Council of Europe allowed the construction of Mater Dei hospital, which is the main public hospital in Malta.

A selection of major health indicators recommended by WHO programs are reported in Table 4. A comprehensive school approach to a healthy lifestyle, policies, and strategies to promote healthy eating and physical activity are regularly and actively implemented in Malta, as the major health challenge affecting schoolchildren in the country is overweight and obesity. In 2012, 47% of 11-year-olds were reported to be either overweight or obese with boys showing increasing trends.

Due to such alarming data, the health and education sectors joined efforts to implement a national school-wide policy and strategy program, in order to achieve better physical activity and nutrition for all schoolchildren, and create a level playing field in all schools. The principle was to offer equal opportunities for all children to engage in physical activity and benefit from improved nutrition in school settings.

A specific program called “A whole-school approach to a healthy lifestyle: healthy eating and physical activity”, is active in Malta, including initiatives that target adolescents in secondary schools. An intersectoral action was developed on existing relations with the education sector further enhancing the opportunities to identifying common goals and working towards them. This approach included for instance dance sessions, which are offered to students during class breaks in accordance with the adolescent girls' preferences. Changes to the types of foods sold in school-based snack shops are also implemented in order to promote healthier eating, and cooking classes on healthy meals for children and parents are proposed in schools as part of the extracurricular activities. Furthermore, a campaign to encourage healthier lunchboxes was promoted by television, radio, and social media.

Governmental institutions are fully involved in the development of policy and strategy of this operational approach. In particular, education and health sectors share the lead and established an intersectoral working group. Civil society is involved at different levels. Parent associations are consulted regularly and the media play an active role in promotion and information dissemination. As a positive important result, the school-based snack shops, controlled by private sector organizations, changed their purchasing choices, as well as food companies were informed of mandatory nutrient levels and sought to promote healthy products complying with the WHO nutrient model. Sports clubs, also controlled by private sector, are now progressively promoting health-enhancing physical activity at schools. For instance, during the summer break, children can enroll in non-competitive swimming classes. From the financial point of view, no additional funding was required for policy and strategy, as each sector used its own budgets and staff time.

These programs aimed at protecting children's health, faced several challenges, mostly related to the resistance shown by the private sector in various circumstances. For instance, fruit juice vendors were initially trying to promote commercial juices arguing that they were fresh fruit equivalents. The important lesson learnt in the development of this program, which can be offered as a useful ex-

perience to larger nations, is that successful intersectoral collaboration requires the effort of each sector to be complementary, as conflicting goals may hamper its success.

Monaco

A selection of major health indicators recommended by WHO programs are reported in Table 4. The health programs of Monaco are particularly concentrated on controlling infectious diseases and protecting the population of all ages against this threat. This is due to their potential to spread very fast and therefore on their particular risk for small countries such as Monaco presenting a high density of population and a large number of visitors by sea each year. From 2013, Monaco has developed a structured alert system for dealing with the arrival of highly infectious diseases. The alert system is based on a coordinated approach at ministerial level, so that affected individuals can receive immediate and appropriate care, while the protection of health workers is ensured.

The programs of intervention have their operational core in the “crisis unit,” which is supported by a team of intersectoral stakeholders and assisted by effective procedures. The crisis unit is convened with relevant sector officials who are in charge of single tasks according to their expertise. The activity of the crisis unit is based on the application of International Health Regulations, which include specific protocols for the health workers and procedures to be followed by all the National infrastructures in the management of affected people. For instance, it is required that every ship entering a foreign country to submit a Maritime Declaration of Health to the Port Authority within 24 hours of arrival. In the event that highly infectious diseases are identified on board, the police are notified, and the Ministry of Health and Social Affairs informed. Several different government institutions are involved in making this procedure effective. The Ministry of Interior receives the Maritime Declaration of Health from the police officers working in the field; the Ministry of Health and Social Affairs alert hospitals upon receipt of the information and hospitals provide care to the affected individuals. Firefighters, who are part of the armed forces, provide rescue services, logistics for citizen protection, and organization of transport to the hospital by protected ambulances. The Department of Maritime Affairs, with the Port Authority, facilitates the docking of the ship, in order to efficiently evacuate sick people while limiting ship crossings at that moment. The intersectoral approach described above, provides an example of collaboration among National institutions, which can be also activated to challenge different health issues. The essential part of the strategy is the support by media, which significantly help to raise the awareness among the population, by dis-

seminating general information about the activity of the crisis unit through their information channels.

This approach emphasizes the notion that bringing together sector-specific expertise facilitates work and the outcome of the interventions. The experience matured in Monaco suggests the need to train all sectors to coordinate and follow established procedures, which should be periodically tested and updated. Regular training of health workers in the workplace are instrumental to minimizing the risk of occupational exposures to infectious diseases. Intersectoral collaboration is a consolidated approach to health issues in Monaco, and the experience has been positive for all sectors involved, possibly serving as a model to larger nations.

Montenegro

A selection of major health indicators recommended by WHO programs are reported in Table 4. National data reports published in 2012 indicated that circulatory system disease affected approximately 50% of the population nationwide in Montenegro. This evidence prompted Montenegro to develop a strong program aimed at reducing salt intake in the population. The reduction of dietary salt intake is considered by Montenegro one of the most cost-effective public-health measures, as an excessive dietary salt intake is directly linked to the development of several NCDs, which are the leading cause of death worldwide. The key factor in the implementation of the strategy for reducing dietary salt intake is the intersectoral approach and action taken by Montenegro’s governmental institutions. There is a positive awareness at national level and among policy-makers that NCD risk factors threaten public health and have a negative economic impact and a negative influence on the National development. This led to an effective health cooperation among public and private sectors, especially with the food and catering industries, because a large part of salt intake is hidden in foods.

A 12-year program (2014–2025) whose goal was to reduce to below 5 g/day per capita the salt intake in the general population is currently active in Montenegro, along the lines of the WHO recommendations. The program plans a reduction in salt intake by 16% over the 2014–2020 period and by 30% by the year 2025.

The initiative demonstrates the importance of intersectoral work. In fact, the health sector shared epidemiologic data with the agriculture sector to communicate that excessive salt intake was a health risk factor. The intersectoral action involving health, agriculture, and the private sector has been developed as a founding principle, and a

multidisciplinary core group was established to develop the draft program for reducing dietary salt intake. A sustainable reduction in salt intake requires both broad intersectoral involvement and broad awareness among the population. An ongoing efficient system of collaboration and communication channels is maintained constantly active by means of periodical consultations, allowing a reduction of salt intake and beneficial results for the population's health, while at the same time assuring that business would not suffer. This mechanism of technical consultations between health, agriculture and the private sector/industry helped to achieve expert consensus, policy-maker commitment and agreement on maximum salt thresholds.

High-level political support and diverse stakeholders including community, civil society, and local municipalities are involved in the program, and the media have a key role in promoting the program and raising awareness among the population on the importance of reducing salt intake.

A national council to support the implementation of the NCD strategy was also established with the Prime Minister acting as council chair. The lessons learnt from this sectorial initiative in the area of public health, emphasize the importance of engaging from the beginning different sectors and to establish regular information sharing. The existence of subregional technical networks in Montenegro facilitates the exchange of knowledge, lessons, and experiences. This model further proves that social and financial benefits are generated by investing in disease prevention, which can be considered as a model for nations with larger populations and with more complex society dynamics and economies.

San Marino

A selection of major health indicators recommended by WHO programs are reported in Table 4. The Health Ministry equivalent in San Marino is the State Secretariat for Health and Social Security. It is structured in two branches, the Health Authority, which is the technical arm of the Secretariat that coordinates and develops health policy, and the Social Security Institute, which is in charge of the management and delivery of health and social services and their implementation.

In San Marino, disturbing reports from the WHO European Childhood Obesity Surveillance Initiative study showed that in 2014, 31% of primary schoolchildren were overweight or obese. In order to best tackle this issue, the Government of San Marino established a program of interventions, the strategic goal of which was to ensure that all children in the country had access to sustainably

grown nutritious foods in school and educational opportunities to learn about healthy food. Sex, equity, and human rights are considered important elements of this program, and all children in San Marino have the right to have a healthy diet, and full support is offered to those who cannot afford to pay for school meals.

Education on nutrition and beneficial agricultural components have been incorporated into the existing projects on nutrition in schools. Actions based on intersectoral approach are used to promote balanced diets and food quality standards that prevent overweight and obesity among children. An important opportunity to further implement health programs in the area of nutrition and healthy food in recent years has been through the World Exposition hosted by Milan, Italy, in May 2015 (EXPO 2015), its leading theme was "Feeding the Planet, Energy for Life."

The programs aiming at tackling obesity are effectively backed by specific Congressional resolutions issued by the Parliament of San Marino, which established a multidisciplinary and intersectoral working group for planning and coordination of the health promotion and education interventions in schools. Along this line of public action, the Minister of Health, with the support and coordination of the Health Authority (Institute for Social Security), provided guidelines on health education in school settings, and guidance to dietitians and pediatricians on menu development and special diets. An intersectoral initiative, including the Ministry of Education, was also developed, which ensures that a close collaboration is maintained between school science lessons and off-campus workshops. In addition, the Ministry of Tourism is in charge of emphasizing internationally the quality of the agricultural products of San Marino, and the public and private agricultural sector (consortium) organize workshops for schoolchildren presenting and discussing their different products. A key role is represented by the media system, which promotes best nutritional practices, by broadcasting programs dedicated to food quality and healthy diets.

The policy of cooperation among sectors involved in public health is a key element for establishing successful health programs in San Marino. A positive understanding by all stakeholders regarding the benefits of integrated work helps streamline activities and lead to better coordination, which can be considered by larger nations as an effective operational model.

Conclusions

The Small Countries Initiative for health, developed with the full support of the WHO, and its case stories may offer

a good operating model to larger European nations. Each small country involved presents specific health issues that need to be challenged, managed, and resolved. Such health issues may be different in nature or importance among the nations. However, the principles that inspired the eight participating countries in building the initiative, are based on the belief that a system founded on a close network of open and unconditioned cooperation, as well as on the sharing of experiences and expertise within the group, will facilitate the capability to develop effective solutions locally.

SCHIN was developed with this intent. The Governments of the eight small countries believe that a well-defined and articulated operating model is in fact an effective bridge between strategy and day-to-day operations that guides the teams, provides the context, and enables the behaviors that will realize the strategy and vision in key areas, as in the case of healthcare and public health. The Small Countries Initiative operating model is not the strategy itself. However, it does help refine and reinforce it, as well as it does not provide operational instructions, but it does help guiding them.

The eight countries also recognize the benefit of networking at international level. The SCHIN is an effective tool, which is expected to help in dealing with the challenge represented by the numerous data collected in areas of common interest for health. A further expected advantage of this cooperative approach is the focusing on ways to rationalize the multiple, uncoordinated data requests by international organizations to the eight states and the collection of valid data, which can be harmonized and made comparable. By the joint and effective reporting of health indicators, the small countries will be able to contribute to elaborate proper solutions for the growing and articulated health issues faced by the whole group of the European nations.

Small countries have very different HISs and each country exhibits certain unique strengths and challenges; nonetheless, there are several common elements and issues that can be better addressed in a joint manner. Operating models exist along a continuum based on a combination of a nation's context and complexity. Regardless of size, all nations should have an operating model, which should be maintained and implemented to help bridge the gap between the why and the how. The small countries are convinced that their operating model may offer useful insights to larger countries and to the whole forum of European countries in general, to better and efficiently deal with their health issues.

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