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Country Cooperation Strategy WHO – Italy

2017 – 2022

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REGIONAL OFFICE FOR Europe

COUNTRY COOPERATION STRATEGY WHO – ITALY 2017–2022

ABSTRACT

This is the first time that Italy and WHO have signed a Country Cooperation Strategy (CCS). The CCS is a medium-term strategic framework for cooperation between the partners and outlines a shared agenda with priority areas of work for six years. The CCS is structured around five chapters. After the introduction, Chapter 2 assesses the public health status and health system in Italy, while Chapters 3 and 4 describe the development cooperation and contribution of Italy to global health, as well as the collaboration between Italy and WHO in the past years. Chapter 5 outlines the strategic agenda for cooperation between Italy and WHO and provides details on the areas of collaboration between the partners. Finally, Chapter 6 describes the monitoring and evaluation process for implementation of the strategy.

Keywords

HEALTH PRIORITIES
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Foreword

Reflecting the critical role played by Italy in global health, the long-term collaboration with WHO regarding the national, regional and global health agenda, including Italy's support as a key donor, the universality of Agenda 2030, which calls for all countries to fully engage in its implementation at all levels, WHO and the Ministry of Health of Italy have jointly developed this document. The achievement of Sustainable Development Goal (SDG) 3, especially its key target of universal health coverage, underpins its strategic orientation.

This Country Cooperation Strategy (CCS) has been shaped through a series of consultations with representatives at all levels of WHO, the Government of Italy and scientific institutions.
It has four strategic priorities:

1. *implementing the Health 2020 policy for health and well-being, aligned with the roadmap on the SDGs and the national SDG agenda, focusing on governance and leadership, supporting Italian national health policies reinforcing whole-of-government and whole-of-society approaches, and tackling inequities to address the social determinants of health, refugees' and migrants' health, climate change and environmental health;*
2. *promoting well-being through the life-course by addressing and mitigating the impact of the major risk factors for noncommunicable diseases, including mental health and women and child health, and by governing innovation of the national health system based on achievements in the field of genomics sciences;*
3. *addressing communicable diseases under the One Health approach, including implementing the national vaccination plan and supporting the strengthening of global responses to international public health emergencies; and*
4. *strengthening the role of Italy as a donor country in global health through the WHO global programmes and enhanced collaboration between WHO and Italy in the Italian Development Cooperation Agency priority countries.*

It gives us tremendous pleasure to present to you this very comprehensive strategic document. We take this opportunity to thank all of those involved in developing this CCS, which has the full commitment of the Ministry of Health of Italy and WHO.

We will all be involved in implementing, monitoring and evaluating this CCS and look forward to working with national counterparts and international partners in advancing the cause of health nationally, regionally and globally.

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Acronyms and abbreviations

AICS	Italian Development Cooperation Agency
AMR	antimicrobial resistance
COSI	Childhood Obesity Surveillance Initiative
COST	(European) Cooperation in Science and Technology
CSS	Country Cooperation Strategy
DALY	disability-adjusted life-year
ECDC	European Centre for Disease Prevention and Control
EU	European Union
FCTC	(WHO) Framework Convention on Tobacco Control
FGM	female genital mutilation
GAVI	Vaccine Alliance
GDP	gross domestic product
GLASS	(WHO) Global Antimicrobial Resistance Surveillance System
GOARN	Global Outbreak Alert and Response Network
GP	general practitioner
ICD-11	Eleventh Revision of the International Classification of Diseases and Related Health Problems
IFFIm	International Finance Facility for Immunization
IHR	International Health Regulation
ISS	Istituto Superiore di Sanita
NCD	noncommunicable disease
NGO	nongovernmental organization
NTD	neglected tropical disease
OECD	Organization for Economic Co-operation and Development
PHAME	Public Health Aspects of Migration in Europe (project)
SCRC	Standing Committee of the Regional Committee
SDG	Sustainable Development Goal
TB	tuberculosis
UHC	universal health coverage
UNFCCC	United Nations Framework Convention on Climate Change

Executive summary

This Country Cooperation Strategy (CCS) has been jointly elaborated by WHO and the Ministry of Health of Italy with the aim of defining a medium-term strategic framework for cooperation between both partners by:

- supporting Italy's priorities for the achievements of Sustainable Development Goal (SDG) 3 (good health and well-being) and other health related SDGs, such as SDG 10 (reduced inequalities), SDG 11 (sustainable cities and communities) and SDG 13 (climate change) through strengthening its health system, reinforcing health promotion and prevention of communicable and noncommunicable diseases with WHO's knowledge and technical expertise;
- supporting the Ministry of Health of Italy in meeting its commitments to the policy framework of Health 2020 and its contribution to the SDG agenda, including crosscutting issues of equity – "leave no one behind" – gender and human rights, and in addressing the social determinants of health;
- cooperating with Italy as a donor country in the contexts of European and global health by supporting WHO's role and programmes; and
- fostering Italy's leading role in global health with neighbouring countries and the entire WHO European Region resulting from the collaboration between Italian scientific centres of expertise and WHO on norms, standards and best practices.

This is the first CCS for Italy and covers the period from 2017 to 2022. It builds on national and European regional policy frameworks and reports, in particular the joint report on a mission of the Ministry of Health of Italy, the Regional Health Authority of Sicily and the WHO Regional Office for Europe titled *Sicily, Italy: assessing health-system capacity to manage sudden large influxes of migrants*, and is aligned with the WHO European policy framework Health 2020 and the WHO's Twelfth General Programme of Work.

The CCS–Italy has four strategic priorities:

- implementing the Health 2020 policy for health and well-being, aligned with the roadmap on the SDGs and the national SDG agenda, focusing on governance and leadership, supporting Italian national health policies reinforcing whole-of-government and whole-of-society approaches, and tackling inequities to address the social determinants of health, refugees' and migrants' health, climate change and environmental health;
- promoting well-being through the life-course by addressing and mitigating the impact of the major risk factors for noncommunicable diseases, including mental health and women and child health, and by governing innovation of the national health system based on achievements in the field of genomics sciences;
- addressing communicable diseases under the One Health approach, including implementing the national vaccination plan and supporting the strengthening of global responses to international public health emergencies; and
- strengthening the role of Italy as a donor country in global health through the WHO global programmes and enhanced collaboration between WHO and Italy in the Italian Development Cooperation Agency (AICS) priority countries.

The Ministry of Health of Italy and WHO will collaborate to achieve these strategic priorities within available resources and expertise by implementing mutually beneficial activities at

national, regional and global levels, generating added value to both partners' health agenda at all three levels.

By working together, the Ministry of Health of Italy and WHO consider that both Parties:

- have the specific and necessary expertise and resource available;
- will develop cooperation by implementing mutually beneficial activities at national, global, regional and global levels; and
- will jointly address the priorities and generate added value to each other's health agenda at all levels.

Chapter 1. Introduction

This Country Cooperation Strategy (CCS) has been elaborated jointly by WHO and the Ministry of Health of Italy. It involved extensive consultations among representatives of all levels of WHO, the Government of Italy, scientific institutions and other international partners working in the country.

In accordance with the principles guiding WHO cooperation in countries, the CCS with Italy is based on:

1. ownership of development by the country;
2. alignment with national priorities and strengthening of national systems to support national health policy frameworks;
3. harmonization with the work of national and international partners; and
4. a two-way collaboration process that fosters the contributions of Italy to the global health agenda.

The overarching goal of the CCS Italy is two-fold.

1. To support the Ministry of Health of Italy in meeting its commitments to the policy framework of Health 2020 and develop a roadmap to implement the health-related Sustainable Development Goals (SDGs), in particular SDG 3 (good health and well-being). Italy will stress the importance of environmental and social determinants of health, reinforcing prevention of the risk factors for noncommunicable diseases (NCDs) and aiming to reduce maternal mortality. It will address the environmental and social determinants of health and climate change and strengthen universal health coverage (UHC), including crosscutting issues of equity – "leave no one behind"[1] – gender and human rights.
2. To foster the joint leading role of Italy–WHO in global health and supporting the achievement of the SDGs in partner countries.

This CCS covers the period from 2017 to 2022 and is aligned with national and European regional policy frameworks, including the Italian national plan for health and national SDGs, the WHO European policy framework, Health 2020, and WHO's Twelfth General Programme of Work.

Additional concepts and laws of Italy and WHO policy framework documents, strategies and programmes were analysed and referred to during the preparation of the CCS and are listed in the bibliography.

[1] Inclusion is at the core of the 2030 Agenda for Sustainable Development. Inclusiveness speaks to the notion of empowerment and the principle of non-discrimination. It is reflected in the pledge to **leave no one behind** and in the vision of a "just, equitable, tolerant, open and socially inclusive world in which the needs of the most vulnerable are met" and "a world in which every country enjoys sustained, inclusive and sustainable economic growth and decent work for all" (paragraphs 8 and 9).

Chapter 2. Health situation

This chapter presents an overview of Italy's health situation. After a brief introduction to Italy's demographic, socioeconomic and institutional context, the chapter analyses the health status of its population and the health system structure, financing, workforce, achievements and challenges, including efforts towards achieving the 2030 Agenda for Sustainable Development.

2.1 Italy's socioeconomic and institutional context

Italy is the sixth largest country in Europe, with a population of 60 million (in 2016). The country has 19 regions and two autonomous provinces, with large variations in size, population and level of economic development. With 22% of the population aged 65 and over in 2015, Italy has the oldest population in Europe. It also has one of the lowest fertility rates in the European Union (EU) and the world: in 2015, it was 1.3 births per woman, far below the replacement level of 2.1. This gives the country a low population growth rate (0.3% in 2012), with immigration the main source of population growth.

2.2 Health status

Italy has the second highest life expectancy in Europe, with an average life expectancy for men of 80.5 years and 84.8 years for women in 2015.[2] There are important gender and geographical differences, however, with a gap of 2.8 years in life expectancy for both genders between the longest- and shortest-lived regions. The lower life expectancy in the southern regions is due to poorer lifestyles, access to health care and quality of services, issues that should be addressed by the health-care system.

Most of the life expectancy gains in Italy since 2000 have been driven by reduced mortality rates after the age of 65. In 2015, an Italian woman at the age of 65 had a life expectancy of 22.2 years, while that of a man at the same age was 18.9 years. At age 65, women can expect to live only about one third (7.5 years) of their remaining life free of disability, while men can expect to live about 40% (7.8 years) of the rest of their life disability-free.[3]

2.2.1 Noncommunicable diseases

Close to two thirds of all deaths in Italy in 2014 were attributable to either cardiovascular diseases or cancer. Cardiovascular diseases represented the main causes of death among women (40%) followed by cancer (24%), while for men one third was related to cardiovascular diseases and another third to cancer (Fig. 1).

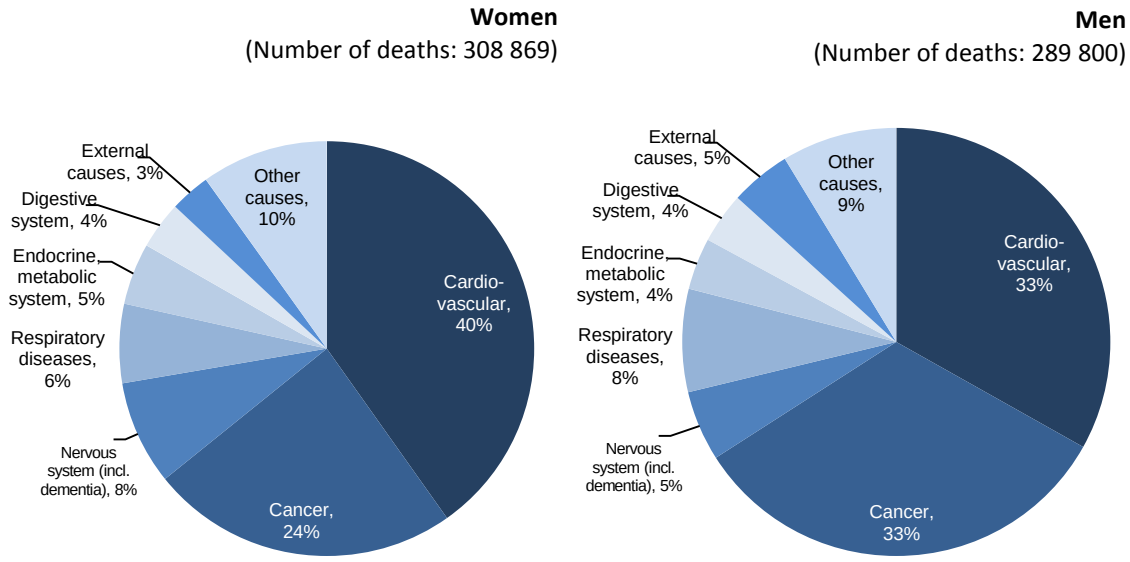
While the reduction in coronary mortality is probably due to reduced exposure to some risk factors, in particular hypercholesterolaemia and high blood pressure, and better access to more effective biomedical technologies and clinical management, the prevalence of adult diabetes mellitus and obesity is on the rise, as in many other countries.

When looking at trends in more specific causes of death, heart diseases and stroke continued to be the leading causes in 2014. Lung cancer remained the leading cause of cancer mortality, followed by colorectal, breast and pancreatic. Deaths from Alzheimer's disease and other

[2] WHO Global Health Observatory data, 2015 (see also Annex 1).
[3] These figures are based on the indicator of healthy life-years, which measures the number of years people can expect to live free of disability at different ages.

dementias increased substantially since 2000 due to the population ageing, but also to better diagnosis and improved recording of different forms of dementia as the primary cause of death.

Fig. 1. Cardiovascular diseases and cancer cause nearly two in every three deaths in Italy



Source: Eurostat database (data refer to 2014).

In addition to the high burden of disease caused by cardiovascular diseases and cancer, musculoskeletal conditions (including low back and neck pain), diabetes and ageing-related conditions, including falls, Alzheimer's disease and other dementias, are major causes of disability-adjusted life-years (DALYs) lost[4] in Italy.

2.2.2 Risk factors

The most important risk factors in Italy for cancer and cardiovascular diseases are smoking, alcohol consumption, overweight and obesity.

2.2.2.1 Smoking

Smoking cigarettes is found to be more common in young adults, with a prevalence of 22.3% among the population aged 15 and over; this has reduced from 23.8% before approval of Law 3/2003 in 2003, which banned smoking in public areas. Prevalence is higher among men than women – 28.7% and 16.7% respectively for all age groups. Despite an annual number of deaths related to smoking of 83 000, with more than 25% of premature mortality in the most productive ages (35–65), Italy has continued to be one of the most advanced countries in combating smoking.

Italy was one of the first countries in Europe to introduce a law banning smoking in closed public places, implemented in 2005. Following the WHO Framework Convention on Tobacco Control (FCTC) promoted by WHO worldwide, Italy has introduced several measures in recent years to reduce supply and demand of tobacco products, such as prohibiting sales to minors, banning smoking in outdoor areas of schools, hospitals and health services for minors and pregnant women, banning smoking in private cars in the presence of minors and pregnant

[4] A DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (Institute for Health Metrics and Evaluation).

women, and adopting all measures included in the EU directive 2014/40/EU (pictorial warnings, regulation of the composition of tobacco products and information that must appear on the packaging, ban of cross-border sales, and introduction of a tracking and tracing system).

2.2.2.2 Alcohol

Alcohol is another risk factor that starts to be important from a young age. Despite the decrease in per capita daily consumption, occasional drinking outside main meals shows a continuous increase, with prevalence in 2014 of 22.7% for males and 8.2% for women.

2.2.2.3 Overweight and obesity

The surveillance system highlighted 20.9% of children being overweight in 2014 and a close association with increases in sedentary behaviours. Similar data on overweight/obesity are found in the adolescent and adult populations; the percentage of adults with overweight/obesity reaches 51% for males and 33% for women. Italy is participating in the European Childhood Obesity Surveillance Initiative (COSI) promoted by WHO.

The traditional Mediterranean diet is known worldwide to be healthy, but Italy, like many other countries, is facing the threats of a modern lifestyle, with increased availability of high-energy or poor-nutrient food products and with many aspects of the environment in which people live and work encouraging incorrect eating habits and/or reduced physical activity. Consequently, Italy is implementing actions to promote healthy diets and an active lifestyle to reduce the risk of obesity and NCDs. One important objective is a reduction in salt consumption, which is high among the Italian population; this is being addressed with the involvement of food producers, retailers and the catering sector to encourage food improvements to make the healthy option the easy one.

2.2.2.4 Chemicals

More than 25% of the global burden of disease is linked to environmental factors, including chemicals exposures. Lead exposure, for example, accounts for 3% of the cerebrovascular disease burden and 2% of the ischaemic heart disease burden worldwide. About 800 000 children each year are affected by lead exposure, leading to lower intelligence quotients and potential mild intellectual disabilities. Some 9% of the global disease burden of lung cancer is attributed to occupational exposure and 5% to outdoor air pollution.

In Italy in 2012, the National Informative System for Surveillance of Toxic Exposures and Poisonings detected 41 698 cases of human exposure. About 45% of cases were aged less than 6 years. Males and females were distributed equally. Around 92% of exposures occurred at home. The reason for exposure was unintentional in about 79% of cases, mainly related to uncontrolled access to the agent (45%), therapeutic error (10%) and pouring from the original container to another (5%). About 40% of cases were exposed to pharmaceuticals and 58% to non-pharmaceuticals. The most common categories of agents involved in human exposures were cleaning substances (household) (20%), cosmetics/personal care products (5%) and pesticides (5%).

2.2.3 Communicable diseases

2.2.3.1 Vaccine-preventable diseases

To meet the target of 95% vaccination coverage set by WHO guidelines and to enlarge the vaccination offer, including new vaccines and those for elderly people, a new national vaccination plan was approved in 2017, stressing the right to vaccination included in the benefits package. Although vaccination coverage rates were mostly above the 95% target around 2012,

there has been a recent downward trend, with rates for specific individual vaccines (DTP3, MCV, HepB3) down by 3–5 percentage points in 2015.

The reduction in vaccination led to a worrying measles cases outbreak in 2017, with 865 cases in 2016 and more than 4000 up to August 2017 (Italian Ministry of Health data). Of the cases reported in 2017, around 89% were not vaccinated, and 6% only received the first dose of the vaccine (thereby increasing the likelihood of contagion compared to those who received both doses).

As a consequence of the vaccination coverage decrease and the measles outbreak and in the framework of the new national implementation plan, a new law was approved by the Italian Parliament on 31 July 2017. Mandatory vaccinations grew from four to 10, adding vaccinations against measles, rubella, mumps, pertussis, chickenpox and *Haemophilus influenzae* type b to those against diphtheria, tetanus, hepatitis B and poliomyelitis that were already compulsory.

2.2.3.2 Implementation of the national vaccination plan

Italy, in common with other European countries, is affected by a trend of scepticism towards, and disinformation about, the benefits of immunization that has spread among health professionals and the general population. The Ministry of Health of Italy is committed to fully implementing the vaccination plan in line with the national legislation and is fighting very strongly against this negative trend and scepticism regarding the safety and effectiveness of vaccines through legislative tools, continuous education events for health professionals and public health promotion campaigns to raise awareness of the benefits of vaccination among the population.

2.2.3.3 Antimicrobial resistance

National health authorities in Italy have great concerns about antimicrobial resistance (AMR), as antibiotic resistance percentages are higher than the European average in every Italian region and there are no signs that this phenomenon is declining for all of the most important pathogens. Italy is supporting many international initiatives focusing on AMR (including those of the G7 and G20 groups and the Global Health Security Agenda) and is collaborating with WHO and the European Commission.

Following WHO recommendations, the Ministry of Health coordinated the development of the first Italian national plan to fight AMR, adopting a One Health integrated approach with a strong commitment to developing local operative plans.

2.2.3.4 HIV and AIDS

HIV infection in Italy has changed throughout the years. Recently, the number of new infections has remained relatively stable. In 2015, Italy had an incidence rate of 5.7 per 100 000 residents (3444 new diagnoses reported), ranking in 13th position among EU countries. A change was noted in the mode of transmission, however, with the proportion of injecting drug users decreasing and cases attributed to sexual transmission, particularly for men having sex with men, increasing, although drug users are more reluctant to access testing services.

The results of recent investigations show that general awareness about HIV is widespread among the population, but specific knowledge, in particular regarding prevention measures, remains scarce. In addition, spontaneous use of HIV testing remains limited and insufficient.

People living with HIV and AIDS have changed dramatically, with the number aged 50 years and more increasing substantially. The number of people receiving permanent treatment with antiretroviral drugs is close to 95 000, which represents 83% of people diagnosed and followed by medical institutions.

Italy has therefore decided to draw up a new action plan based on analysis of the current epidemiological situation and evidence-based assessment of results achieved so far. This will be prepared by the Italian Ministry of Health in collaboration with all stakeholders to improve approaches to the disease.

2.2.3.5 Tuberculosis

Italy is a low tuberculosis (TB) incidence country, yet 3769 TB cases, of whom 110 were multidrug-resistant TB, were reported in 2016. The unprecedented and continuing flow of migrants arriving in Italy in recent years indicates the need to strengthen surveillance. WHO and Italy are collaborating closely in this field, with three active TB collaborating centres in Italy.

2.2.3.6 Neglected tropical diseases

Although few neglected tropical diseases (NTDs) (such as leishmaniasis, echinococcosis and leprosy) are acquired locally in Italy, many can be travel-acquired and therefore represent a risk to Italian residents due to increases in trade and travel/migration, and climate change. The One Health approach is implemented in surveillance and control activities for zoonotic infections such as leishmaniasis.

In relation to imported vector-borne diseases, a specific surveillance and response plan is dedicated to chikungunya, dengue and Zika viruses, including case-based surveillance, vector surveillance and risk communication. Surveillance was extended to the congenital syndrome associated with Zika virus infection in 2017, in line with WHO recommendations. After the local outbreak of chikungunya in 2007, some regions developed innovative approaches and tools for vector control that can be shared as best practices with other countries.

The leprosy epidemiological pattern in Italy completely changed over the last decades. While local cases almost disappeared, the number of imported cases increased, highlighting the need to strengthen international cooperation.

Historically, Italy has several scientific institutions working on the control/elimination of NTDs and studying NTDs both in Italy and in the tropics. These include the Institute for Infectious Diseases “Lazzaro Spallanzani”, ASST Fatebenefratelli Sacco, the Italian Society of Infectious and Tropical Diseases, and the Italian Society of Tropical Medicine and Global Health.

2.2.3.7 Migration: refugees’ and migrants’ health

Europe generally, and Italy in particular, have experienced a large and unprecedented influx of refugees and migrants in the last few years. Since 2014, the escalation of crises in the Middle East area has increased the phenomenon of landings. Over 181 000 people arrived on Italian shores via the Mediterranean Sea in 2016 alone, and the figure for 2017 had reached over 93 000 by July. The increase of migration flows is also manifest at global level: the number of international migrants worldwide reached a historical record of 244 million, according to 2015 figures.

The health status of migrants arriving in Europe is generally good, with low prevalence of infectious diseases, but migrants may have complex health profiles due to the difficulties of the

journey, including dehydration, starvation, trauma and injuries, untreated NCDs, exposure to toxic vapours and, sometimes, signs of torture and violence, especially gender-based violence. The proportion of women among refugees ranged globally between 47% and 49% from 2003 to 2015, while that of children ranged more widely, from 41% in 2009 to 51% in 2015. Refugee and migrant women and girls are disproportionately affected by displacement and face multiple challenges, including health challenges, in these contexts. Pregnant women may have increased medical risks, such as gestational hypertension and anaemia, along with adverse pregnancy outcomes, including low birth weight or preterm birth. They also face issues related to violence, including sexual violence and rape, experienced during the journey.

The onset of the migration crisis limits economic opportunities, weakens social institutions, and increases the chance of sexual violence against women and girls. Documented and undocumented migrants are eligible to receive the same public health services provided to Italian citizens, but central government has cut financial streams to regions and local administrations, resulting in decreased budgets for disability, child health and other welfare policies. As a result, vulnerable groups, such as the very poor, migrants and prisoners, are more disadvantaged.

Italy is highly committed to moving the refugee and migration health agenda forward. The Italian Ministry of Health hosted the first European high-level meeting on refugee and migrant health in Rome on 23–24 November 2015. Ministers and senior representatives of Member States of the WHO European Region met to discuss the numerous public health challenges posed by large-scale movements of refugees and migrants to transit and destination countries. The objective was to move towards a shared understanding of refugee and migrant health. Guided by discussion at the Rome high-level meeting, the WHO Regional Office for Europe adopted the first-ever strategy and action plan on refugee and migrant health at the 64th session of the Regional Committee for Europe.

The Regional Office held its inaugural summer school on refugee and migrant health in Syracuse, Italy on 10–14 July 2016. The summer school, which aimed to promote knowledge-sharing and better understanding of refugee and migrant health, served as the starting point for a vast collaborative effort to learn about and improve the way the European Region protects and promotes the health of refugees and migrants. WHO also teamed up with the Italian Government and military to offer summer school participants a unique glimpse of the way Italy has aided thousands of refugees arriving via the Mediterranean Sea. The Italian authorities, who have significant experience in carrying out search-and-rescue operations, welcomed participants to view a simulation of the Italian Coast Guard's response to a migrant boat emergency.

2.2.3.8 Environment and health

Italy, with a total surface of around 300 000 km^2, is placed in the middle of the Mediterranean area within the temperate zone of the boreal hemisphere. The territory comprises a continental northern sector, a peninsular central-southern sector, two large islands (Sardinia and Sicily) and various archipelagos and minor islands. It has a varied physiography with two major mountain ranges (the Alps and the Apennines) with different lithological features, active volcanoes and alluvial plains.

Despite recent progress, Italy still faces significant environmental challenges, with direct and indirect impacts on health. These involve the exploitation of non-renewable natural resources, a general reduction in biodiversity, constrained disposal of household and hazardous solid waste, inland water contamination due to natural and anthropogenic pollution (the latter representing ancient and recent emissions), poor quality of many urban areas and spreading of environmental

outlaw management. Due to its geological and geomorphological characteristics, Italy is also susceptible to hydrogeological instability, which makes the country particularly vulnerable.

Several conditions made Italy a pilot country for assessment of the impact of climate change, design and validation of strategies of prevention, and adaptation to the negative effects. Italy is surrounded by seas for two third of its surface, with an exuberant urban-development and anthropogenic coastal zone. The direct dependence between climate and deep movement of marine masses, which serves the oxygenation of the seas, means the Mediterranean Sea is more affected by climate change than other seas.

Italy recognizes that water is the most fragile segment in the ecosystem and needs to be carefully protected and managed now, in view of possible future challenges. Water supply systems and wastewater treatments are being affected by extreme events (such as droughts and flooding), with increased hydrogeological risk, soil erosion, coastal-zone flooding, and modification of inland water, marine and mountain ecosystems.

2.2.3.9 Climate change

The climatic change trend is expected to worsen in the future, with rising temperatures, water resource scarcity, coastal erosion, modification of inland water, marine and mountain ecosystems, loss of biodiversity, flooding and drought leading to re-emerging problems for water access (six of Italy's regions requested the government to call a state of emergency due to water stress in 2017), reduction in agricultural production, higher risk of forest fires, desertification and a threat to key economic sectors all possible. Climate change also affects air quality, particularly in urban settings, and causes changes in the spatial distribution of flora and fauna, which degrades biodiversity. Other climate-related impacts Italy is facing include glacial and snow-cover loss in the Alpine ecosystem and landslides and flood risks in the basin of the Po River, the most productive area of the country.

Due to climate change, there is a concrete risk of the re-emergence of previously endemic agents (with the occurrence of wild poliovirus in neighbouring countries and a potential increase of TB incidence in migrants), or the arrival of exotic communicable diseases, such as dengue, chikungunya, Zika, Crimea Congo fever, West Nile fever and blue tongue: they are either surrounding Italy or already getting into the country, with severe damage already incurred (10% of the national blood reserve has been lost because of West Nile fever contamination). Implications are clear and protection strategies have been strengthened, but there is an obvious, constant and increased risk, including the impact of population movements (see section above on refugees' and migrants' health).

A warming trend in Italy has been observed in recent decades, bringing greater risk of heat-related morbidity and mortality, vector-borne diseases, and an increased risk of waterborne, foodborne and respiratory diseases.

2.2.3.10 2030 Agenda for Sustainable Development: national strategy

In 2015, Italy started a process coordinated by the Ministry of the Environment and involving all stakeholders from institutions and civil society to develop a national strategy to meet the goals of the 2030 Agenda for Sustainable Development. The national strategy is based on five thematic areas: 1) people; 2) planet; 3) development and poverty reduction; 4) peace; and 5) partnership. Each area includes strategic choices and national objectives matching the targets of the 2030 Agenda and monitored through regular reports to the United Nations.

The health sector is well represented in all the thematic areas:

- people: Italy stresses the importance of healthy lifestyles and reinforcing prevention on risk factors for NCDs; the country aims to reduce maternal mortality and will strengthen UHC;
- planet: Italy focuses on preservation of the environment, climate change, water resources and sustainable cities with clear air and clean transport;
- development and poverty reduction: Italy gives importance to creating an economic model of development that looks at employment and gender equality, addresses environmental factors affecting the sustainability of cities, aims to stop climate change and reduces carbon emissions in line with the Paris Agreement;
- peace: Italy links this strictly to the implementation of social protection policies and gender equality; despite the challenges of organized crime, violence and corruption, it will be extremely important to answer global challenges, like inclusion of the migrant population; and
- partnership: the national strategy refers to the objective of the International Cooperation for Development defined by the Ministry of Foreign Affairs, bringing the national strategy to an international environment to support achievement of the 2030 Agenda in less advantaged countries in geographical areas where Italy can make a positive impact through bilateral and multilateral programmes.

2.3 Health system response

2.3.1 Health services delivery

Italy has a National Health Service that is regionally based, with the central government sharing responsibility for health care with the country's 19 regions and two autonomous provinces. At national level, the government exercises a stewardship role, controls and distributes the tax-financed health budget and defines the national benefits package (known as the Essential Levels of Care) that must be guaranteed to all residents. The regions are responsible for the organization, planning and delivery of health services through local health authorities. Public hospital-based physicians are salaried employees.

Regions enjoy substantial autonomy in how they structure their health systems within the general framework established nationally (building on previous decentralization efforts and incomplete market-oriented reforms). Since 2016, several regions have introduced new organizational models and health service delivery processes, while others have merged local health authorities into larger entities. The overall aim of these reforms is to achieve efficiency gains and improve quality of care through economies of scale and better organizational integration. Despite the commitment to decentralized health systems being legally enforced, policy concerns have been raised over regional differences in population health status, and access to, and quality of, health services.

Despite pervasive improvements in life expectancy at birth and adult ages, regional differences remain. The northern and central regions provide health services aligned with international practices and in line with central government orientations, but southern regions appear to lag behind. While equitable access to health care is one of the statutory objectives of the health-care system, important inequities in health status and health-care provision appear to exist across socioeconomic groups, including immigrants.

The gaps in provision of health-care reflect socioeconomic and cultural factors but may also be explained by decentralization policies introduced in the last decades that have left the southern regions with less central support to cope with more difficult social contexts.

2.3.2 Primary health care

Health-care services are delivered through public providers (such as district and regional hospitals and university hospitals) and private accredited providers. Great emphasis is placed on primary care, and people are required to register with a general practitioner (GP) (or a paediatrician for children up to the age of 14), who has financial incentives to act as a gatekeeper and prescribe and refer only as appropriate. Primary care services in health centres are guaranteed 24/7 through the primary care out-of-hours service (called the guardia medica). Financial incentives have been provided in recent years for GPs to move towards various models of group practice with fellow GPs and/or other health professionals. In an effort to improve the coordination of care, some regions have also introduced chronic disease management programmes, focusing on conditions such as diabetes, congestive heart failure and respiratory conditions.

2.3.3 Health workforce

The health workforce has been growing steadily over the past decade, but again there are wide variations in regional distribution. The ratio of doctors to population (3.8 per 1000) is higher than the EU average (3.6), but the density of nurses is relatively low (6.1 nurses per 1000 population, compared to an EU average of 8.4). The role of nurses is currently being strengthened in Italy, especially with regard to management of chronic-care patients and the introduction of nurse-led professional groups in primary care.

2.3.4 Medicines

Despite policy efforts to improve efficiency in pharmaceutical spending, generics still constitute a small share of the overall volume of prescribed drugs. Recent policies have promoted the prescription of generics by requiring GPs explicitly to state the active ingredients of prescribed drugs to facilitate substitution, but still the share of generics in Italy remains much lower than in most other EU countries. There is also limited capacity for health technology assessment at national level.

2.3.5 Health financing

Italy spent nearly 9.1% of its gross domestic product (GDP) on health in 2015, which is aligned with the Organisation for Economic Co-operation and Development (OECD) average, although health spending has fallen in Italy, as in many other European countries, as part of government efforts to reduce budgetary deficits following the economic crisis. The reduction in pharmaceutical spending has contributed to the overall reduction in health spending.

Despite the country's decentralized structure, most regions cannot totally fund health-care budgets with their own resources and must rely on central transfers. Regions also allocate their funds using different criteria and methods. As a consequence, some southern regions still suffer from large deficits and hospital care receives more funds than primary and community health services.

Despite increasing financial controls from central government, the costs per patient treated per service provided and per input units (costs per hospital bed, for example) in secondary care have

not decreased over the last 25 years. On the contrary, they have increased and are higher than in most OECD countries. A possible reason might be the high number of small hospitals.

2.3.6 Universal health coverage

The Italian National Health Service automatically covers all citizens and foreign residents, making the health system theoretically universal in terms of population coverage. It also gives access to basic services, such as emergency care, to people with no residence permit without the need for registration in the national health system. Other health-care services for people without residence permits are increasingly covered by nongovernmental organizations (NGOs), but costs outside of basic services are covered mainly through out-of-pocket payments. The market for voluntary health insurance is quite limited (0.9 % of total health expenditure in 2012).

Despite full coverage for basic medical services, 7% of Italians report some unmet needs for medical examination, either for financial or geographic reasons (having to travel too far) or waiting times. The proportion of people in the lowest income group reporting some unmet needs for medical care is particularly high (over 14% in 2014), compared with about 2% among those in the highest income group. Most of the unmet medical needs are attributable to care being too expensive (6.5%), with waiting lists at 0.5% and distance at 0.1%.

National studies have found a significant level of inequity in health service use by socioeconomic status, with a significant amount of pro-rich inequity in specialist care, diagnostic services and basic medical tests, and pro-poor inequity in the use of primary care (see Glorioso & Subramanian in the bibliography). Disparities in use of specialist care, diagnostic services and basic medical tests are largely connected to the higher health literacy of the well-off (affecting utilization rates of preventive services and screening), flat-rate co-payments (limiting access to mainly specialist outpatient care for people on low incomes), and low-quality services and long waiting lists (particularly in the southern regions) that lead citizens to turn to private health care, with the ability to pay for those services positively associated with socioeconomic status. According to the WHO Global Health Expenditure Database for 2014, over 20% of health expenditure in Italy was paid for out of pocket. While primary and hospital inpatient care are free at the point of service, flat co-payments are levied on outpatient specialist visits (with a GP referral, otherwise the full cost is paid), diagnostic procedures and medicines with full or partial reimbursement (regions determine co-payments).

2.3.7 Mental health system

Italy was one of the first countries in Europe to promote the de-institutionalization of mental health patients. Reform of psychiatry started in Italy after the passing of the Basaglia Law in 1978 and terminated with the end of the Italian state mental hospital system in 1998. Among European countries, Italy was the first to publicly declare its antagonism to mental health-care systems that led to social exclusion and segregation.

Reform was directed towards the gradual dismantling of the psychiatric hospitals and required the development of a comprehensive, integrated and responsible community mental health service. The objectives of community care are to reverse the practice of isolating people with mental illness in large institutions, promote their integration in the community by offering them a milieu which is socially stimulating, and avoid subjecting them to too intense social pressures.

2.4 National response to new challenges

Italy is also engaged in two other challenges: governance and stewardship; and genomics. The experience gained in these fields could potentially contribute to the global health agenda.

2.4.1 Governance and stewardship

As one of the four major functions of health systems, stewardship is expected to play an important role in the health agenda of countries worldwide, particularly those that have devolved powers (as is the case for Italy). There is, however, little empirical evidence to support or guide its implementation, and relevant data and information for its proper measurement are lacking.

Based on the WHO conceptual framework, and in accordance with the Tallinn Charter, Italy started to apply the suggested framework in the process of policy-making (the preventive national plan and the cancer plan) and in the management of challenging public health interventions (cancer screening programmes).

2.4.2 Genomics

The issue is how to promote innovation in the National Health Service based on research findings in the field of the so-called omic sciences (genomics and others). The timeliness and importance of advances in genomics in medicine call for cooperation to share best practice and solutions among countries. So far, genomics has often been outside the public health arena, yet public health officers and practitioners should take the lead in identifying the best paths for integrating genomics into public health and health care to benefit population health.

2.5 Conclusion

In summary, the biggest challenge the health-care system faces is meeting budgetary limits without reducing the provision of health services to patients. This is related to equity across regions, with gaps in service provision and health-care system performance.

Other issues include ensuring the quality of professionals managing facilities, promoting group-practice and other integrated care organizational models in primary care, and ensuring that the concentration of organizational control of health-care providers by regions does not hinder innovation.

With regard to the increasing number of migrants, emergency preparedness and response, interministerial coordination and aspects of the existing health information system are key issues that need to be strengthened further.

Availability of data is vital to identify problems, monitor performance and ensure accountability in the health-care system. Accordingly, several recent interventions have been directed at improving existing information systems and making data available to the public, although implementation has been slow.

Chapter 3. Contributions of Italy to global health

3.1 International initiatives

Italy has been a Member State of WHO since the founding of the organization and has a long history of collaboration. Italy has always been an active partner in major health initiatives and has been one of the leading donors for voluntary contributions for many years.

WHO is funded through assessed and voluntary contributions. The assessed contribution to WHO paid through the Ministry of Health of Italy in accordance with the share of the country will top US$ 42 million in the biennium 2016–2017, equating to US$ 21 million annually.

Italy is also an active donor through ad hoc voluntary contributions, mainly via the Ministry of Foreign Affairs. The country has been contributing for many years to funding the emergency response programmes supporting WHO's responses to humanitarian and complex emergencies. The emergency logistic hubs in Brindisi provide a good example of Italy's active involvement in health emergency preparedness and response.

Italy has been very active in the governing bodies of WHO, participating regularly at the Regional Committee for Europe.[5] It has several times been a member of the Standing Committee of the Regional Committee (SCRC), which comprises representatives of 12 countries, with each member elected by the Regional Committee to serve for three years at European level. Italy has hosted the WHO Regional Committee for Europe at various times in past years and is scheduled to host it again in 2018. Italian representatives have also been active participants at the World Health Assembly.

Italy took a post in the WHO Executive Board in May 2017. The Executive Board is composed of 34 technically qualified members elected for three-year terms, with the main functions of implementing decisions and policies approved at the World Health Assembly.

3.2 Cooperation in global health

Rome hosted WHO's European Office for Health and Environment, supported economically by Italy between 1991 and 2011. The office was a contributing factor to WHO's achievements in this specialized field on risk factors, environmental pollution, lung cancer and children's allergies. Since 2003, the WHO European Office for Health and Development has been hosted in Venice, focusing on the social determinants of health.

The Public Health Aspects of Migration in Europe (PHAME) three-year project was established in 2012, responding to recent migration in the European Region. The Ministry of Health extended the PHAME project for a second three-year period in 2015 (see also Chapter 4 on cooperation on refugees' and migrants' health).

Italy strongly supports multilateral international politics, endorsing the United Nations and its international security activities.

[5] The WHO Regional Committee for Europe is WHO's decision-making body in the European Region, formulating regional health policies, commenting on the programme budget and nominating the regional directors every five year for WHO Executive Board approval.

Italy has contributed to the Vaccine Alliance (GAVI) since 2006, when it became a founding member of the International Finance Facility for Immunization (IFFIm); Italy is its third largest contributor, with a 20-year commitment of €473.5 million. The country also contributes to the Global Fund and the Advanced Market Commitment to AMR.

The Fifth Ministerial Conference on Environment and Health, organized by the WHO Regional Office for Europe, was hosted in Parma in 2010, representing a key milestone in the European environment and health process. The Conference focused on the protection of children's health in a changing environment and set Europe's agenda on emerging environmental health challenges for the years to come through the Parma Declaration.

Italy, in collaboration with WHO, hosted an international high-level meeting on health and migration in November 2015, attended by ministers and senior representatives of Member States of the WHO European, African and Eastern Mediterranean regions, with the aim of discussing the numerous public health challenges posed by large-scale movements of refugees and migrants to transit and destination countries. Representatives of the European Commission, the European Centre for Disease Prevention and Control (ECDC), the Office of the United Nations High Commissioner for Refugees, the International Organization for Migration and the United Nations Children's Fund, among other international organizations, also attended the Conference.

Italy, in collaboration with WHO, organized the first global/interregional meeting on TB in Catania in May 2016 to review existing tools and discuss the way forward to provide timely diagnosis and treatment of TB among migrants and ensure continuity of care for people crossing borders.

Italy has been a Party of the FCTC since 2008 and has been participating actively in the Conference of the Parties since its second meeting (as an observer). It participated specifically to working groups on Article 6 (price and tax measures to reduce the demand for tobacco) and Article 17–18 on economically sustainable alternatives to tobacco-growing.

The country is also a member of the G7 and G20 groups, the global forums for heads of state to discuss global foreign policy issues and through which Italy has always fostered health dialogue. A multi-institutional-financed project involving WHO and Italian health authorities (Ministry of Health, the National Institute of Health and regional health agencies) entitled *Climate change and health in a vision of planetary health* is in progress. This will produce original scientific information useful in setting up, conducting and following actions in support of health decisions regarding the Italian presidency of the G7 (2017), either referring to the heads of state meeting in May 2017 or the health ministerial meeting in November 2017. The project is focused particularly on defining and propagating a strategy for mitigating the effects of climate change on human health and the planet, in accordance with the Planetary Health vision. The WHO/United Nations Framework Convention on Climate Change (UNFCCC) climate and health country profile for Italy is a milestone of the project.

The G7 meeting was hosted again by Italy in May 2017. The outcome declaration for health stated the commitment of the G7 to advancing global health security and pursuing policies that promote physical and mental health improvements across the globe. It also recognized that healthy lives and well-being are important to broader economic, social and security gains, acknowledged the role of environmental factors in affecting human health, and committed to strengthening health system preparedness for a prompt, effective and coordinated response to

public health emergencies and long-term challenges. In addition, a specific focus on women's and adolescents' health was included in the final G7 summit declaration.

Chapter 4. Italy's cooperation with WHO

The following review is based on regular reporting and discussions with programme managers at the WHO Regional Office for Europe and WHO headquarters, along with national counterparts at the Ministry of Health and the Ministry of Foreign Affairs. Specialized institutions, including WHO collaborating centres, also contributed.

4.1 Cooperation with the Ministry of Health

4.1.1 Collaborating centres

Italy hosts 25 WHO collaborating centres that support the organization's technical work and programmes contributing to scientific work of WHO in the European Region. The full list of collaborating centres in Italy is shown in Annex 2.

4.1.2 Cooperation on refugees' and migrants' health

The WHO Regional Office for Europe and the Italian Ministry of Health established a specific project for health and migration in 2012 at the WHO European Office for Investment for Health and Development in Venice.[6]

As a result of this cooperation, WHO was able to provide technical advice to all European countries faced with large migration, promote the model developed in Italy for providing immediate and necessary interventions to tackle the specific health needs of migrants, and start a sensitization, advocacy and coordination process on migration. As the arrival of refugees and migrants increased across the European Region, especially in 2015 through the so-called Balkan route, the Ministry of Health reiterated its support by extending the PHAME project for an additional three-year period.

With financial support from the Ministry of Health, the Regional Office prepared a strategy and action plan on refugee and migrant health in the Region to bring forward a region-wide framework on health and migration. The plan was prepared under the guidance of the SCRC subgroup on migration and health, chaired by Italy, and was approved at the Regional Office's governance meeting in September 2016. This work in the European Region has informed the migration and health policy process at global level.

The Regional Office hosted the first organization-wide meeting on the development of a global framework on migration and health in December 2016, where Italy presented its work and leadership through the SCRC subgroup. The Regional Office has been providing support since then to WHO headquarters for the global process; at the World Health Assembly in 2017, Member States agreed to develop a global action plan on refugee and migrant health in 2018, and on the relevance of WHO's input into the process of development of the global compacts on refugees, and to safe, orderly and regular migration.

4.1.3 Cooperation on social determinants of health: the WHO European Office for Investment for Health and Development

Italy is very much involved in evaluating the impact of social determinants of health. In line with this, the country sponsored the opening of the WHO European Office for Investment for Health

[6] The office was established through a memorandum of agreement between the Government of Italy (the Ministry of Health and the Veneto Region) and the WHO Regional Office for Europe, and opened in 2003.

and Development in Venice in 2003. The office has provided an evidence-based, systematic and accountable approach to the integration of social and economic determinants of health for Member States of the European Region.

The Venice office coordinates initiatives that support implementation of Health 2020 in the Region at various levels of government. One remarkable output is the Small Countries Initiative, which targets the eight countries in the Region with a population of less than 1 million. Additionally, the office provides assistance to the WHO Regions for Health Network, which complements the work on health carried out at national level by working with subnational actors, and provides technical assistance to the hosting Italian region, Veneto, specifically in the area of health promotion.

4.1.4 Cooperation on environmental health

Italy is a leading country in promoting the reduction of environmental contamination and adaptation to climate change, including its impact on health and development. Between 1991 and 2011, Italy hosted and financially supported the WHO European Office for Health and Environment in Rome, contributing to the implementation of many European policies and WHO guidelines on environmental hazards.

This office has also been very active in collaborating with WHO on water issues, publishing water guidelines developed by the Ministry of Health and the Istituto Superiore di Sanita (ISS) and driving parallel actions focusing on developing health criteria and methods for water reuse at national and European levels. The office moved recently to the United Nations compound in Bonn, Germany.

WHO and the Italian ministers of health and environment, land and sea participated in the Fifth Ministerial Conference on Environment and Health, “Protecting children’s health in a changing environment”, hosted in Parma in March 2010. Among the resulting actions, the following have strategic value:

- water issues: publishing water guidelines developed by the Ministry of Health and ISS and driving parallel actions focusing on developing public health criteria and methods for water reuse at national and European levels;
- industrially contaminated sites: building on collaborative assessments of Italian sites and undertaking international projects to develop and disseminate methods and strategies for dealing with human health in contaminated sites; and
- waste and health: collaborating on specific Italian cases of waste disposal sites (Turin) and hazardous waste (Campania), producing impact assessments and developing consensus-based guidance for waste management options at European level.

The Ministry of Health, in collaboration with the National Institute of Health and the WHO Collaborating Centre ITA-97, organized a side event on the impact of industrially contaminated sites on human populations, a global environmental health priority, at the 6th Ministerial Conference on Environment and Health in Ostrava, Czechia in June 2017.

4.1.5 Cooperation on mental health

Italy and WHO have a long history of collaboration in the field of mental health. An important area of collaboration concerns implementation of the comprehensive mental health action plan for 2013–2020. The action plan focuses on four key objectives: strengthening effective leadership and governance for mental health; providing comprehensive, integrated and

responsive mental health and social care services in community-based settings; implementing strategies for promotion and prevention in mental health; and strengthening information systems, evidence and research for mental health.

The Italian WHO collaborating centres and experts have contributed to the development of the Mental Health Gap Action Programme guidelines and intervention guide to support countries to scale up services for mental, neurological and substance use disorders. Experts are also supporting synthesis of information on mental health policies, services and resources as part of the Mental Health Atlas project and facilitating reporting on implementation of the comprehensive mental health action plan.

Italian scientists have been much involved in the development and field-testing of the chapter on mental, behavioural and neurodevelopmental disorders for the Eleventh Revision of the International Classification of Diseases and Related Health Problems (ICD-11). People are only likely to have access to the most appropriate mental health services when the conditions that define eligibility and treatment selection are supported by a precise, valid and clinically useful classification system.

Italy is also collaborating in the area of dementia and supporting implementation of the recently approved global action plan on the public health response to dementia. The country is working closely with WHO in developing a global dementia observatory, which is an interactive web-based data and knowledge-exchange platform being developed to strengthen health and social-care systems to support people with dementia and their caregivers.

4.1.6 Cooperation on neglected tropical diseases

In Italy, two WHO collaborating centres work on NTDs.

Ospedale Sacro Cuore – Don Calabria, in Negrar, is the WHO Collaborating Centre on strongyloidiasis and other intestinal parasitic infections. The centre is very active in research and diagnosis, with a special focus on epidemiological studies on local and migrant populations; and ISS, in Rome, is the WHO Collaborating Centre for the epidemiology, detection and control of cystic and alveolar echinococcosis (in humans and animals). It provides support to validate strategies to generate baseline data for the control of cystic and alveolar echinococcosis through studies on the epidemiology, detection, molecular characterization and evaluation of the disease’s burden. The centre also maintains, and is expanding, the prospective, observational, multicentre International Register that focuses on the epidemiology and clinical management of cystic echinococcosis while maintaining and strengthening the international network for epidemiology, detection and control of alveolar and cystic echinococcosis in humans and animals.

In addition, Italian experts were actively involved in defining the new manual on case management and surveillance of the leishmaniases in the WHO European Region and were consulted on the development of emergency risk communication materials to support responses to outbreaks of Zika virus and other mosquito-borne diseases in the European Region.

4.2 Cooperation with the Ministry of Foreign Affairs

Italy has funded one of the most important United Nations logistic hubs for delivering emergency supplies, known as the emergency supply warehouse in Brindisi, since its inception.

The warehouse is strategically located to transport by air medical supplies and WHO kits to countries in the Middle East and Africa.

The Ministry of Foreign Affairs is funding several WHO projects via multilateral channels contributing to the global health agenda. WHO's multi/bilateral initiatives sponsored through the AICS are in progress in:

- Afghanistan: support to the WHO programme for health system responses to gender-based violence and the polio-eradication initiative;
- Eritrea: support to the local health system, with reference to cardiology services;
- West Bank and Gaza Strip: development of a hospital information system to improve the quality of hospital services; and
- Sudan: support for international health regulations.

A regional programme of technical assistance aimed at tackling the tobacco epidemic is also running in four African countries (Ethiopia, Mozambique, Uganda and the United Republic of Tanzania).

While the Ministry of Health represents the main referral point for WHO, the Ministry of Foreign Affairs, supported by the AICS and the diplomatic mission in Geneva, has been very active in funding global projects and will be the referral interlocutor for WHO regarding the implementation of this strategic priority.

Italy has been an important donor to WHO in support of its development of the first guidelines on management of health consequences from female genital mutilation (FGM), which was launched in May 2016 and is being disseminated through regional and country offices.

The country funded a project on promoting access to modern, sustainable energy in health-care facilities in Africa with a particular focus on countries vulnerable to climate change, such as Ethiopia and Kenya. The project addressed interlinkages between three key development issues – energy, poverty and climate change – and women's and children's health. The findings are expected to shed light on the energy situation in this category of hospitals overall in Ethiopia and Kenya, providing them with tools to drive strategies to meet the new SDG 7 target focusing on clean and modern energy. They will also be used to explore the feasibility of including the greening of health sector energy infrastructure as a focus area under national commitments to climate change, particularly the Intended Nationally Determined Contributions framework of the UNFCCC.

Chapter 5. A strategic agenda for cooperation

This CCS aims to strengthen both partners' roles in global health and achievement of the SDGs, support Italy in implementation of national health priorities in line with the European Health 2020 framework and national SDG agenda, and improve health governance and the impact of priority health programmes in countries supported by the AICS under the Ministry of Foreign Affairs.

5.1 Prioritization process

Priorities were set in a multi-stage consultation with all stakeholders, including representatives of all levels of WHO, the Government of Italy, scientific institutions and other international partners, beginning with an analysis of the current health situation and joint activities involving the Ministry of Health and WHO.

Key issues in line with Italy's health policy and new priorities, the SDGs agenda, Health 2020 and WHO's Twelfth General Programme of Work were identified. The CCS working group reviewed the findings and identified four strategic priority areas for cooperation between Italy and WHO.

5.2 Strategic priorities

The following four priorities were jointly identified by the Ministry of Health of Italy and WHO:

1. implementing the Health 2020 policy for health and well-being, aligned with the roadmap on the SDGs and the national SDG agenda, focusing on governance and leadership, supporting Italian national health policies reinforcing whole-of-government and whole-of-society approaches, and tackling inequities to address the social determinants of health, refugees' and migrants' health, climate change and environmental health;
2. promoting well-being through the life-course by addressing and mitigating the impact of the major risk factors for noncommunicable diseases, including mental health and women and child health, and by governing innovation of the national health system based on achievements in the field of genomics sciences;
3. addressing communicable diseases under the One Health approach, including implementing the national vaccination plan and supporting the strengthening of global responses to international public health emergencies; and
4. strengthening the role of Italy as a donor country in global health through the WHO global programmes and enhanced collaboration between WHO and Italy in the AICS priority countries.

The Ministry of Health and WHO will work to achieve these strategic priorities under the following conditions, considering that both Parties:

- have the specific and necessary expertise and resource available;
- will develop cooperation by implementing mutually beneficial activities at national, global, regional and global levels; and
- will jointly address the priorities and generate added value to each other's health agenda at all levels.

5.2.1 Strategic Priority 1

Implementing the Health 2020 policy for health and well-being, aligned with the roadmap on the SDGs and the national SDG agenda, focusing on governance and leadership,

supporting Italian national health policies reinforcing whole-of-government and whole-of-society approaches, and tackling inequities to address the social determinants of health, refugees' and migrants' health, climate change and environmental health.

Health 2020 is the current overarching European health policy framework. It aims to support action across government and society to improve significantly the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality. Italy is also interested in joint collaboration on practical research on health system stewardship within implementation of the Health 2020 policy.

In the European Region, Health 2020 provides a stepping stone towards achieving the SDGs and "leave no one behind", as it incorporates approaches and priorities common to the 2030 Agenda.

This strategic priority will support the achievement of SDG 3 (good health and well-being), targets 3.8 (UHC) and 3.9 (reduce the number of deaths and illnesses from air, water, soil pollution), SDG 6 (access to safe water and sanitation and sound management of freshwater ecosystem), SDG 10 (reduced inequalities), target 10.7 (facilitate orderly, safe, regular and responsible migration and mobility of people) and SDG 11 (sustainable cities and communities).

5.2.1.1 Refugees' and migrants' health

Italy has committed a large amount of financial and human resources from different sectors to provide rescue operations in the Mediterranean Sea and assistance, including health care, once the migrants arrived in the islands around Sicily, the farthest south Italian region and the first one to be involved in receiving migrants.

The phenomenon of irregular migration, together with the large influx of refugees and asylum seekers, causes considerable pressure on the national health system, not only in addressing the need to provide immediate assistance, but also at later stages in integrating migrants into regular health-care benefits like any other Italian citizen.

The WHO Regional Office for Europe has collaborated with the Italian Ministry of Health on migration and health since 2012. Several assessment missions have been conducted in Sicily, after which the Regional Office supported health authorities to develop the first public health contingency plan for large-scale migration. Following the experience of Italy, the Regional Office continued to support European countries in the development of migrant-sensitive public health policies and health system strengthening to provide equitable access to health services, and advocate for intercountry coordination and cooperation on this issue.

The first strategy and action plan for refugee and migrant health, endorsed by the Regional Office in September 2016, set nine priority areas for implementation in the upcoming years in relation to migration and health. The Regional Office is supporting countries along these lines by acting on four main fronts: strengthening the available evidence and health information; providing country-tailored technical assistance; conducting communication and advocacy activities; and moving forward the policy agenda at European and global levels. In addition, thanks to the financial support of Italy and Sicily, the Regional Office has established a Knowledge Hub on Health and Migration to establish the first knowledge library on this topic, provide online and in-person training opportunities, and convene policy dialogues and political summits to reach consensus. The Knowledge Hub acts as a convener in the field of migration and health, gathering all key stakeholders to build on their strengths and coordinate actions.

5.2.1.2 Climate change and environmental health

It is scientifically established that greenhouse gas emissions generated by human activity change the earth's climate, with impacts observed on all continents. Climate change must be addressed, as it increases the likelihood of severe, pervasive and irreversible impacts for people and ecosystems. Mitigation in the form of human interventions to reduce the sources or enhance the sinks of greenhouse gases, including responses by health services and adaptation in a health system context, is available.

Growing urban development obliges Italy to confront numerous environmental, climatic, energy, infrastructure and social inclusion challenges at different levels. Environmental degradation, particularly air pollution, contributes to the additional burden of noncommunicable chronic diseases and exacerbates the risk of dysmetabolic conditions through, inter alia, endocrine disruptors linked to diabetes and obesity.

Environmental changes are key determinants of health. Environmental pollution is a major cause of illness in industrialized countries, especially cardiovascular, respiratory and neoplastic diseases. In this field, Italy is working to develop targeted investments, currently limited to sporadic experiences that could help to reduce significantly the increasing number of chronic diseases globally, and at the same time reduce costs to the health-care system.

In response to the threat of climate change, Italy is committed to a low-carbon future and has developed a national adaptation strategy, which includes specific adaptation measures for the health sector, and is currently developing a national adaptation plan.

Contaminated sites and waste are strictly connected to human health. Among the activities coordinated by the WHO Collaborating Centre on Environmental Health in Contaminated Sites in force at the ISS, the most important is the 2015 launch of a European Cooperation in Science and Technology (COST) action on the Industrially Contaminated Sites and Health Network. The COST action currently involves WHO, the EU and European Commission bodies and the public environmental health institutions of 33 countries.

Urban health is another complex issue, as actions aimed at enhancing the living conditions of cities depend not only on the health sector, but also on decisions pertaining to other sectors, such as local government, education, urban planning and social services. A healthy city is one that is continually creating and improving the physical and social environment and expanding community resources. Urban planning to create healthy cities should be considered as a form of prevention and health promotion, as it could promote healthy lifestyles through a transport system that encourages pedestrian and cycle accessibility, and a design of green and open areas responsive to all citizens' needs and aimed at supporting wellbeing and social interaction.

There is also long-standing cooperation between Italy and WHO in the field of water and health. Italian experts co-authored several editions of WHO guidelines on drinking-water quality and provided assistance to the WHO Regulatory Network of Drinking-water Regulators and the WHO–United Nations Economic Commission for Europe protocol on water and health. Specific cooperation among WHO, the Ministry of Health and the National Institute of Health is being drafted to implement a two-year programme on training health and environmental institutions and water suppliers on implementation and approval of water safety plans.

The adoption of the water safety plan approach in policies and regulations is a universally recognized public health benchmark for the provision of safe drinking-water. A national

roadmap towards scaling up water safety plans in practice – including institutional capacity-building and training – is a priority action in Italy. In addition, preliminary experience and implementation of the sanitation safety plan approach offers a means to systematically manage health risks along the entire sanitation chain to ensure safe disposal or reuse of human waste.

5.2.1.3 Social determinants of health

Italy shows strong interest in the impact of social determinants of health, reflected in its hosting and financing of the WHO European Office for Investment for Health and Development in Venice.

The economic crisis in Europe in 2007/2008 led to a decline of 3.3% in GDP per person in 2009. WHO recommends that Italy and other Member States in Europe should nevertheless avoid budget reductions for health services, as this might increase health inequalities affecting mainly vulnerable groups, causing a negative impact on the general health status of the population in the longer term.

It is now widely recognized that to increase economic growth and welfare together, a multi-stakeholder approach is the most effective strategy to ensure sustainable development in health and promote the maintenance of good health throughout the life-course. Intersectoral collaboration allows the development of actions on health determinants (to be activated in places and social contexts in which people live, work or interact with each other) in more effective, efficient or sustainable ways than those developed only by the health sector.

To ensure multisectoral action to address social determinants of health and to promote participatory governance and investments for health and development, the Ministry of Health will facilitate WHO approaches aligned with the Health 2020 framework and the 2030 Agenda for Sustainable Development. This will also be done through collaboration at subnational levels (Regions of Health and the Healthy Cities Networks) and by using the findings of the WHO European health equity status report to support implementation of national and regional cross-sectoral policies for health equity.

5.2.1.4 Biodiversity and human health

The European Conference on Biodiversity and Health in the Face of Climate Change held on 27–29 June 2017 in Bonn, Germany highlighted how climate change represents a significant and growing threat to the conservation of biodiversity and human well-being, how biodiversity in rural and urban areas can protect health, and how nature-based solutions can reap benefits in terms of mitigating climate change and its effects.

Italy and WHO are cooperating on strengthening policy coherence and maximizing synergies among key agencies working at the intersection between human health and biodiversity. This contributes to supporting mandates based on decisions XIII/6 and XII/21 of the Conference of the Parties to the Convention on Biological Diversity and other relevant mandates. Collaboration in this intersection is supported by the Parties to better integrate biodiversity and health relations into the implementation of the 2011–2020 strategic plan for biodiversity, SDGs and global commitments to supporting approaches to health quotas, and promote the multiple dimensions of health and well-being.

5.2.1.5 Development of formal and informal education and training on the relationship between biodiversity, ecosystem services and health (SDG 4)

The entire educational system, from pre-primary schools to universities, can play a key role in disseminating knowledge of complex and interlinked environmental and health issues, as discussed at the Paris Conference on Promoting Intersectoral and Interagency Action for Health and Wellbeing (7–8 December 2016). To be able to shape a better future, governments, NGOs, civil society and all other stakeholders should improve formal and informal education (SDG 4.7) oriented towards sustainable development and centred on healthy life promotion, aiming to mitigate health risks associated with climate change and environmental pollutants.

5.2.2. Strategic Priority 2

Promoting well-being through the life-course by addressing and mitigating the impact of the major risk factors for noncommunicable diseases, including mental health and women and child health, and by governing innovation of the national health system based on achievements in the field of genomics science.

This strategic priority will support the achievement of SDG 3 (good health and well-being), target 3.4 (reduce by one third premature mortality from NCDs), target 3.7 (universal access to sexual and reproductive health care services, family planning and integration of reproductive health into national strategies and programmes), and SDG 5 (gender equality), target 5.2 (eliminate all forms of violence against all women and girls in the public and private spheres).

5.2.2.1 Address and mitigate the impact of major risk factors for NCDs, including mental health

The Italian national strategy to reduce the main risk factors linked to unhealthy behaviours and prevent NCDs is two-fold: promoting a healthy lifestyle for individual people; and fostering an intersectoral approach aiming to gain health knowledge about many health determinants that lie outside of health system components, and the need to establish policies in other sectors.

The Italian strategy, named *Gaining health: making healthy choices easier*, led by the Ministry of Health, emphasizes the importance of a multi-stakeholder approach, with the involvement of central and local government and partnerships with sectors such as education, agriculture, transport and sport in pursuit of the final goal of improving the health of citizens in line with the principles of health in all policies.

According to *Gaining health*, the Italian national prevention plan for 2014–2018, which is implemented at regional level, provides an integrated approach to facilitating multisectoral policies and processes that affect public health and promote health, addressing individual behaviour but also the quality of living and working environments. All Italian regions have implemented projects for NCD prevention, with particular emphasis on unhealthy diets, physical inactivity, harmful consumption of alcohol and tobacco use. The national prevention plan also addresses the issue of environmental exposures that are potentially harmful to health through actions to improve the monitoring of environmental pollutants and strengthen epidemiological surveillance, and supports policies for the improvement of air, water and soil quality.

The prevention plan is based on decreasing the burden of diseases and premature mortality by fighting risk factors, investing in welfare of the young generation, addressing the needs of vulnerable groups by fighting inequities and including migrants, and promoting the relationship between environment and health.

WHO is able to provide guidelines and tackle risk factors affecting the development of NCDs, including alcohol and hazards in the working environment. Activities may include promoting healthy lifestyles and diet, and tackling obesity and inadequate physical activity.

A life-course approach is necessary to combat NCDs and their risk factors, addressing the study of social and environmental determinants throughout life. Italy has one of the longest life expectancies and knowledge about the elderly population, which is consequently of high relevance.

WHO can support a European policy articulated around an intersectoral approach as a cornerstone for future health gains.

5.2.2.2 Mental health

Based on its long-term experience of community-based mental health care, Italian scientific institutions developed a broad knowledge that has been shared for many years with WHO to produce modern guidelines. WHO will continue to work with Italian scientific institutions and experts to develop more updated documentation and promote de-institutionalization and community-oriented approaches to mental health problems.

Collaboration on the implementation of the comprehensive mental health action plan for 2013–2020 will continue.

ICD-11, which involved Italian scientists revising the chapter on mental, behavioural and neurodevelopment disorders, is due to be approved by WHO in 2018. Italian scientists will be instrumentally involved in the translation, dissemination and implementation of the new classification systems in ways intended to realize potential benefits for the quality of health information and practice improvement.

5.2.2.3 Women's health rights, mother and child health

Italy has always given primary importance to gender issues. Women's and adolescents' health protection and promotion are key strategic components of health systems building and strengthening in every country, given women's roles as health drivers and caregivers. Investing in adolescents brings health benefits over short and long terms, reduces health costs and enhances social capital. Women and adolescents are not only health service users, but may also have a major impact on improving systems by changing behaviours and fighting against the roots of diseases, violence and inequality. They can, if listened to and empowered, contribute to improving health systems' quality and resilience, given their position in the family and society.

The national fertility plan, a health and education strategy, was launched in 2015 to make people aware of possible ways to maintain and preserve fertility and at the same time inform them of infertility prevention methods, such as early detection and treatment of medical conditions that can threaten fertility. Implementation of the plan addresses sexuality education for young people, training for health-care professionals, and upgrading and updating of health services.

In 2015, Italy also launched an extraordinary action plan against sexual and gender violence, fostering public policies against violence and supporting victims. A network of local services and inpatient, outpatient, social and health-care providers deliver integrated interventions to all women victims of violence. A dedicated pathway for women victims of violence is going to be implemented in the emergency departments of some hospitals, with a protected space and time to

offer physical, psychological and legal information and assistance while showing fundamental respect for confidentiality.

The Minister of Health launched the first national Women's Health Day in 2016 and presented a manifesto for women's health. This cornerstone for building initiatives over the next five years includes contributions from the entire National Health Service and involves other institutions that are convinced multisectoral commitment is a winning tool for achieving significant results in promoting women's health.

All these initiatives are in line with, or based on, WHO collaboration and recommendations. On health and well-being of children and adolescents, the Ministry of Health devotes much attention not only to the birth period, but also to actions in the first 1000 days of life (from conception to 2 years of age), considering that timely preventive interventions made in this period lead to positive short-, medium- and long-term health outcomes. These actions are in line with the Minsk Declaration of October 2015.

Special attention has been dedicated to policies on health care for mother and child, with the 16 December 2010 agreement between central and regional government on *Guidelines for the promotion and improvement of the quality, safety and appropriateness of care interventions during the birth pathway and for the reduction of caesarean sections*. This presents an organizational model of assistance that accompanies a women/couple and their newly born baby before, during and after the birth, under continuous monitoring for the Ministry of Health by the National Birth Pathway Committee. Another agreement concerning guidelines for the promotion and improvement of the quality, safety and appropriateness of care interventions in paediatric and adolescent fields is ongoing.

Besides health promotion and disease prevention, Italy has invested in surveillance systems to monitor the health of children and adolescents, such as those on maternal and perinatal mortality, Zerodue (surveillance to monitor the effectiveness of some specific preventive actions in children aged 0–2 years), Okkio for school-aged children and the Health Behaviour in School-aged Children survey for adolescents.

Italy has also invested in women's and children's health, strengthening the health-care system in this field by developing scientific institutions. Some of these institutions are WHO collaborating centres, including the Paediatric Hospital Burlo Garofalo in Trieste, which has contributed to many WHO guidelines on child and adolescent hospital care and children's care in countries with limited resources. This institution will continue to play an important role in future projects with WHO. The Ministry of Foreign Affairs also collaborates with WHO in this area through providing funding support via multilateral channels for several projects contributing to the global health agenda.

WHO has collaborated with Italian institutions, including the Parliament, on issues related to women's and children's health, such as violence against women, traditional practices such as child, early and forced marriage, and FGM.

5.2.2.4 The importance of genomics

Advances in genomics have crucial implications for public health, offering new ways of differentiating individuals and groups within the population that go beyond the measures normally used by public health professionals, such as gender, age, socioeconomic status, physiological measurements and clinical biomarkers. Genomics may bring benefits in stratifying

individuals according to genetic risk, enabling better targeting of preventive and therapeutic interventions.

While several European countries, including Italy, have implemented a legal framework or even national plans for the integration of genomics advances into public health, the survey initiative of the European Chief Medical Officer is currently struggling to find any structured example of existing policies on this topic. Coordinated efforts among EU Member States, with the development of dedicated policies and harmonization, will nevertheless be possible following EU Council resolutions adopted by the end of 2015.

WHO recognizes that so-called personalized medicine is emerging as a major topic in e-health. WHO could be instrumental in promoting harmonization of policies on genomics in all Member States of the European Region and providing guidelines for proper integration of the complexity of genomics science into health systems.

5.2.3 Strategic Priority 3

Addressing communicable diseases under the One Health approach, including implementing the national vaccination plan and supporting the strengthening of global responses to international public health emergencies.

This strategic priority will support the achievement of SDG 3 (good health and well-being), target 3.3 (end epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, combat hepatitis, water-borne diseases and other communicable diseases). Regarding communicable diseases, Italy has adopted a One Health approach, comprising human and animal health linkages.

5.2.3.1 Implementation of the national vaccination plan

The Ministry of Health of Italy is committed to fully implementing the vaccination plan in line with the national legislation, the international protocol and WHO recommendations, considering immunization as one of the most valuable preventive and sometimes lifesaving approaches to preventing death from infectious diseases. It must reflect various regional policies, however, creating different approaches to reaching full immunization of the whole country population.

Italy, in common with other European countries, is affected by a trend of scepticism towards, and disinformation about, the benefits of immunization that has spread among health professionals and the general population. The Ministry of Health is fighting very strongly against this negative trend and scepticism regarding the safety and effectiveness of vaccines through legislative tools, continuous education events for health professionals and public health promotion campaigns to raise awareness of the benefits of vaccination among the population. WHO will provide all the technical tools, international standards and technical assistance, if requested, to revert the negative trend among the general population and health workers .

5.2.3.2 HIV and AIDS

The new national plan on HIV/AIDS aims to outline the best possible ways to achieve the objectives identified as priorities by international agencies like the ECDC, the Joint United Nations Programme on HIV/AIDS and WHO, and is in line with measures in the action plan for the health response to HIV in the WHO European Region presented at the WHO Regional Committee for Europe in Copenhagen, Denmark in 2016.

5.2.3.3 Tuberculosis

Italy is a low TB-incidence country. WHO and the ECDC review national programmes and provide key findings and recommendations jointly with national experts, the results of which can be used to develop national TB elimination plans. Italy is hosting three WHO collaborating centres focusing on TB, each of which is highly engaged in national and international activities. The country is also coordinating a pilot project involving all Member States launched by the ECDC aimed at the evaluation of whole-genome sequencing as a tool for surveillance of TB transmission and rapid identification of cross-border clusters.

The increase in the migrant population suggests that TB rates will increase, so Italy needs to prepare itself to ensure early diagnosis and full treatment of vulnerable groups.

5.2.3.4 Neglected tropical diseases

The WHO global vector control response for 2017–2030 and the new TDR strategy for 2018–2023 are key documents for strengthening cooperation on NTDs, vector-borne diseases and vector control.

WHO will foster Italy's role in the European Region on strengthening bilateral cooperation in supporting laboratory capacity and implementing integrated surveillance for NTDs using the One Health approach and best practices through Italian scientific centres of expertise.

5.2.3.4 Antimicrobial resistance

National health authorities in Italy have great concerns about AMR, as antibiotic resistance percentages are higher than the European average in every Italian region and there are no signs that this phenomenon is declining for all of the most important pathogens. Italy is supporting many international initiatives focusing on AMR (including those of the G7 and G20 groups and the Global Health Security Agenda) and is collaborating with WHO and the European Commission.

Following WHO recommendations, the Ministry of Health coordinated the development of the first Italian national plan to fight AMR, adopting a One Health integrated approach with a strong commitment to developing local operative plans. Italy intends to participate in the WHO Global Antimicrobial Resistance Surveillance System (GLASS) for assessing the burden of AMR and providing necessary information for action in support of local, national and global strategies.

Considering the importance of preparedness and early response, the Ministry of Health is studying a platform that permits exchange of information about microbiological alerts among hospitals and regional and national levels. The objectives of the platform are to provide a tool to facilitate the control of national/international outbreaks, monitor the circulation of pathogens with unusual antibiotic profiles or genotyping, and exchange information about alert microorganisms with international organizations (including WHO).

Italy is planning to build, in collaboration with WHO, a network of local and regional laboratories supporting the surveillance and alert systems, defining minimal capacity criteria regarding AMR diagnosis for participation in the network and for each level. Such a network would support the national reference laboratory for AMR located in the national public health authority.

5.2.3.5 Improving the response to international public health emergencies

The Italian Ministry of Health and WHO are collaborating on the implementation and improvement, whenever necessary, of the International Health Regulation (IHR). Since the updated version was finalized in 2005, the IHR has demonstrated its effectiveness in detecting public health threats around the world. WHO improved the IHR after the Ebola experience and as part of emergency reform.

Italy further strengthened collaboration with WHO during the Ebola crisis through enhanced engagement of the Italian WHO collaborating centres and scientific institutions like the ISS and the Hospital Spallanzani, which have successfully treated some of the Ebola cases that reached Europe. The ISS is a member of the Global Outbreak Alert and Response Network (GOARN), a collaboration of institutions and networks that is constantly alert and ready to respond. The network pools human and technical resources for rapid identification, confirmation and responses to outbreaks of international importance. WHO coordinates international outbreak responses using GOARN resources.

5.2.4 Strategic Priority 4

Strengthening the role of Italy as a donor country in global health through the WHO global programmes and enhanced collaboration between WHO and Italy in the Italian Development Cooperation Agency priority countries.

This strategic priority will support the achievement of SDG 1 (no poverty), target 1.5 (reduce exposure and vulnerability to disasters), SDG 3 (good health and well-being), target 3.1 (maternal mortality), target 3.2 (newborns and child health), target 3.4 (NCDs and mental health), target 3.7 (universal access to sexual and reproductive health-care services, family planning and integration of reproductive health into national strategies and programmes), target 3.8 (UHC), target 3.9 (reduce the number of deaths and illnesses from air, water, soil pollution), SDG 5 (gender equality), target 5.6 (ensure universal access to sexual and reproductive health and reproductive rights) and SDG 10 (reduced inequalities).

5.2.4.1 Italy as a donor country and WHO global programmes

Italy, as a donor country via multilateral channels, has always been committed to the global agenda of WHO and has financed projects and activities beyond the European Region, mainly in Africa, the Middle East and a few Asian countries, especially through Ministry of Foreign Affairs' voluntary donations to projects submitted by various WHO departments.

The country has also been committed for a long time to supporting WHO in emergency responses; it remains committed to supporting the emergency logistic hub of Brindisi for selecting specific intervention proposals.

Several global programmes might continue to attract interest, as well for funding support, from Italy, such as TB and multidrug resistance, mother and child health, women's health and human rights, the health consequences and management of FGM, child care, climate change and environmental health, and NTDs.

WHO will continue to provide high-level technical assistance and targeted projects to improve the health status of the poorest populations, respond to humanitarian complex emergencies, and address infectious disease threats through a more effective and transparent work methodology.

WHO will collect and coordinate project proposals at headquarters in Geneva and coordinate with all technical departments and the Italian diplomatic mission in Geneva to submit project proposals meeting the technical areas of interest of WHO and Italy, but with the specific aim of continuing to support people in need worldwide.

WHO will also make a commitment to report timeously and in a proper format to the donor country.

5.2.4.2 Enhanced collaboration between WHO and Italy in the AICS priority countries

The aim is to improve communication, coordination and collaboration between Italy and WHO and strive to further support WHO's leading and coordination role at country level, together with national health authorities, focusing on better health governance. In this regard:

- WHO should facilitate Italy's engagement in dialogue on health policy development and implementation in the AICS priority countries;
- Italy should support WHO in its role of convening health development partners and engage in technical cooperation; and
- the systematic exchange of expertise between Italy and WHO should be expanded in the priority countries.

Chapter 6. Implementing the Country Cooperation Strategy

6.1 Implementation of the strategic agenda

Under the strategic agenda, the Ministry of Health and WHO are expected to work together to implement the CCS. The agreed CCS priorities will serve to guide the direction of strategic cooperation between Italy and WHO during the next six years.

The Ministry of Health, which represents Italy at the World Health Assembly and the Regional Committee for Europe, will be the main partner for WHO through its relevant departments. The Ministry of Foreign Affairs and its diplomatic mission in Geneva play a crucial role in fostering Italy's participation in international organizations and in selecting projects and providing funds for global initiatives; it will also represent a referral point for WHO.

The importance of some of the strategic areas identified, such as refugees' and migrants' health and NCD risk factors, may require a wider approach and the involvement of other partners and ministries at various levels. The Ministry of Health is expected to coordinate this intersectoral approach in Italy to fully implement the health priorities identified, using tools such as the Health 2020 framework and the SDGs to foster collaboration.

In turn, WHO will cooperate with Italy at all of its levels, guided by the Health 2020 framework, which was endorsed by all 53 Member States of the European Region, to ensure multisectoral working and technical interactions with the Ministry of Health of Italy are consistent and based on the CCS priorities.

Italy, as a donor country at global level, is providing financial support for various WHO priorities at global and European levels.

WHO headquarters in Geneva will be the referral level for the Ministry of Health and the Ministry of Foreign Affairs for global public health issues and for negotiating financial support to WHO for global activities in line with the SDG agenda.

The WHO Regional Office for Europe will foster and coordinate regional collaboration with the Ministry of Health of Italy, especially in relation to the Health 2020 framework.

Finally, WHO will continue to support Italy with technical expertise and European Member State coordination in facing the new health dynamics of migration and developing new public health policies for migrants, building on Italy's experience as one of the most important European entry points and recipient countries for migrants.

6.2 Requisites for effective implementation of the strategic priorities

The Ministry of Health and WHO are committed to promoting the CCS to the Government of Italy and to their respective relevant technical departments and units to guide the collaborative programmes and joint activities and ensure successful completion of joint targets and common shared goals set within the CCS strategic framework.

The CCS will serve as a useful tool for resource mobilization for health at global, regional and national levels.

6.3 Monitoring and evaluation of the strategic priorities

The CCS is not a binding document, but a guide for future planning, allocation of resources and partnership.

A CCS focal team is expected to facilitate implementation of the CCS and to meet once a year, or whenever deemed appropriate by the Parties, to assess progress with its implementation, highlight successes, identify and tackle any constraints hindering implementation, and discuss issues of common interest.

The CCS focal team should comprise, on the Italian side, representatives of the Ministry of Health, Ministry of Foreign Affairs and Italian Development Cooperation, and on the WHO side, representatives of the main entities involved in the implementation of the CCS (including, in particular, the unit on Strategic Relations with Countries at the WHO Regional Office for Europe, and the Department of Country Cooperation and Collaboration with the United Nations in WHO headquarters).

In addition, representatives of the Ministry of Health of Italy and WHO will discuss, monitor and evaluate the partnership during the meeting happening aside of the World Health Assembly and Regional Committee for Europe annually.

The Strategic Monitoring Framework for the CCS is shown in Table 1.

Table 1. Strategic Monitoring Framework for the CCS

CCS strategic priority	Related, indicative SDG 3 targets	Other SDG targets
1. Implementing the Health 2020 policy for health and well-being, aligned with the roadmap on the SDGs and the national SDG agenda, focusing on governance and leadership, supporting Italian national health policies reinforcing whole-of-government and whole-of-society approaches, and tackling inequities to address the social determinants of health, refugees' and migrants' health, climate change and environmental health	3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all 3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	10.7 Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies 11.6 By 2030, reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality and municipal and other waste management and strengthening climate resilient water and sanitation safety plan implementation at national level 13.3 Improve education, awareness-raising and human and institutional capacity on climate change mitigation, adaptation, impact reduction and early warning

CCS strategic priority	Related, indicative SDG 3 targets	Other SDG targets
2. Promoting well-being through the life-course by addressing and mitigating the impact of the major risk factors for noncommunicable diseases, including mental health and women and child health, and by governing innovation of the national health system based on achievements in the field of genomics science	3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
3. Addressing communicable diseases under the One Health approach, including implementing the national vaccination plan and supporting the strengthening of global responses to international public health emergencies	3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases 3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	SDG 6 – Clean water and sanitation
4. Strengthening the role of Italy as a donor country in global health through the WHO global programmes and enhanced collaboration between WHO and Italy in the Italian Development Cooperation Agency priority countries	3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births 3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases 3.4 By 2030, reduce by one third	1.5 By 2030, build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters 4.2. Ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education 5.1 End all forms of discrimination against all women and girls everywhere 5.3 Eliminate all harmful

CCS strategic priority	Related, indicative SDG 3 targets	Other SDG targets
	premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being 3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination 3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	practices, such as child, early and forced marriage and female genital mutilation

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Annex 1

WHO GLOBAL HEALTH OBSERVATORY KEY INDICATORS, 2015

Key indicators: **Italy**	
WHO region	**Europe**
Child health	
Infants exclusively breastfed for the first six months of life (%) (1999)	5
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (2015)	93
Demographic and socioeconomic statistics	
Gender inequality index rank (2014)	10
Human development index rank (2014)	27
Health financing	
Total expenditure on health as a percentage of gross domestic product (2014)	9.25
Private expenditure on health as a percentage of total expenditure on health (2014)	24.39
General government expenditure on health as a percentage of total government expenditure (2014)	13.65
Health systems	
Physicians density (per 1000 population) (2014)	3.945
Nursing and midwifery personnel density (per 1000 population) (2014)	6.475
Mortality and global health estimates	
Neonatal mortality rate (per 1000 live births) (2015)	2.1 [1.8–2.4]
Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2015)	3.5 [3.1–4.0]
Maternal mortality ratio (per 100 000 live births) (2015)	4 [3–5]
Public health and environment	
Population using improved drinking-water sources (%) (2015)	100.0 (Total)
	100.0 (Urban)
	100.0 (Rural)
Population using improved sanitation facilities (%) (2015)	99.5 (Total)
	99.5 (Urban)
	99.6 (Rural)

Sustainable development goals	
Life expectancy at birth (years) (2015)	84.8 (Female)
	82.7 (Both sexes)
	80.5 (Male)
Births attended by skilled health personnel (%) (2013)	99.9
World Health Statistics	
Population (in thousands) total (2015)	59797.7
Population proportion under 15 (%) (2015)	13.7
Population proportion over 60 (%) (2015)	28.6
Literacy rate among adults aged >= 15 years (%) (2007-2012)	99

Annex 2

WHO COLLABORATING CENTRES

Reference	Institution name	City	Title
ITA-34	University of Milan	Milan	WHO Collaborating Centre for Epidemiology and Community Dentistry
ITA-38	University of Verona	Verona	WHO Collaborating Centre for Research and Training in Mental Health and Service Evaluation
ITA-40	University of Naples	Naples	WHO Collaborating Centre for Research and Training in Mental Health
ITA-49	Istituto Superiore di Sanità	Rome	WHO Collaborating Centre for Reference and Research on Poliomyelitis
ITA-56	Istituto per l'Infanzia IRCCS Burlo Garofolo	Trieste	WHO Collaborating Centre for Maternal and Child Health
ITA-73	State University of Milan	Milan	WHO Collaborating Centre for Traditional Medicine
ITA-74	Associazione Oasi Maria Santissima I.R.C.C.S	Troina	WHO Collaborating Centre for Research and Training in Neuroscience
ITA-79	Istituto Superiore di Sanità	Rome	WHO Collaborating Centre for Research and Health Promotion on Alcohol-related Health Problems
ITA-80	Fondazione Salvatore Maugeri, Clinica del Lavoro e della Riabilitazione	Tradate	WHO Collaborating Centre for Tuberculosis and Lung Diseases
ITA-81	Italian National Insurance for Work Accidents and Occupational Diseases (INAIL)	Rome	WHO Collaborating Centre for Occupational Health and Safety
ITA-85	Regional Central Health Directorate	Udine	WHO Collaborating Centre for Family of International Classifications
ITA-86	University of Pavia	Pavia	WHO Collaborating Centre for Clinical Management of Cystic Echinococcosis
ITA-89	National Institute for Infectious Diseases IMNI 'L. Spallanzani'	Rome	WHO Collaborating Centre for Clinical Care, Diagnosis, Response and Training on Highly Infectious Diseases

Reference	Institution name	City	Title
ITA-90	University of Brescia	Brescia	WHO Collaborating Centre for TB/HIV collaborative activities and the TB Elimination Strategy
ITA-91	Azienda per i Servizi Sanitari n. 1 Triestina (A.S.S. n. 1)	Trieste	WHO Collaborating Centre for Research and Training in Mental Health
ITA-92	Azienda Ospedaliera San Paolo	Milano	WHO Collaborating Centre for Occupational Health
ITA-96	Centro Nazionale Trapianti	Rome	WHO Collaborating Centre on Vigilance and Surveillance for Human Cells, Tissues and Organs
ITA-97	Istituto Superiore di Sanità (National Institute of Health)	Rome	WHO Collaborating Centre for Environmental Health in Contaminated Sites
ITA-98	Fondazione San Raffacle	Milan	WHO Collaborating Centre on Tuberculosis Laboratory Strengthening
ITA-100	Agenzia Internazionale per la Prevenzione della Cecitá – IAPB Italia Onlus	Rome	WHO Collaborating Centre on Prevention of Blindness and Rehabilitation
ITA-101	Azienda ospedaliera Città della salute e della scienza, Torino	Turin	WHO Collaborating for cancer early detection and screening
ITA-102	Ospedate Sacro Cuore – Don Calabria	Negrar	WHO Collaborating Centre on strongyloidiasis and other intestinal parasitic infections
ITA-104	Centre for Clinical Risk Management and Patient Safety (GRC)	Florence	WHO Collaborating Centre in Human Factors and Communication for the Delivery of Safe and Quality Care
ITA-106	Catholic University of the Sacred Heart	Rome	WHO Collaborating Centre for Health Policy, Governance and Leadership in Europe
ITA-107	Istituto Superiore di Sanitá	Rome	WHO Collaborating Centre for Epidemiology, Detection and Control of Cystic and Alveolar Echinococcosis (in humans and animals)

The WHO Regional Office for Europe

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