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POTENTIAL OF THE SEEHN MEMBER STATES TO IMPLEMENT HEALTH 2020 AND LOCALIZE SDGS THROUGH LOCAL PLANNING FOR HEALTH AND WELLBEING

1. Introduction

A healthy community is one in which all systems work well (and work together), and in which all citizens enjoy a good quality of life. This means that the health of the community is affected by the social determinants of health and development – the factors that influence individual and community health and development[1].

The keywords of local planning for health and wellbeing are the following: governance, governance for health, health equity, health inequality, health in all policies, health literacy local, policy planning, social capital, health, and wellbeing. Understanding the concepts behind those keywords is important for those who embark in the journey of policy development and implementation at local level. European policy framework for health and

1 "Chapter 2. Other Models For Promoting Community Health And Development | Section 3. Healthy Cities/ Healthy Communities | Main Section | Community Tool Box". Ctb.ku.edu. N.p., 2017. Web. 12 June 2017.

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well-being - Health 2020[2] (Health 2020) of the World Health Organization (WHO) incorporates all of those concepts and brings about a wealth of evidence of what works best for achieving health and wellbeing at both national and other levels of governance in a country, including local level.

Coherence in policy for health and wellbeing at all levels of governance in a country is of importance for organizing societal efforts. The best way to achieve it is through coherent planning. Local and municipal planning for health and wellbeing presents a governance challenge for increasing social capital to achieve belter health and wellbeing of the population.

This paper aims to contribute to the most recent discussions of how to use Health 2020 and localize Sustainable Development Goals in the Member States of the South- eastern European Health Network (SEEHN): Albania, Bosnia and Herzegovina, Bulgaria, Moldova, Montenegro, the Former Yugoslav Republic of Macedonia, Serbia and Romania. Local planning for health and wellbeing is seen useful to this end.

This paper defines key concepts of community action for health and wellbeing, presents a snap -shot of the status of local governance and competencies in the selected countries and some conclusions in order to inform discussion on the potential for furthering community action through implementing Health 2020 approaches and localizing Sustainable Development Goals, at the local level.

2. European Policy for Health and Wellbeing – Health 2020 defines key concepts of community action for health and wellbeing

WHO defines **health** as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[3]. **Well-being** is an integral part of the WHO definition of health. It exists in two dimensions, subjective and objective. It comprises an individual's experience of his or her life, and a comparison of life circumstances with social norms and values.

2 World Health Organisation. (2012). Health 2020: the European policy for health and well-being. [online] Available at: http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being [Accessed 11 Jun. 2017].

3 Constitution of the World Health Organization. Geneva, World Health Organization, 1946 (Official Records of the World Health Organization, no. 2, p. 100; http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf).

Subjective well-being can include a person's overall sense of well-being, psychological functioning, as well as affective states. Examples of objective well-being and life circumstances include health, education, jobs, social relationships, environment (built and natural), security, civic engagement and governance, housing and leisure[4]. In addition, Health 2020 uses the term "**health asset**" to define, at a broad level, any factor (or resource) that enhances the ability of individuals, communities and populations to protect, promote and sustain their health and well-being. These assets can operate at the level of individual, group, community, and/or population as protective factors to buffer against life's stresses and as promoting factors to maximize opportunities for health[5].

Governance is about how governments and other social organizations interact, how they relate to citizens, and how decisions are taken in a complex and globalized world[6]. Governance for health is related to the attempts of governments and other actors to steer communities, countries or groups of countries in the pursuit of health as integral to well-being through both whole-of-government and whole-of-society approaches[7]. "**Whole-of–government**" refers to the diffusion of governance vertically across levels of government and arenas of governance and horizontally throughout sectors. Whole-of-government activities are multilevel, encompassing government activities and actors from local to global levels, and increasingly also involving groups outside government. Health in all policies is one whole-of-government approach to making governance for health and well-being a priority for more than the health sector, working in both directions: taking account of the impact of other sectors on health and the impact of health on other

4 Constitution of the World Health Organization. Geneva, World Health Organization, 1946 (Official Records of the World Health Organization, no. 2, p. 100; http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf). Measurement of and target-setting for well-being: an initiative by the WHO Regional Office for Europe. First meeting of the expert group, Copenhagen, Denmark, 8–9 February 2012. Copenhagen, WHO Regional Office for Europe, 2012.

5 Adapted from: Ziglio E et al. Maximizing health potential: the asset model for health and development. Copenhagen, WHO Regional Office for Europe (forthcoming).

6 Graham J, Amos B, Plumptre T. Principles for good governance in the 21st century. Ottawa, Institute on Governance, 2003 (Policy Brief No.15, http://unpan1.un.org/intradoc/groups/public/documents/UNPAN/UNPAN011842.pdf).

7 Kickbusch I, Gleicher D. Governance for health in the 21st century. Copenhagen, WHO Regional Office for Europe, 2012 (http://www.euro.who.int/__data/assets/pdf_file/0019/171334/ RC62BD01-Governance-for-Health-Web.pdf, accessed 21 June 2013).

sectors[8]. "**Whole-of-society**" refers to an approach that aims to extend the whole-of-government approach by placing additional emphasis on the roles of the private sector and civil society, as well as of political decision-makers such as parliamentarians. By engaging the private sector, civil society, communities and individuals, the whole-of-society approach can strengthen the resilience of communities to withstand threats to their health, security and wellbeing. A whole-of-society approach goes beyond institutions: it influences and mobilizes local and global culture and media, rural and urban communities and all relevant policy sectors, such as the education system, the transport sector, the environment and even urban design[9].

Local planning for health and wellbeing is about getting all stakeholders at local level together in planning for health for all. **Health for all** presents a policy goal consisting in the attainment by all the people of the world of a level of health that will permit them to lead a socially and economically productive life[10]. Contemporary global 2030 Agenda paraphrases health for all in "nobody to be left behind[11]".

Intersectoral collaboration has become a key approach to address major influences that shape the health of populations and the distribution of health inequities that are located outside the health sector. The fact that most of these influences lie outside of the exclusive jurisdiction of the health sector, requires the health sector to engage with other sectors of government and society to address the determinants of health and well-being[12]. The Adelaide Statement[13] introduces a strategic approach for governments to take when setting policies – an approach that emphasizes collaboration across government agencies, so that all sectors can reap the benefits of a healthy society. In the context of Health 2020, a Health in All Policies approach is

8 Kickbusch I, Gleicher D. Governance for health in the 21st century . Copenhagen, WHO Regional Office for Europe, 2012 (http://www.euro.who.int/__data/assets/pdf_file/0019/171334/ RC62BD01-Governance-for-Health-Web.pdf, accessed 21 June 2013).

9 Kickbusch I, Gleicher D. Governance for health in the 21st century. Copenhagen, WHO Regional Office for Europe, 2012 (http://www.euro.who.int/__data/assets/pdf_file/0019/171334/RC62BD01-Governance-for-Health-Web.pdf, accessed 21 June 2013).

10 Adapted from: Glossary of terms used in Health for All series. Geneva, World Health Organization, 1984.

11 "Transforming Our World: The 2030 Agenda For Sustainable Development". Sustainabledevelopment.un.org. N.p., 2017. Web. 10 June 2017.

12 "WHO | Intersectoral Action". Who.int. N.p., 2017. Web. 10 June 2017.

13 Adelaide Statement on Health in All Policies: moving towards a shared governance for health and well-being: report from the International Meeting on Health in All Policies, Adelaide 2010. (2010). Geneva, Switzerland: World Health Organization.

designed to make governance for health and well-being a priority for more than the health sector. It works in both directions, ensuring that all sectors understand and act on their responsibility for health, while recognizing how health affects other sectors. The health sector can therefore, support other arms of government by actively assisting their policy development and goal attainment. To harness health and well-being, governments need institutionalized processes that value cross-sector problem-solving and address power imbalances. This includes providing the leadership, mandate, incentives, budgetary commitment and sustainable mechanisms that support government agencies to work collaboratively on integrated solutions[14].

There is a difference in health status between individuals or groups, as measured by, for example, life expectancy, mortality or disease. **Health inequalities** are the differences, variations and disparities in the health achievements of individuals and groups of people. Some differences are due to biological or other unavoidable factors such as age; others, however, are avoidable[15].

Local health planning that incorporates all of the concepts aims to achieve, inter alia, **equity** in health. Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically. "**Health equity**" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential[16]. **Health inequity** refers to a difference or inequality in health that is deemed to be avoidable, unfair or stemming from some form of injustice. Inequities in health status can be between groups of people within countries and or between countries. Health inequities arise from differences within and between societies and the distribution of resources and power. Inequities are those differences in health that arise not from chance or from the decision of the individual but from avoidable differences in social, economic and environmental variables (such as living and working conditions, education,

14 Adapted from: Adelaide Statement on Health in All Policies. Geneva, World Health Organization, 2010 (http://www.who.int/social_determinants/hiap_statement_who_sa_final. pdf).

15 Kawachi I. A glossary for health inequalities. Journal of Epidemiology and Community Health, 2002, 56:647.

16 Health systems topics – Equity [web site]. Geneva, World Health Organization, 2012. (http://www.who.int/healthsystems/topics/equity/en) and Glossary: Health equity [web site]. Copenhagen, WHO Regional Office for Europe, 2012 (http://www.euro.who.int/observatory/Glossary/TopPage?phrase=Equity).

occupation, income and access to quality health care, disease prevention and health promotion services) that are largely beyond individual control and that can be addressed by public policy. It should be noted that the terms health inequalities and health inequities are often used interchangeably, while in most languages other than English there is only one term to describe such differences. Thus the term health inequalities is also used to refer to those differences in health that are deemed to be avoidable and unfair and that are strongly influenced by the actions of governments, stakeholders and communities, and that can be addressed by public policy. Therefore the terms health inequality and health inequity are commonly used to refer to those health differences that are unfair and avoidable[17].

Intersectoral action for health and wellbeing at local level aims also to enhance health literacy and social capital. **Health literacy** refers to the cognitive and social skills that determine the motivation and ability of individuals to gain access to, understand and use information in ways that promote and maintain good health[18].

Social capital[19]

Social capital represents the degree of social cohesion that exists in communities. It refers to the processes between the people that establish networks, norms and social trust, and which facilitate coordination and cooperation for mutual benefits[20].

Social progress and stability have been achieved most successfully in countries that ensure the availability of services promoting good health and education, and of effective social safety nets, through strong public services and sustainable public finances. Failure to achieve these goals can be reflected in a decline in societies' social capital of civic institutions and social networks.

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17 Kawachi I. A glossary for health inequalities. Journal of Epidemiology and Community Health, 2002, 56:647. Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2008 (http://whqlibdoc. who.int/publications/2008/9789241563703_eng. pdf). Memo: questions and answers on solidarity in health: reducing health inequalities in the EU. Brussels, Commission of the European Communities, 2009 (http://ec.europa. eu/health/ph_determinants/socio_economics/documents/com2009_ qa_en.pdf).

18 Glossary Health promotion glossary. Geneva, World Health Organization, 1998 (http:// www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf)

19 Adapted from Health 2020

20 World Health Organization, 1998.Health promoting Glossary. Geneva, World Health Organization. http://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf

Social capital is defined by the OECD as "networks together with shared norms, values and u understandings that facilitate co-operation within or among groups". Social capital provides the glue, which facilitates co-operation, exchange and innovation.
Source: OECD, 2001. The new economy beyond the hype: the OECD growth project, Paris: Organisation for Economic Co-operation and Development.

Building resilience is a key factor in protecting and promoting health at both the individual and community levels. The health of any individual is closely linked to the health of the larger community. Communities play a vital role in providing health promotion and disease prevention activities and ensuring the social inclusion of people with chronic diseases and people with disabilities. This role is influenced and shaped by the complex inter-relationship between natural, built and social environments. Policy action to make such environments healthier will help communities and the people in them, to be empowered in their choices and to sustain their own health given rapidly changing environments, focusing on continually striving to improve living and working conditions is key to supporting health.

At the macro level, social and economic policies need to create environments which ensure that people at all times of life are better able to reach their full health potential. At the micro level, action initiated in specific settings where people live, love, work and play – homes, schools, workplaces, leisure environments, care services and older people's homes – can be very effective.

The WHO Healthy Cities and Communities movement provides extensive examples of how to build such resilience, especially by involving local people and generating community ownership of health issues. Other settings-based networks – such as health-promoting schools or workplaces – provide similar experiences. Health and social services, and especially primary health care services reaching out to families in their homes, to workers at their workplaces and to local community groups, are important entry points for systematically supporting individuals and communities over the lifespan and especially during critical periods.

People cannot be empowered by others but can only empower themselves by acquiring more powers, making use of their own inherent assets, facilitated by external structures and life circumstances. Communities can support individuals and patients by establishing social networks and by mobilizing social support, which together promote cohesion between individuals and can support people through difficult transitions in life and periods of vulnerability and illness. Communities should provide structures, resources

and opportunities for individuals, groups and neighbourhoods to network, to become better organized and build capacity with other actors, to develop leadership and to take responsibility for their health, their diseases and their lives. In recent years, tools have been developed and on-the-ground experiences have been accumulated in this domain. Several examples have been reported by the literature on health assets and on community resilience. These innovations aim to identify available assets for individuals and communities to solve local issues in a sustainable way and ensure that external support through welfare and other service can be used more effectively. For example, the recently formed Assets Alliance in Scotland is a platform for sharing assets and guiding the Scottish government and national agencies on policy development.

The existence of an adequate social protection system influences health and health equity. Government social spending substantially affects poverty rates which, in turn, are associated with higher mortality, especially among women and children, and particularly women with a low educational level. Social protection influences health among adults, especially in low- and medium- income countries.

Whole-of-government responsibility for health requires that the effects on health be fundamentally considered in developing all regulatory policies. The persistent and often increasing socially determined inequity in health requires integrated action and a systems approach. Strong political commitment, effective and high-performing health systems and coherence across government policies are all needed, as are well-functioning institutions capable of influencing policy-making across health and other policy sectors. Systematically targeting public policies and private initiatives, and aligning the financial, human and environmental resources, will mobilize action for better health and well-being and its equal distribution in society.

A key aim of policy should be to maintain the minimum standards needed for healthy living. Evidence shows that social spending is more generous in countries with more universal social protection policies and higher rates of labor force participation. Specific actions to be recommended on social protection include ensuring that women and children have access to the minimum income needed for healthy living; that social spending is sufficiently generous, especially among women with a low educational level; that social protection systems in low- and medium-income countries are generous and universal; and that active labor market programs, linked to generous social protection, promote high rates of labor force participation.

Addressing the social determinants of health and tackling health inequities require going further than the traditional model for providing health and

social care. In addition to providing public services to address the deficits in a given community, efforts should also be directed towards harnessing any inherent assets and support that may exist within communities and which can enhance and complement the offerings of the public sector. Many well- meant programs to promote health and reduce socially caused inequity in health fail because they are not based on such a system-wide approach.

As health assets relate to the social determinants of health, asset-based approaches have the potential to overcome some of the existing barriers to maximizing health and well-being and reducing health inequities. Such approaches are strongly linked to health promotion and intervention models and emphasize the importance of strengthening protective and promoting factors for individual and community health by identifying the skills, strengths, capacities and knowledge of individuals and the social capital of communities. These models focus on identifying what assets are available to protect, maintain and promote the health of individuals and communities. The aim is to maximize these assets in order to solve local health issues in a sustainable way and ensure that any external support (such as providing services to enhance health and well-being) can be used more effectively (279– 281).

Efforts to reduce vulnerability and counter the operation of exclusionary processes are important. Smarter governance is necessary to enable communities to steer governments and other agencies to pursue health and well-being as collective goals. new structures for governance and leadership are needed to do this. Rather than building capacity from the outside, empowering social, political and economic systems should be created that release capacity within organizations, professional groups, communities, families and disadvantaged groups. Creating this empowerment requires various types of knowledge and evidence, built on the experience and interpretation of people in the groups and communities affected.

These approaches help to translate such concepts and principles into local action. The goal is public investment in local communities, building on local strengths and assets to raise levels of aspiration build resilience and release potential. Thus, asset-based approaches are an integral part of health promotion and should become an integral part of strategies to improve health and reduce health inequities .

Raising awareness in communities, families and individuals that there are opportunities for change and support, and that everybody can help to remove barriers to a better and healthier life, can offer greater freedom for people with health problems, in particular for individuals with chronic diseases and those with disabilities, and foster their meaningful contribution to

the community. The aim is to recognize and enhance the roles of different stakeholders and enhance follow-up and accountability. Actions include: involving patient and family caregiver associations and related nongovernmental organizations in providing care for patients and supporting them with public funds; building supportive communities to enable people to live as independently as possible; promoting support for disease self-management at workplaces; strengthening means of social support in communities that encourage participation and contact with people with chronic diseases and with disabilities; and initiating and funding anti-stigma programs, to change negative attitudes towards people with chronic conditions and people with disabilities. Health literacy is a promising actionable concept that addresses the dynamic interaction between individuals and the environments in which they live and work, focusing on learning and skill development for health, including the ability to navigate the complex social and health systems to benefit one's health. Health literacy applies a life-course approach, is sensitive to cultural and contextual factors and is concerned with both individuals and organizations.

Informal caregivers provide the largest share of care. Supporting their role, training them and protecting their well-being create positive outcomes for the health both of caregivers and of the people for whom they care. Key action points are to provide official recognition, financial support and social security benefites to informal caregivers; to involve informal caregivers in decision- making processes on health policy and services; to provide home visits and regular communication between professionals and informal caregivers, including assessment of health and safety conditions and technical aids; to use informal caregivers' experience of the individual being cared for when training professional caregivers; and to provide mental health protection measures for informal caregivers, such as opportunities for flexible and part-time work, peer support and self-help, and training and tools to evaluate caregivers' own mental health needs.

In such a complex environment, seven approaches have been suggested to support policy makers:

- Integrated and forward-looking analysis. If the key factors that affect policy performance are identified and scenarios are drawn up for how these factors might evolve in the future, policies can then be made robust in response to a range of anticipated conditions, and indicators can be developed to help trigger important policy adjustments when needed.
- Multi-stakeholder deliberation. This entails a collective and collaborative public effort to examine an issue from different viewpoints

before making a decision. Deliberative processes strengthen policy design by fostering acknowledgement of common values, shared commitment and emerging issues and by providing a comprehensive understanding of causal relationships.

- Automatic policy adjustment. Some of the inherent variability in socioeconomic and ecological conditions can be anticipated, and monitoring of key indicators can help trigger important policy adjustments to keep the policy functioning well.
- Enabling self-organization and social networking. Ensuring that policies do not undermine existing social capital, creating forums that enable social networking, facilitating the sharing of good practices and removing barriers to self-organization all strengthen the ability of stakeholders to respond to unanticipated events in a variety of innovative ways.
- Decentralization of decision-making. Decentralizing the authority and responsibility for decision-making to the lowest effective and accountable unit of governance, whether existing or newly created, can increase the capacity of a policy to perform successfully when confronting unforeseen events.
- Promoting variation. given the complexity of most policy settings, implementing a variety of policies to address the same issue increases the likelihood of achieving the desired outcomes. The diversity of responses also constitutes a common risk management approach, facilitating the ability to perform efficiently in the face of unanticipated conditions.
- Formal policy review and continuous learning. Regular review, even when the policy is performing well, and the use of well-designed pilot schemes throughout the life of the policy to test assumptions related to performance, can help to address emerging issues and trigger important policy adjustments.

Policy planning[21]

Health policies focus on the pursuit of specific and measurable health gain, especially the increase of healthy life-years and the ability to live independently with chronic disease. Concern about health is a key policy priority at all levels of governance, requiring an effective and integrated health system serving public health needs and focusing on primary health care. Achieving these goals involves preparing a comprehensive plan for

21 Excerpts from Health 2020

developing health and well-being, including developing and strengthening health services. Related to this is the aim of strengthening intersectoral approaches.

Such planning instruments must transcend delivering only health care and address the broad agenda of improving health and the social determinants of health, as well as the interaction between the health sector and the other sectors of society. A national health strategy – which can take many different forms – can provide an inspirational overarching or "umbrella" policy, involving a comprehensive range of stakeholders and sectors and focusing on improving population health. Such a strategy can support shared values, foster synergy and promote transparency and accountability. For low- and medium-income countries, the process of developing health policies, strategies and plans can also assist donors in health planning work and contribute to effective donor coordination. The process should be informed by a comprehensive health needs assessment that is sensitive to age, gender, social position and condition.

Research and other intelligence shows that many policies and services, despite having an established evidence base (such as reducing salt and saturated fat in diets, increasing taxes on tobacco, detecting and managing hypertension, managing stroke by multidisciplinary teams, and actively managing the third stage of labor), do not reach populations in need. There are many reasons for a failure to apply evidence to policy and practice. Some are technical and arise from the type and nature of the evidence collected; some are organizational and occur when partnerships or cross-sector working is weak; others are political and arise because what the evidence says is not welcomed by those charged with setting priorities and making investment decisions. Response to interventions also depends upon individuals being empowered to sustain the potential benefits.

Of course, evidence is rarely the only or even the principal factor governing how decisions are made. Values and other influences are also important. Nevertheless, there remains scope to scale up the delivery of core cost- effective services and free up resources, but this means efforts must be made to expand evidence-informed interventions aimed at those with greater needs and reduce the delivery of inappropriate care or public health interventions of limited utility. For such an approach to succeed, researchers, policy-makers and practitioners need to work in new and different ways, centered on the co-production of knowledge and evidence that truly meets their respective needs.

In addition to necessary, and often new, funds, a commitment to address the inefficient use of resources in the health sector is vital to secure popular

and political support for more spending. Efficiency gains need to be a central part of health plans and strategies rather than a short-term response to budget cuts, because the transition to a new, lower-cost delivery system needs to be carefully managed and may require investment in the short term. The goal is to achieve sustainable efficiency gains, such as improving energy efficiency, shifting more care to outpatient settings, allocating more resources to primary health care and cost-effective public health programmes, cutting the least cost-effective services, and improving the rational use of medicines.

The performance of often fragmented health systems may be mismatched with the rising expectations of societies and citizens. People expect greater participation, empowerment, fairness and respect for human rights in health system delivery. The expectation is for increased domestic expenditure on health, but resources are always limited. Strengthening health systems and health system governance are crucial for meeting these expectations. Health ministers and health ministries, and other national authorities, need help and support in improving health system performance and in increasing accountability and transparency.

Health policy is usually developed through diverse approaches and levels and with differing aims. Mechanistic approaches are not sufficient and in any case have been found wanting. More flexible and integrative approaches are required, which are able to respond rapidly to changing circumstances and to sound evidence of what works well and not so well. Comprehensive development of health strategy is inherently a highly political process, and this has to be acknowledged at every stage.

Political and legal commitments are of crucial importance for ensuring long-term sustainability. Flexibility is needed to adapt to unexpected developments in the political, economic and health environment. The value largely lies in the process. Such strategies are more likely to be implemented if they are made and "owned" by the people who will implement them and if they are aligned with capacity, resources and constraints. The instruments must chart realistic ways of developing capacity and resources by mobilizing partners and stakeholders, who may have competing interests.

3. The potential for furthering community action in four countries that are Member States of the South-eastern European Health Network

Council of European Municipalities and Regions (CEMR) has published most contemporary data on structure and competences of the local and regional government in Europe in its 2016 report Local and regional

government in Europe Structures and competences.[22] This overview scopes data on local structure and governance for the South-eastern Europe Health Network Member States.

Albania		
Local level 61 municipalities (*bashkia*)		
The **municipal council** (*Këshilli Bashkiak*) is the local authority's deliberative body. Its members are elected by direct universal suffrage for a period of four years. The municipal council, among others, is responsible for the approval of the local budget, the usufruct right of its property, the organization and supervision of the municipal administration, and local taxes. The **mayor** (Kryetarri) is the head of the executive body of the municipality and is elected by direct universal suffrage for a four-year mandate. The mayor of the municipality is entitled to three consecutive mandates and is also a member of the regional council. He/she approves and implements municipal council decisions, guarantees that all the local authority's obligations are met, and represents the commune or municipality vis-à-vis third parties.	The mayor has the right to ask the municipal council to reconsider decisions, should he deem tham harmful to the community's interest. **Municipalities** can be subdivided into several **administrative units** that have traditional, historic, economic and social ties. The territory of the administrative units of a municipality, their name, and their creation shall be set forth in a law. The administrative units are comprised of towns (*qytete*) and/or villages (*fshatra*). Towns may be divided into smaller units called quarters or neighborhoods (*lagje*). As a rule, a quarter can be established in territories with over 20,000 residents. A town's division into quarters and its territory shall be approved upon a decision of the municipal council.	***Competences:*** **The functions and competences of municipalities in Albania are divided in two: the exclusive functions and the functions and powers delegated by the central government institutions.** ***Exclusive functions*** • **Budget** • **Public infrastructure and services** • **Welfare service** • **Culture, sports and recreational services** • **Environmental protection** • **Agriculture** • **Rural development** • **Public forests and meadows** • **Nature and biodiversity** • **Local economic development** • **Public defense and security** • **Pre-school education**

22 Ccre.org. (2017). CCRE : Studies / brochures. [online] Available at: http://www.ccre.org/papiers/index_broch/8 [Accessed 10 Jun. 2017].

Bosnia and Herzegovina

Local level 57 municipalities and 7 cities in the Republic of Srpska, 74 municipalities and 6 cities in the Federation of Bosnia and Herzegovina, and Brcko District

Municipalities and cities (gradovi) are also called local self-government units and are both executive and legislative authorities. The **municipal assembly** (*skupština opštine* or *općinsko vijeće*) is the local authority's decision and policy-making body. It is composed of members elected by direct universal suffrage for a period of four years. The municipal assembly notably adopts the municipal budget and can appoint or dismiss members of the municipality or city's permanent and temporary working bodies.	The **mayor** (*naćelnik opština* or *općina* in the municipalities or *gradonaćelnik* in cities) is the executive body of the local authority. He/she is elected by direct universal suffrage for a period of four years*. The mayor can put forward draft legislative proposals to the municipal assembly. He/she also implements local policy, has responsibility for the execution of the municipal budget and enforces national laws and regulations to be implemented at the local level.	***Competences:*** **City and municipalities are the key providers of essential public and social services.** • **Economic development** • **Spatial and social planning** • **Social care** • **Civil protection and defense** • **Environment** • **Heating** • **Local roads** • **Sewage and solid waste disposal** • **Water** • **Culture and tourism**

Bulgaria

Local level 265 municipalities

The **municipality** is Bulgaria's only administrative and territorial level of local governance. It is an independent legal entity which owns property and has responsibility for its own budget. The population lives in 5,600 settlements (*naseleno myasto*), organized in 265 municipalities. The average number of settlements per municipality is 20. The **municipal council** (*obchtinski savet*) is the municipality's legislative body and decides on local policy. Its members are elected by direct universal suffrage for a four-year term. The municipal council elects a chairperson from among its members (between 11 and 61 councillors). The chairperson convenes the council meetings and guides the preparation of these meetings.	The chairperson also coordinates the work of standing committees, assists councilors with their activities and represents the Council before third parties. The **mayor** (*kmet*) is the municipality's executive body. The mayor of the municipality is elected by direct universal suffrage based on a majority system for a four-year term. His/her role is to implement and manage the policies of the municipal council, to represent the municipality and to manage the municipal staff.	***Competences:*** **Management of municipal property, municipal companies and enterprises, municipal budget and borrowing, and the municipal administration** • **Public safety*** • **Education*** • **Social and welfare services*** • **Cultural activities*** • **Public works** • **Parks and recreation** • **Sports and leisure** • **Water supply and sewage** • **Tourism** • **Household refuse collection** • **Spatial planning** • **Public transportation**

Former Yugoslav Republic of Macedonia

Local level 81 municipalities (*opstina*) and the capital city of Skopje

The **local council** (*sovet na opstinata*) is elected by direct universal suffrage for a period of four years. The number of municipal councilors is determined by law and depends on the demographic size of the municipality. **The mayor** (*gradonacalnik*) is the municipality's executive body and is elected by direct universal suffrage for a four-year mandate. He/she executes decisions made by the municipal council and submits draft municipal acts to the local council. The mayor represents the municipality, acts on its behalv and is responsible for the organization, performance and quality of services of its administration. He/she cannot be a local councilor at the same time as mayor.	The country's capital, the city of Skopje is a special unit of local self-government made up of 10 independent municipalities. The capital's independent municipalities have individual competences, some of which are shared with Skopje, and which set them apart from the country's remaining 74 municipalities. Examples of these shared competences include property tax, road maintenance, urban planning and building permits.	***Competences:*** • **Urban and spatial planning** • **Environment** • **Local economic development** • **Water supply and treatment** • **Road maintenance** • **Culture** • **Sports and leisure** • **Tourism** • **Social services** • **Health care** • **Child care** • **Elementary and secondary education** • **Fire services** • **Disaster protection and assistance**

Moldova

Local level 1,547 villages (sate) and communes* (*comune*), 5 municipalities (*municipii*) and 61 cities (*orașe*) plus about 66 villages (*sate*) within cities structur

The **local council** (*consiliu local*) is the deliberative body of the local authorities. Its members are elected by direct universal suffrage for a period of four years, either on the basis of political party lists or independent candidates. Budget setting, local policies and territorial planning are the main competences.	The executive body is represented by the **mayor** *(primar*), who is elected by direct universal suffrage for a period of four years, and by the **mayor's office** (*primarie*).	***Competences of communes, cities and municipalities**** • **Urban and spatial planning** • **Waste management** • **Water management and sewerage systems** • **Local roads management** • **Local public transport** • **Cemeteries** • **Local property management** • **Educational centre management** • **Local gas and heating distribution** • **Culture, sport and recreation** • **Economic development** • **Social housing** • **Fire services**

The Gagauzia Autonomous Territorial Administrative Unit (Gagauz-Yeri)		
Gagauzia is an autonomous territorial unit having a special statute and representing a form of self-determination of the Gagauzian people. As a special territorial unit it has its own assembly, the **Gagauzian people's assembly** (in Gagauz: *HalkTopluşu*, in Romanian: *Adunarea Populara*), which enjoys lawmaking powers within its own jurisdiction, and a **governor** (Gagauz: *Başkan*, Romanian: *Guvernatorul Gagauziei*) holds the executive power. She/he is elected by direct universal suffrage for a period of four years.	Permanent executive power in Gagauz-Yeri is exercised by an **executive committee** (*Balkannik Komiteti/Comitetul Executiv*). Its members are appointed by the governor or by asimple majority vote in the assembly in its first session. The executive committee ensures the application of the laws of the Republic of Moldova and those of the Gagauzian assembly.	***Competences:*** • **Science** • **Culture** • **Education** • **Housing management** • **Urban planning** • **Health services** • **Physical culture and sports** • **Local budget, financial and taxation activities** • **Economy and ecology** • **Labour relations and social security** • **Own police force** • **International and foreign policy**

The municipality of Chisinau (*Municipiul Chisinau*) and the municipality of Balti		
The municipality of Chisinau and Balti have competences of both local and district level.		***Competences:*** • **Social and economic development** • **Maintenance of public roads** • **Construction of hospitals, schools, roads** • **Health care** • **Maintenance of sanitation and social institutions** • **Assistance to young families** • **Social protection to the unemployed** • **Public order** • **Environment** • **Youth activities and sports** • **Secondary education and professional education**

Montenegro		
Local level 23 municipalities (*opština*)		
The **municipal assembly** (skup*ština opštine*) is the municipality's legislative body. Its members are elected by direct universal suffrage for four years. Each assembly is made ups of 30 councilors plus an additional councilor for every 5,000 voters. The municipal assembly adopts regulations and the budget, and also establishes the level of local taxes. It can establish internal commissions and boards and is chaired by a speaker elected from among the councilors.	The **mayor** (*predsjednik opštine* in municipalities and *gradonaćelnik* in cities) is elected by the municipal assembly for a four-year mandate. He/she is the municipality's executive body. The mayor proposes regulations to be adopted by the assembly and is responsible for their implementation. He/she also supervises the work of the municipal administration and can appoint or dismiss deputy mayors. The capital city of Podgorica is made up of two districts each of which enjoys the status of a municipality.	***Competences:*** • **Local development** • **Urban and spatial planning** • **Environmental protection** • **Social welfare** • **Public transport** • **Culture and sports**

Romania		
Local level 2,861 municipalities (*commune*), 217 towns (*orase*) and 103 cities (*municipii*)		
The **local council** (*consiliul local*) is the local authority's deliberative assembly. It is composed of councilors elected by direct universal suffrage for a four-year term. The number of councilors is determined by order of the perfect based on the demographic size of the local authority. The local council's work revolves around economic, social and environmental development, public and private property and the management of public services.	The **mayor** (p*rimarul*) is the local authority's executive body and is elected by direct universal suffrage for a period of four years. He/she is responsible for the local budget and public services. The mayor also represents the local authority vis-à-vis other authorities, represents the national government within the municipality, town or city, and cooperates with the decentralized departments of national government ministries and specialized units present within its jurisdiction.	***Competences:*** • **Local housing** • **Local police** • **Urban planning** • **Waste management** • **Public health** • **Transport infrastructure and urban transport planning** • **Water supply and sewage system** • **District heating** • **Pre-school, primary, secondary, vocational and technical education** • **Local heritage administration** • **Administration of parks and open green public areas**

Serbia		
Local level 174* municipalities (*opstina*) and cities (*grad*)		
The **municipal** or **city assembly** (*skupstina opstine* or *skupstina grada*) is composed of councilors elected by direct universal suffrage for a four-year term. The assembly enacts municipal or city statutes, rules of procedure, development programmes, the municipal budget, urban planning and other municipal regulations. It also appoints and dismisses the mayor, the deputy mayor, the members of the municipal or city council and the president of the assembly. The **municipal** or **city council** (*opstinsko* or *gradsko vece*) is composed of members elected by the municipal or city assembly by secret ballot for a period of four years. It monitors the work of the municipality's administration and is chaired by the mayor.	The council has a legally defined role to propose draft decisions (including draft budget proposal) to the assembly, to take decisions on appeal in relation to administrative procedures, and to assist the mayor in his work. The **mayor** (*predsednik opstine* in municipalities or *gradonacelnik* in cities) is the executive body of the city or municipality and is elected by the assembly for a period of four years. The mayor represents the city or municipality, chairs the city or municipal council, implements city or municipal assembly decisions, and dictates the work of the local administration. He/she proposes the deputy-mayor and the members of the city or municipal council to the assembly.	***Competences:*** • **Tourism** • **Public transport (including waterway line transport) and taxi services** • **Urban planning and residential buildings (shared competence with central authorities, the local governments are in charge of investment and the maintenance of buildings)** • **Primary education and primary healthcare, sport** • **Social services and protection** • **Communal services (waste, energy efficiency, water, electricity, transport, markets, parks, green public spaces, public parking, cemeteries, spatial planning)** • **Additional competences***

4. Potential of the SEEHN Member States to implement Health 2020 and localize Sustainable Development Goals through local planning for health and wellbeing

Competencies established at local level (Table 1) provide Member states of the SEEHN to implement Health 2020 goals in its priority areas (Table 2) and work towards achieving SDGs through developing local plans for health and well-being. Regarding SDGs, local communities need to interpret the SDGs in their own contexts and then incorporate them into their strategies[23] .

23 Ias.unu.edu. (2017). Symposium Discusses Application of SDGs in Local Communities in Japan - Institute for the Advanced Study of Sustainability. [online] Available at: https://ias.unu.edu/en/news/news/symposium-discusses-application-of-sdgs-in-local-communities-in-japan.html [Accessed 11 Jun. 2017].

Table 1. Goals and priority areas of Health 2020

HEALTH 2020 GOALS			
Improving health for all and reducing inequalities		**Improving leadership and participatory governance for health**	
HEALTH 2020 PRIORITY AREAS			
Strengthening people centered health systems, public health capacity, and emergency preparedness, surveillance and response	**Tackle Europe's major burdens of NCDs and CDs**	**Investing in health through a life course approach and empowering people**	**Create supportive environments and resilient communities**

Table 2. Entry points for local planning for health and well-being in the SEEHN MSs

COUNTRY	LOCAL LEVEL COMPETENCIES	COUNTRY	LOCAL LEVEL COMPETENCIES
ALBANIA	• Budget • Public infrastructure and services • Welfare service • Culture, sports and recreational services • Environmental protection • Agriculture • Rural development • Public forests and meadows • Nature and biodiversity • Local economic development • Public defense and security • Pre-school education	**MOLDOVA**	• Urban and spatial planning • Waste management • Water management and sewerage systems • Local roads management • Local public transport • Cemeteries • Local property management • Educational centre management • Local gas and heating distribution • Culture, sport and recreation • Economic development • Social housing • Fire services

BOSNIA AND HERZEGOVINA	• Municipalities are the key providers of essential public and social services • Economic development • Spatial and social planning • Social care • Civil protection and defense • Environment • Heating • Local roads • Sewage and solid waste disposal • Water • Culture and tourism	**MONTE NEGRO**	• Local development • Urban and spatial planning • Environmental protection • Social welfare • Public transport • Culture and sports
BULGARIA	• Management of municipal property, municipal companies and enterprises, municipal budget and borrowing, and the municipal administration • Public safety* • Education* • Social and welfare services* • Cultural activities* • Public works • Parks and recreation • Sports and leisure • Water supply and sewage • Tourism • Household refuse collection • Spatial planning • Public transportation	**ROMANIA**	• Local housing • Local police • Urban planning • Waste management • Public health • Transport infrastructure and urban transport planning • Water supply and sewage system • District heating • Pre-school, primary, secondary, vocational and technical education • Local heritage administration • Administration of parks and open green public areas

FORMER YUGOSLAV REPUBLIC OF MACEDONIA	• Urban and spatial planning • Environment • Local economic development • Water supply and treatment • Road maintenance • Culture • Sports and leisure • Tourism • Social services • Health care • Child care • Elementary and secondary education • Fire services • Disaster protection and assistance	**SERBIA**	• Tourism • Public transport (including waterway line transport) and taxi services • Urban planning and residential buildings (shared competence with central authorities, the local governments are in charge of investment and the maintenance of buildings) • Primary education and primary healthcare, sport • Social services and protection • Communal services (waste, energy efficiency, water, electricity, transport, markets, parks, green public spaces, public parking, cemeteries, spatial planning) • Additional competences*

Localization refers to the process of adapting, implementing, and monitoring the SDGs at the local level. While the specific role of urban and local governments in implementing the SDGs will depend on individual countries, their systems of decentralization and local government mandates, the four basic steps for getting started with SDG localization in cities are the following[24]:

Step 1: Initiate an inclusive and participatory process of SDG localization. This includes raising awareness of the SDGs at the local level, setting the stage for multi-stakeholder discussion and involvement, and prioritizing sustainable development through strong political leadership and integrated governance arrangements.

24 Sustainable development solutions network, (2017). Getting Started with the SDGs in Cities.A Guide for Stakeholders July 2016 [online] Available at: http://unsdsn.org/wp-content/uploads/2016/07/9.1.8.-Cities-SDG-Guide.pdf [Accessed 11 Jun. 2017].

Step 2: Set the local SDG agenda. SDG localization is key to ensuring that no one and no place are left behind in the development of a more sustainable future. Cities need to adapt the global SDGs into an ambitious yet realistic local agenda, through evidence-based decision-making that is backed by public support and input.

Step 3: Plan for SDG implementation. Implementing the SDGs to be achieved by 2030 will require goal-based planning that adopts a long-term, multi-sectoral perspective, and is supported by adequate implementation capacity and financial resources, and multi-stakeholder partnerships.

Step 4: Monitor SDG progress. Disaggregated data systems are necessary to measure local progress on SDG indicators, and to review the efficiency of program implementation. Local monitoring and evaluation (M&E) systems ensure that SDG implementation remains on track, and support the development of local capacity for more responsive and accountable governance.

Urban and local governments often struggle to drive action on sustainable development due to a number of constraints. These include limited political and fiscal power, lack of access to development finance, low levels of institutional capacity, absence of robust multi-level government cooperation and integration, and the inability to attract or be part of strong multi-stakeholder partnerships. Without first acknowledging and addressing the challenges faced by local governments in many parts of the world, SDG localization will not benefit the majority of the global urban population, will fail to build sustainable governance structures, and will constrain the achievement of sustainable outcomes.

Conclusions

European policy framework for health and wellbeing has developed all the concepts relevant to local planning for health and wellbeing and has brought about a wealth of evidence that may be used in such an endeavor. In addition, 2030 Agenda has added to it and open a new opportunities for intersectoral collaboration in the area.

Local community action on health and wellbeing is a must if a must if a country is deliberate to respond to health and wellbeing needs of the population and international commitments. Health planning is an unavoidable in organizing societal efforts to that end. Local settings, and especially cities have long tradition of planning and this should be further upgraded and strengthened.

However important is to provide for coherence between the national health policies and international commitments, no less of importance is to provide

for policy coherence among different levels of governance arrangements within the country (vertical) and with other sectors that affect health impact (policies of other sectors).

SEEHN Member States have developed their national health policies and most recently have started to use them to localize SDGs. Most of them have also endorsed their development policies and brought them into coherence with the health policies.

A snap-shot of the competencies of local governments in eight Member States of the SEEHN presents big potential for developing overarching local plans for health and well-being that will be used to bring about better health and wellbeing in the community, create and sustain resilience and respond to international commitments.

SEEHN Member States should use this opportunity for joint action at sub-regional level (SEE) to develop and implement a model of local health plan, using their centers for expertise (Regional Health Development Centers) to support development of the specific areas of this model local health plan.

Abstract

The keywords of local planning for health and wellbeing are: governance, governance for health, health equity, health inequality, health in all policies, health literacy local, policy planning, social capital, health, and wellbeing. Understanding the concepts behind those keywords is important for those who embark in the journey of policy development and implementation at local level. European policy framework for health and well-being - Health 2020 of the World Health Organization incorporates all of those concepts and brings about a wealth of evidence of what works best for achieving health and wellbeing at both national and other levels of governance in a country, including local level. In addition, 2030 Agenda has added to it and opens new opportunities for intersectoral collaboration in the area. Local community action on health and wellbeing is a must if a country is deliberate to respond to health and wellbeing needs of the population and international commitments. Health planning is an unavoidable in organizing societal e orts to that end. Local settings, and especially cities have long tradition of planning and this should be further upgraded and strengthened.

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