

REVIEW ARTICLE

The South Eastern Europe Health Network: A model for regional collaboration in public health

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Abstract

Inter-country alliances, articulated through regional approaches, have increasingly been used to drive economic development and social progress in the past several decades. The South Eastern Europe Health Network (SEEHN) stands out among these types of initiatives for the tangible improvements it has achieved in regional governance for health, with several important lessons for public health leaders worldwide.

This review paper, written by several key participants in SEEHN operation, follows the main milestones in network development, including its foundation under the Stability Pact's Initiative for Social Cohesion and the three ministerial forums that have shaped its evolution, in order to show how it can constitute a model for regional collaboration in public health.

Herewith we summarise the main accomplishments of the network and highlight the keys to its success, drawing lessons that both international bodies and other regions may use in their own design of collaborative initiatives in health and in other areas of public policy.

Keywords: collaborative networks, health systems, public health, regional cooperation, South Eastern Europe.

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Introduction

Inter-country alliances, articulated through regional approaches, have increasingly been used to drive economic development and social progress in the past several decades. The European Union (EU), with its common currency, open borders and well-established governing institutions, is the most consolidated regional political alliance, but many other blocs have been established across the globe as a way to catalyse development and cooperation. Although founded primarily to promote free trade – not social cohesion or justice – their leaders have gradually begun to understand that social and economic development are inextricably linked.

The Charter of Fundamental Rights (part of the Treaty of Lisbon) set the stage for dozens – if not hundreds – of EU-led initiatives in public health and education, including the Black Sea Cooperation and the Union of the Mediterranean. Other regions have taken steps to articulate a common approach to public health as well, for example in Asia (1) and South America (2). The South Eastern Europe Health Network (SEEHN) stands out among these types of initiatives for the tangible improvements it has achieved in regional governance for health, with several important lessons for public health leaders worldwide.

This paper follows the main milestones in SEEHN development, including its founding and the ministerial forums that have shaped its evolution (<http://www.myhistro.com/story/seehn-founding-story/147935/>), in order to show how it can constitute a model for regional collaboration in public health. Herewith we highlight the keys to success and draw lessons that both international bodies and other regions may use in their own design of collaborative initiatives, in health and in other areas of public policy, paying due attention to the specific context of the region.

The roots of SEEHN development: Public health as a bridge to peace, reconciliation and development

In the decade following the disintegration of the Soviet Union and the neighbouring Yugoslavia, the South Eastern European (SEE) region plunged into a long period of turmoil, transitioning rapidly from a state-command to market economy amidst the violent combustion of ethnic tensions in the former Yugoslavia. The consequent financial instability, decline in social expenditures and inadequate organisational structures (3,4) led to a breakdown of already tenuous health and social care systems. When Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Republic of Macedonia, Romania and Yugoslavia signed the Stability Pact for South Eastern Europe in 1999, the health indicators in these regions reflected that crisis. As just one example, infant mortality in the SEE region nearly tripled that of the EU-15, at 13.9 deaths per 1000 live births (5).

Although the “non-productive” social sector was deemed by the states as a consumer of income rather than as a producer of value (6), investing in public health was nevertheless considered a worthy way to maintain social unity. It was also considered as a particularly appropriate area for regional cooperation; after all, the tradition of public health in SEE dates back to one of the key architects in the creation of the World Health Organization (WHO), Dr. Andrija Štampar, a fitting symbol of how health can function as a force of peace and cooperation between otherwise fractious governments. In 2001, the SEEHN was established as part of the Stability Pact’s Initiative for Social Cohesion, under the leadership of the Council of Europe, the Council of Europe Development Bank and the WHO Regional Office for Europe.

At the same time, the need to reconstruct the training programmes for public health professionals, especially in the successor states of the former Yugoslavia, became obvious.

Therefore the German sponsored section of the European Stability Pact agreed to fund the Forum for Public Health in South Eastern Europe (FPH-SEE) (7) from 2000-2008 with the following main objectives:

- i. To develop up-to-date teaching materials for public health sciences;
- ii. To determine and analyse comparable health indicators for South Eastern Europe;
- iii. To support the institution building for public health, especially with regard to Schools of Public Health, Institutes of Public Health and Public Health Associations;
- iv. To organise professional meetings, workshops and conferences in the South Eastern European Region.

During this period, six volumes with more than 3500 pages of teaching materials were published (8) and their utilisation analysed (9) with a 2nd online edition in 2014 (10); a revised shortlist of indicators was published in 2006 (11), and new Schools of Public Health were established in Belgrade, Bucharest, Chisinau, Novi Sad, Pleven, Skopje, Sofia, Tirana, and Varna. By 2008, more than 25 conferences and summer schools had been organised and more than 50 articles been published, beginning with Kovacic & Laaser in 2001 (12).

Public health thus became the common denominator of both a political and academic movement to improve the health and wellbeing of the SEE populations. The strong commitment of the Ministries of Health in the region surfaced as an urge to address the emerging changes across the societies; together with the strategic guidance of SEEHN's external partners and burgeoning academic communities, the Ministers of Health of seven countries¹ planted the seed for an exemplary initiative of regional cooperation.

Learning by doing: Forging partnerships in public health to protect the most vulnerable populations (2001–2005)

The WHO Regional Office for Europe, along with the Council of Europe and the Council of Europe Development Bank, eleven donor states (Belgium, France, Greece, Hungary, Italy, Norway, the Netherlands, Slovenia, Sweden, Switzerland and the United Kingdom) and the health ministers of the founding member states themselves, worked to shape an institutional model capable of empowering national leadership as well as regional collaboration. The achievement of this goal is a testament to Member States' commitment to SEEHN's goals, particularly that of professional exchange and regional partnership, but it is also a result of the wisdom of external leaders and donors, who knew how to make their role redundant in just seven years.

The founding Dubrovnik Pledge committed the states to mobilising human and financial resources to meet the needs of their most vulnerable citizens. Seven priorities were laid out: (i) enhanced access to quality health and public health services; (ii) development of community health services; (iii) regional self-sufficiency in the provision of safe blood and blood products; (iv) integrated and universal healthcare; (v) better surveillance and control of communicable diseases; (vi) food safety and security, and; (vii) regional exchange of social and health information (13).

This first Health Minister's Forum set the political vision for SEEHN policy, but technical policy and implementation also had to be developed. At the beginning, the technical side was also led by experts from the Council of Europe, the Council of Europe Development Bank

¹ The founding Dubrovnik Pledge included signatories from Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Romania, the Republic of Macedonia and Yugoslavia. However, the Republic of Moldova joined a year later (2002), and in 2006, two independent countries (Montenegro and the Republic of Serbia) from the former Yugoslavia formally pledged their adherence. Finally, Israel joined the network in 2011, bringing current SEEHN membership to ten countries.

and the WHO Regional Office, together with the national health coordinators (high-level officials designated by each Member State). By 2004, however, this structure had given way to a rotating presidency, held personally by health ministers for a six-month term. These leaders, along with representatives of the Regional Office and donors, would hold a regional meeting of the national health coordinators, high-level officials designated by each Member State. The regional meetings would forge the technical policy through consensus among all participants.

As for implementation, regional project offices were established in the lead country for each technical area. Since then, these offices have managed and coordinated technical work at a regional level, fostering a collaborative network of professionals region-wide. Member States have chosen the project areas they led from the start, thereby cultivating ownership and leadership in one area and providing a natural incentive to collaborate and learn from initiatives led by other countries (14).

The first major SEEHN project, on mental health, was led by Bosnia and Herzegovina (15). Initially planned for just two years, its success led to a four-year extension, which has now been consolidated and given continuity through the transformation of the Sarajevo regional project office into the network's first Regional Health Development Centre, or RHDC (box 1). The mental health project also provided an excellent model on which to base subsequent initiatives during the first period of SEEHN development, which have successfully tackled blood safety (16), food safety (17), tobacco (18) and other challenges.

Box 1. Tangible achievements in mental health through SEEHN

Three million Euros from external donors provided the resources that experts within SEE needed to implement SEEHN's flagship project, which started by establishing a regional project office in Sarajevo as well as national offices and teams in all of the member states. These professionals worked together to analyse existing mental health policies in their countries and to set a common vision and strategy for the region; this work led to the endorsement of new National Mental Health strategies and laws in all Member States.

The second phase began in 2005 and saw the establishment of pilot mental health centres in every country, which provided a practical basis for the development of a regional model of service provision, including firsthand and collaborative experience in developing care standards, leadership modules and case management systems. A monitoring and evaluation system was also established, facilitating the exchange of data that would prove crucial to external consultants and regional partners in the refinement of policy and practice. Eleven centres, serving a catchment area of over one million citizens, were fully integrated into the countries' primary health care system, contributing greatly to the de-institutionalisation of people with mental health disorders.

The final phase focused on training and advocacy programmes, which seeded the reform movement for mental health policy in the region. When SEE health ministers released a joint declaration on mental health in 2007 (19), all Member States responded by revising their mental health policy in line with its recommendations. Today, dozens of mental health centres operate in every SEE country, supported by a clearly articulated national policy and a coherent regional framework, which are all in line with current European recommendations (20).

Moving forward: Reforming health systems and public health services (2005–2011)

By the second Health Minister's Forum in 2005 in Skopje, a reservoir of regional trust, expertise and leadership had accumulated. In recognition of the enhanced regional capacity for managing the network, an Executive Committee was established to oversee implementation of the decisions made during the ministerial forums, facilitate regional action

and monitor progress. The Skopje Pledge (21) also saw the assumption of SEEHN ownership over all regional projects, marking a decisive turning point towards a pro-active leadership. In 2008, and coinciding with the replacement of the Stability Pact by the Regional Cooperation Council, SEEHN's self-governance was consolidated through a Memorandum of Understanding. This document set new terms for network organization (Figure 1) and operation included by means of a formal Secretariat in Skopje (inaugurated in 2013) and a number of Regional Health Development Centres (RHDCs) across SEE. Starting in 2010, these were established to give continuity to the results achieved and to provide ongoing services and policy advice in particular areas of action. This structural configuration has allowed each country to benefit from the concentration of expertise in other Member States, without having to maintain national centres in all the technical areas at anything close to the same level. By pooling the resources, Member States all have access to world-class institutions in a variety of technical fields. These developments set the stage for SEE Member States to take full control of the network, although the WHO Regional Office and other partners would continue to provide technical input and guidance.

Figure 1. Governance of the SEE Health Network in 2014



The policy focus of SEEHN also shifted during this period. Without abandoning the strategic launch of individual projects in specific technical areas (indeed, the goals pursued in Dubrovnik were reiterated and affirmed), participants in Skopje pledged to apply the efforts of the SEEHN towards a comprehensive reform of public health capacities and services. Systematic problems in these areas had been identified during a study by the Council of Europe Development Bank and the Regional Office (22), including low levels of investment, poor workforce capacity, under-developed primary care services, and suboptimal follow-up and implementation of formal agreements. At the same time, the report highlighted the cascading effects of ill health on economic development, engaging the interest of the region's Finance Ministers. Together, the Ministers of Health and Finance in SEE recognised health as a vital part of the economic development and regional integration processes; they committed

to further regional collaboration, advocacy for intersectoral policy and empowerment of health professionals, in order to optimise the full economic potential of health as a means to increase productivity and decrease public expenditures related to ill-health.

The project that best illustrates this new focus was the Evaluation of Public Health Services in South Eastern Europe. A regional project manager in the Republic of Macedonia, along with the national focal points in other SEE states, collaborated at a technical level with the WHO Regional Office, which commissioned the development of an innovative web-based self-assessment tool to evaluate the delivery of ten Essential Public Health Operations. Assessments were carried out in all Member States in conjunction with technical experts from the WHO Regional Office, revealing a somewhat antiquated approach to public health services, which was still primarily focused on sanitation and hygiene rather than on a holistic integration of public health concepts throughout the health system and beyond. The final report (23) concluded with 11 specific recommendations for all SEE countries, as well as individual profiles on all Member States. These recommendations and observations have constituted the basis for sweeping reforms to public health services and capacities in the SEE region, which are still ongoing today. Likewise, the experience established SEE as a pioneer in efforts to strengthen public health services through a regional approach, setting an important precedent for the European Action Plan for Strengthening Public Health Capacities and Services (24), which would be eventually adopted by the 53 Member States of the WHO European Region in 2012.

Connecting the dots: Towards a whole-of-government, whole-of-society approach to public health (2011– present)

After conceptually consecrating public health's role as a pillar of the health system, the next milestone in the development of the network was to introduce a societal perspective. Given the social and economic diversity in the region and the rapidly changing national, European and global landscape, the SEEHN Ministers of Health sought to make health a priority on the agendas of all sectors and in all policies. The Third Ministerial Forum in 2011 brought the signing of the Banja Luka Pledge (25), with the ministers' unanimous commitment to sustain and strengthen the regional cooperation in public health in SEE; achieve equity and accountability in health; strengthen public health capacities and services; and foster intersectoral collaboration within national governments, with regional and international partners, and among all stakeholders interested in promoting sustainable health and wellbeing for the population.

Banja Luka marked the first ministerial forum in which the SEE countries had full control over the finances, policy direction and technical agenda, but rather than cut ties with international partners, the network strengthened them. The role of the Regional Cooperation Council was reaffirmed, and partnerships with almost all the important players from the international health and development scene were broadened. Indeed, this period has even seen a geographical expansion of SEEHN membership through the acceptance of Israel as a tenth Member State, a decision made to deepen the existing collaboration with that country, which had supported SEEHN since its inception. Likewise, the Banja Luka Pledge explicitly supported the vision of the WHO Regional Office and its main projects for strengthening public health, namely Health 2020 (26), the European Action Plan for Strengthening Public Health Capacities and Services (24), and the European Strategy for the Prevention and Control of Non-communicable Diseases (27).

At a technical level, the consolidation of managerial control and implementation structures in the hands of SEE experts has been very positive. The establishment of RHDCs has taken off,

and today, ten centres focus on mental health, antibiotic resistance, organ transplantation, human resources for health, blood safety, health care accreditation and quality improvement, public health services, communicable diseases, non-communicable diseases and healthy ageing. Together, the RHDCs represent a coherent, integrated, increasingly comprehensive response to the major public health challenges faced in the SEE region in the twenty-first century (14), both in the health sector and in the broader developmental agenda. Likewise, and thanks to SEEHN action, the recently adopted South Eastern Europe Growth Strategy 2020 (28) saw the incorporation of the health dimension as an integral part of inclusive growth, economic development and prosperity of the region. This politically important move has helped SEEHN follow through on its commitment to work for better health side-by-side with other sectors, including other government ministries, academia, civil society, and the private sector, to truly realize a whole-of-government, whole-of-society approach to public health.

Regional learning, global lessons

Among the many regional initiatives that give life to cooperation in South Eastern Europe, the ever-changing SEEHN, now in its second decade of life, emerges as an outstanding example of one that has implemented a wide range of successful initiatives with positive results in the realm of public health (Table 1). Its founding documents planted the seed for success, while strong political commitments from members and partners cemented its effectiveness and influence in the region.

Meanwhile, the political direction was shaped by local, regional, and global trends, especially those promoted by WHO, from the Health for All policy framework of 1998 (29) to the Health 2020 programme, currently under implementation. Isolated events (e.g., the 2014 floods affecting SEE, the H1N1 swine flu scare) have enabled a more mature understanding of the power the network embodies and of the moral obligation to cooperate for the benefit of the population.

In the SEE context, a network approach has a particular added value. The fact that Member States are relatively small, with limited leverage on the world stage, means that a unified position—in health or in health-related policies—amplifies their individual influence and power. This fact can be seen in international fora such as the WHO Regional Committee, where SEE countries speak with one voice. At the same time, the small size of these states may also constitute an advantage for governance, as involving relevant stakeholders and maintaining close links with the population is more straightforward than it would be in larger countries. Indeed, several countries were able to quickly mobilise assistance where it was most needed in response to the 2014 floods thanks to close connections with national social media networks (30). This lesson is relevant for other coalitions composed of small countries, for example the incipient sub-regional network of countries with less than one million inhabitants in the WHO European Region (still under development).

Table 1. Main accomplishments of the South Eastern Europe Health Network

TECHNICAL AREA	MAIN ACCOMPLISHMENTS
Mental health	<ul style="list-style-type: none"> • Establishment of ten pilot community mental health centres covering more than one million inhabitants as the basis for an entirely new mental health community-oriented system for SEE. • Decreased stigmatisation of mental health patients and increased acceptance in the community. • Establishment of information systems for community health services.
Antibiotic resistance	<ul style="list-style-type: none"> • Implementation of system for exchanging knowledge and expertise on antibiotic resistance and molecular diagnostics in SEE Member States.
Non-communicable diseases	<ul style="list-style-type: none"> • Ratification of the WHO Framework Convention on Tobacco Control and approval of tobacco control laws in all SEE states. • Passage of food safety laws and regulations to protect consumers.
Communicable diseases	<ul style="list-style-type: none"> • Development of regional hub for communicable diseases with online information portal and exchange platform (www.secids.com). • Strengthening of communicable diseases surveillance and response in SEE. • Support for implementation of the International Health Regulations, surveillance of communicable diseases and preparedness for disease threats and pandemics.
Organ donor and transplant medicine	<ul style="list-style-type: none"> • Establishment of regional centre of excellence for exchange of knowledge in organ donor and transplant medicine. • Expert missions for transfer of knowledge and skills in transplantation medicine (to Romania, Macedonia, Montenegro and Albania). • Bilateral collaboration in transplantation surgeries, with joint teams performing in Montenegro (deceased donor transplantation) and Macedonia (deceased donor and live kidney transplantations).
Accreditation and continuous quality improvement of healthcare	<ul style="list-style-type: none"> • Narrowing the gap with EU standards: promoting quality of care standards and patient safety in SEE. • Regular training of professionals on patient safety and accreditation procedures for hospitals and maternity wards.
Blood safety	<ul style="list-style-type: none"> • Increase in regional self-sufficiency of safer blood and blood components. • Narrowing the gap with EU standards: increasing blood availability and providing the highest donor and patient safety in transfusion therapy in emergency special circumstances.
Human resources in health	<ul style="list-style-type: none"> • Integrative and intersectoral approaches to provide excellence in human resources in health. • Leadership in profiling human resources in health across the region.
Public health services	<ul style="list-style-type: none"> • Expanded integration of public health services and increased outreach for health promotion and disease prevention. • Completion of a round of self-assessments of public health services of Member States as coordinated sub-regional action. • Development and updates of national strategies to improve maternal and neonatal health.
Healthy aging	<ul style="list-style-type: none"> • Work on participatory and empowering approaches, which include advocacy and stimulating activities for and with elderly people that result in “healthy living/active aging”. • Enhance the ability of SEE countries and communities to identify and implement effective strategies and programs to promote and protect the health of elderly. • Promotion of health and preservation of health-related quality of life for the elderly.

Although no regional public health alliance can be copy-pasted into a different geopolitical and socioeconomic context, there are a number of lessons for other coalitions, both in public health and in other areas of policy (Table 2).

Table 2. Keys to success in the South Eastern Europe Health Network

SEEHN STRENGTHS	DESCRIPTION
Structure	<ul style="list-style-type: none"> Decision-making structures aligned with regional leadership capacity. Balance of power among regional partners; countries lead in some areas and are led in others. Continuity; project offices transformed into sustainable Regional Health Development Centres.
Promotion of ownership among national and local stakeholders	<ul style="list-style-type: none"> Strong political commitment from national stakeholders required to move forward. Political direction for network decided by national leaders. Technical areas led by local/national stakeholders (with specific guidance solicited from external experts). Explicit recognition of leaders and good practices, supported by excellent monitoring and evaluation of programmes.
Utilization of regional assets	<ul style="list-style-type: none"> Good governance practices through pooling of human and financial resources. Strong historic tradition in public health.
Adaptive capacity	<ul style="list-style-type: none"> Dynamic organisation, with new decision-making structures emerging as experience accumulates. Policies are responsive to regional needs. New partnerships emerging on a continuous and ad hoc basis, without compromising regional ownership. Proactive capitalisation on investments made over the course of the network. Continuous efforts to mitigate challenges and limit the role of special interests.
Alignment with European and global movements	<ul style="list-style-type: none"> Close collaboration with WHO Regional Office for Europe, including in implementation of European and global policy and programmes. Common commitment among SEE countries to the political goal of integration into the European Union. Effective synergy between political and technical spheres of the network.
Intersectoral action	<ul style="list-style-type: none"> Evidence-based arguments tying health gains to economic development and security for the SEE region. Integration of health into a broader agenda for growth.

The most decisive strength of the network, perhaps, has been the positive role of SEE's political institutions. Although the countries making up the region had limited experience in government (indeed, many of the Member States had only just achieved independence), their leaders still demonstrated a key quality necessary for good governance: the commitment to accomplish both political and technical objectives through collaborative learning. External donors and partners had an important role in guiding the network development at its inception, but it was the national stakeholders who knew how to take advantage of the guidance and achieve operational ownership of the initiative.

Today, both new and old challenges await the incoming SEEHN Secretariat. To strengthen network operation, the Skopje office must lead the renewal of political and financial commitments from SEE Member States as well as initiate contacts with other regional initiatives and partnerships as part of the Regional Cooperation Council, including with the WHO Regional Office and the European Commission. In the same way, the network itself must be renewed by engaging new talents and allies within SEE and beyond. The official SEEHN website (<http://studiorum.org.mk/seehn/>) will see further development as a platform to disseminate network achievements, and the Secretariat will also work to integrate SEEHN action into the daily work, not only of Ministries of Health, but also the authorities in charge of international affairs and trade. This new line of work in health diplomacy is incredibly

timely, as globalisation has increased interdependence in human and economic development as well as internationalising public health emergencies.

Imminent projects to tackle these new challenges will be the formation of an emergency coordination aid task force and the development of a strategy to address health professional mobility, as the network continues to pave new roads for regional cooperation in public health. By strengthening the bonds among SEEHN Member States through trust and shared governance for health, these countries will themselves become stronger and more capable of achieving common objectives. In essence, SEEHN exemplifies a positive policy cycle, in which population health, regional cooperation and economic development have mutually fed into each other for the benefit of everyone, from the most vulnerable populations all the way up to their highest elected officials.

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