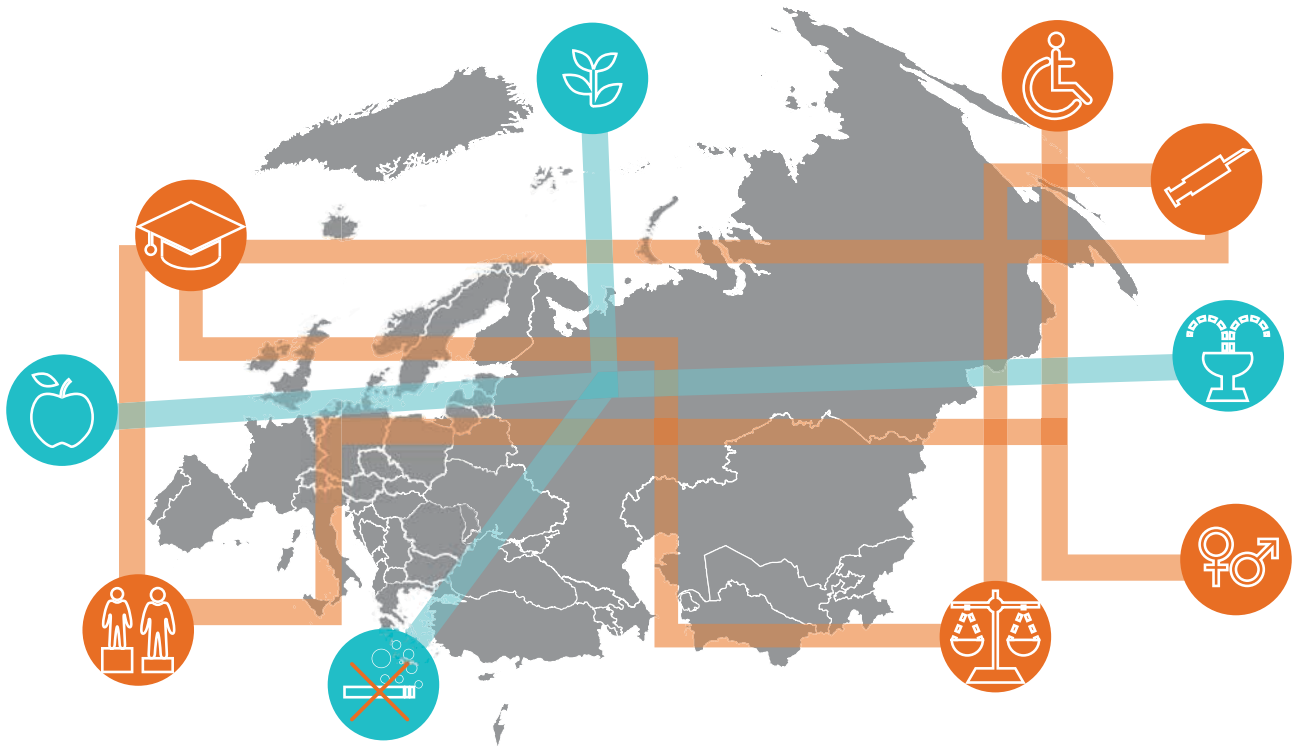




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Multisectoral and intersectoral action for improved health and well-being for all: mapping of the WHO European Region

Governance for a sustainable future:
improving health and well-being for all



Final Report

Multisectoral and intersectoral action for improved health and well-being for all: mapping of the WHO European Region

Governance for a sustainable future:
improving health and well-being for all

Abstract

Achieving the 2030 Agenda for Sustainable Development, and the strategic objectives of Health 2020, requires an innovative and new model of governance. A mapping exercise was undertaken by the Governance for Health Programme to identify instances of multisectoral and intersectoral action for improved health and well-being for all and to share best practices for multisectoral and intersectoral health and well-being policy development and implementation across the WHO European Region. Case stories, or narratives of good practice, detailing successful multisectoral and intersectoral initiatives were collected through consultations in 36 Member States of the WHO European Region. The case stories are collected and analysed in this report.

Keywords

intersectoral action
health
wellbeing
governance
coherence

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Foreword

Multisectoral and intersectoral action is crucial for health and well-being. Without working beyond the health sector, we will simply be unable to address the complex challenges that we face in our efforts to improve health and well-being, and reduce inequalities and inequities.

There is a significant legacy of multisectoral and intersectoral action in the WHO European Region. Knowledge and experience in the Region on the subject is broad and increasing, but in order to support change, we need to increase our efforts towards documenting, understanding, and drawing lessons from new and old practices and initiatives.

WHO European Member States are committed to the goals of the United Nations 2030 Agenda for Sustainable Development, and to the ongoing implementation of Health 2020, the European policy and framework for health and well-being. They recognize that this requires developing good policies and actions across all sectors that impact on health, well-being, and health equity, and that this must be done by developing new models of governance that focus on partnership and the scaling up of multisectoral and intersectoral working.

In 2015, WHO European Member States adopted the decision at the 65th session of the Regional Committee for Europe on *Promoting intersectoral action for health and well-being in the WHO European Region: health is a political choice*. They requested support in the development and implementation of multisectoral and intersectoral action. The WHO Regional Office for Europe has committed to providing this support through documenting, understanding and drawing lessons from new and existing practices and initiatives.

This mapping exercise is an important contribution to the knowledge and understanding of governance for health and well-being; it provides lessons and evidence from practice in the process of the implementation Health 2020, in the context of WHO's contribution to the achievement of the 2030 Agenda and the 17 Sustainable Development Goals, and in the broader work of WHO on governance for health and well-being. Multisectoral and intersectoral action for health and well-being requires new and improved approaches to governance, and the mapping will inform the WHO European Region Governance for Health Programme in the development of systematic approaches to strengthening governance for health and well-being.

Monika Kosinska
Programme Manager, Governance for Health
Regional Focal Point, WHO European Healthy Cities Network
Division of Policy and Governance for Health and Well-being
WHO Regional Office for Europe

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Abbreviations

| | |
|-------|--|
| AMR | antimicrobial resistance |
| DART | German antimicrobial resistance strategy (Deutsche Antibiotika-Resistenzstrategie) |
| EU | European Union |
| HiAP | health in all policies |
| NCDs | noncommunicable diseases |
| NGO | nongovernmental organization |
| SDG | Sustainable Development Goal |
| SEEHN | South-eastern Europe Health Network |
| SCI | Small Countries Initiative |

Executive summary

Many of our most pressing health and well-being problems and challenges cannot be solved without addressing their underlying determinants, many of which lie beyond the health sector and require engagement with sectors beyond health. As recognized in the United Nations 2030 Agenda for Sustainable Development (2030 Agenda) and in Health 2020, the European health policy framework, engaging sectors beyond health requires new and improved approaches to governance for health and well-being. In particular, a focus on whole system approaches, such as whole-of-government, whole-of-society, whole-of-city, health in all policies (HiAP) and other multisectoral and intersectoral approaches.

These approaches not only help to address health and well-being challenges that transcend traditional sectoral boundaries but also promote good governance for health and well-being by building accountability across sectors that impact health and well-being, encouraging broader participation in the policy process, enhancing policy coherence and strengthening collaborations and partnerships to improve health and well-being.

A two-part mapping exercise was undertaken across the WHO European Region by the Governance for Health programme to identify examples of good practice of multisectoral and intersectoral action for health and well-being, and to identify lessons learned for health policy development and implementation. Part One consisted of an internal mapping within the WHO European Office. Part Two was external, with case stories or narratives of good practice, detailing multisectoral and intersectoral initiatives drafted through consultations in 36 Member States of the WHO European Region. This report summarizes the findings of Part Two the mapping exercise.

Summary of the main findings

This analysis focuses on four key areas: (i) why and how multisectoral and intersectoral action was initiated (initiators and triggers); (ii) the focus and nature of multisectoral and intersectoral action across the case stories (policy areas); (iii) how multisectoral and intersectoral action was implemented in each Member State (implementation actions); and (iv) the impact and lessons learned (Facilitators, challenges and barriers).

Initiators and triggers

Across the case stories, multisectoral and intersectoral action was initiated primarily for three reasons: (i) when the health sector was unable to address health and well-being challenges on its own; (ii) to improve coherence across sectors; and (iii) to mobilize increased resources for improving health and well-being.

Three elements were identified as the most frequent triggers for initiating multisectoral and intersectoral action: (i) high-level political support from ministers and ministries responsible for health and well-being, (ii) engagement from WHO, and (iii) the introduction of data and evidence.

Policy areas

In the case stories collected, multisectoral and intersectoral action for health and well-being focused on an array of different policy areas. Most common, however, were the three policy areas of broader national or regional health policies, the prevention and control of noncommunicable diseases (NCDs) and health promotion in schools.

Implementation actions

The multisectoral and intersectoral approaches to health and well-being presented were implemented in various ways, at different levels and in different contexts. They primarily took the form of strategies and action plans, longer-term initiatives rather than short-term projects and as permanent coordinating structures. Interministerial committees were identified as the primary mechanism through which these forms of multisectoral and intersectoral action were initiated, established and implemented.

Implementation was seen predominantly at the national level as indicated in 20 of the 36 case stories; by contrast, only four case stories had an international dimension. A local level dimension to the multisectoral and intersectoral action was far more common, occurring in 14 case stories; eight of these were examples of coherence between the national, regional and local levels but only two also included coherence at the international level. This coherence throughout the levels, from international through national and regional to the local level, could be strengthened through increased WHO support to local level implementation through existing networks such as the WHO European Healthy Cities Network and the Regions for Health Network.

Facilitators

Several factors were found to enable and facilitate the implementation of multisectoral and intersectoral action for health and well-being, including political will and good governance; a clear mandate to reach out beyond the health sector; sufficient resources; supporting data and evidence; sufficient capacity; strong cross-sectoral collaboration; and civil society and media engagement, along with other contextual factors. In particular, identifying co-benefits and 'win-win' situations proved essential in motivating actors beyond the health sector to consider health and well-being goals in their activities.

The most obvious co-benefit identified was that many policy goals and objectives outside the health sector are easier to attain with healthy people; healthy people are productive

and better contribute to the social and economic development. Other co-benefits include an increased exchange of information across different sectors, more effective and efficient implementation of evidence-informed policies, and improved coordination between sectors. In the case stories presented, the focus remains mainly on the health-related benefits, which included an enhanced capacity to address health challenges, increased financing for health promotion, strengthening equity goals, decreased duplication of work, new cross-sectoral health indicators, and increased coherence.

The quality of cross-sectoral collaboration at the interpersonal level was also seen to be a determining factor; the early engagement of collaborators, effective working methods, trust, and open communication were considered to be critical for success. Other facilitating factors include the engagement of civil society and international partners. A number of cases highlighted the role of public pressure and media involvement in persuading governments to implement comprehensive cross-sectoral initiatives to tackle various health and well-being challenges. Additionally, some contextual factors were identified as facilitators and enablers, such as the smaller size of the Member State, the working culture of governing jointly, openness of the system to allow learning and the implementation new mechanisms, and an environment that encourages risk, creativity and innovation.

Challenges and barriers

Many of the challenges and barriers to multisectoral and intersectoral action for health and well-being are the contrast to the facilitating factors. A lack of political will or commitment has been cited as a clear challenge. Other common challenges include a lack of resources and coordination; inability or failure to identify co-benefits and to act in win-win situations; poor communication and ambiguous use of language; and entrenched siloed thinking, where resources are restricted for use only within a specific sector or programme. In a few cases, the health sector's own perceived superiority was mentioned as a barrier to collaboration with other sectors. In several cases, multisectoral and intersectoral approaches struggled to overcome conflicting interests between sectors, power imbalances and competition for resources, which made sustainability over time unachievable. A change of government or ministers was also found to present a challenge in terms of continuity and sustainability of policies and initiatives.

Recommendations

The case stories here suggest that the implementation of multisectoral and intersectoral initiatives could be strengthened by providing policy-makers, civil servants and technical experts with training on how to coordinate and structure multisectoral and intersectoral work in practise. One common concern was that high-level policy recommendations and guidelines were not translated into action because their implementation was not adequately supported. Suggested themes for training included general guidance on multisectoral and intersectoral

coordination, developing new engagement and mobilization strategies for different stakeholders and developing improved indicators and other monitoring tools for measuring progress. In terms of improving coherence among all levels of governance, WHO could give stronger support for implementation across levels, from international to local, through existing networks such as the WHO European Healthy Cities Network and the Regions for Health Network.

More specifically, a need was identified for tools and toolkits for planning, implementation and monitoring of multisectoral and intersectoral action. Several case stories called for broader public health education at the tertiary level, with a focus on the competencies necessary across sectors for effective implementation multisectoral and intersectoral initiatives.

Summary of main conclusions

Overall, the analysis found that multisectoral and intersectoral action for health and well-being has the potential to provide the transformative change called for by the 2030 Agenda and to mobilize additional resources for health and well-being. However, approaches need to be integrated into a new model of governance for health and well-being that is built around a stronger focus on partnerships, through a whole-of-society approach, and increased governance coherence, both horizontally across sectors and vertically through all levels of governance.

A new model of governance for health and well-being requires high-level political support. With this, multisectoral and intersectoral action for health and well-being can be an integral element of long-term political visions and strategies, ensuring sustainability for multisectoral and intersectoral approaches over time, and the building of a strong, accountable foundation for partnerships and collaboration in the era of the 2030 Agenda.

Moving forward, the data and analysis from this exercise can be used to inform and contribute to a new and improved model of governance for health and well-being. Achieving the 2030 Agenda and fulfilment of the strategic objectives of Health 2020 require transformative governance. This necessitates the involvement of diverse actors across all levels of government, and beyond, if global, regional and national goals and targets are to be achieved and today's complex global challenges effectively addressed.

The mapping exercise can contribute to addressing a number of gaps in the current understanding of multisectoral and intersectoral approaches. It highlights the need for an enhanced focus on governance for health and well-being, and for a framework and tools to aid Member States in implementation. The Member State case stories also contribute to an improved understanding of the role of the WHO Regional Office for Europe in supporting inter- and multisectoral action, both through engagement and support at the country level and through developing and delivering the new models of governance required to support multisectoral and intersectoral for health and well-being throughout the 53 Member States.

Introduction

There is a long-standing consensus that the root causes of poor health and well-being cannot be solved without addressing their underlying determinants. As these determinants span sectors beyond the health sector, addressing them requires collaboration and partnerships with other sectors. Multisectoral and intersectoral action is therefore critical (Box 1) for addressing many of today's most pressing challenges for improving health and well-being. In particular, it is necessary for the achievement of the goals and targets of the 2030 Agenda (1) and of the strategic objectives of Health 2020 (2), the framework guiding health policy throughout the WHO European Region and which aims to improve health for all, reduce health inequalities and improve leadership and participatory governance for health and well-being.

Utilizing whole system approaches such as whole-of-government, whole-of-society and HiAP, as well as other multisectoral and intersectoral approaches can strengthen governance for health and well-being by improving coherence and coordination across sectors and by enhancing accountability and responsibility in sectors that impact health and well-being.

Box 1. Definition of intersectoral action for health and well-being

This report uses an umbrella term intersectoral action for health and well-being to refer to a number of approaches that highlight the importance of working collaboratively across sectors (e.g. a whole of government, whole of society, HiAP, healthy public policy and social determinants of health) to improve health and well-being.

As a general definition, WHO and the Public Health Agency of Canada have described intersectoral action for health and well-being as “actions undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector, on health or health equity outcomes or on the determinants of health or health equity” (3).

The intersectoral action can be contrasted with action within a single sector, which is appropriate when one sector has complete or near-complete control or influence over a given health problem. However, a wide range of social and environmental factors influence health and, therefore, an intersectoral approach is preferable in many situations, “to achieve health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector working alone” (4).

Multisectoral and intersectoral action for health and well-being: a long-standing consensus

Many of the determinants of health and well-being – commercial, cultural, economic, environmental, political and social – are influenced by policies beyond the health sector. Therefore, multisectoral and intersectoral action is required for effective health promotion at the local, national, regional and global levels.

Recognition of the importance of a multisectoral and intersectoral approach to health policy dates back as far as the Alma-Ata Declaration of 1978, where Article 4 called for the involvement of all related sectors in efforts to promote health (5). In the 1980s, the health for all movement highlighted the importance of intersectoral collaboration and of prioritizing equity in health policy (4,6); in particular, the 1986 Ottawa Charter put forward the concept of healthy public policy and called for the involvement of other sectors in health promotion (7).

More recently, the seminal 2008 report of the WHO Commission on the Social Determinants of Health revived calls to address the root causes of ill health through intersectoral action for health and well-being (8). The Commission stated that reducing health inequalities would require actions to “improve daily living conditions” and “to tackle the inequitable distribution of power, money, and resources” (8). In 2011, the Rio Political Declaration called for increased engagement of all sectors, stating that “We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community” (9).

In 2013, the review of social determinants and the health divide in the WHO European Region recommended developing more “partnerships at all levels of government that enable collaborative models of working, foster shared priorities between sectors and ensure accountability for equity” (10). Globally, intersectoral action for health and well-being was called for in the Sixty-seventh World Health Assembly resolution A67/R12 (11). The 65th session of the Regional Committee for Europe discussed the working paper Promoting intersectoral action for health and well-being and well-being in the WHO European Region: health is a political choice (12), which concluded that “intersectoral action is difficult to achieve, yet it is essential for the coherence, synergy and coordination of various sectors and provides a basis for accountability in the area of health”.

Current approaches to multisectoral and intersectoral action for health and well-being and well-being

The 2030 Agenda consists of 17 Sustainable Development Goals (SDGs) with 169 targets that Member States aim to achieve (1,13) (Box 2). Goal 3 focuses explicitly on health, with 13 specific targets; however, almost all other goals are related to or contribute to health and well-being (14). Work related to the SDGs is multisectoral and intersectoral in nature and, therefore, the 2030 Agenda (1) constitutes an important policy framework that can further action on the social determinants of health and promote greater health equity on a global scale. Establishing a better understanding of the challenges and facilitators for multisectoral and intersectoral collaboration can better inform policy-making and help to achieve the SDGs and their accompanying targets.

Box 2. The United Nations 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs)

The United Nations 2030 Agenda for Sustainable Development was adopted by all 193 Member States of the United Nations at the United Nations Sustainable Development Summit on 25 September 2015 in New York.

The 17 Sustainable Development Goals (SDGs), otherwise known as the Global Goals, are a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity. They build on the successes of the Millennium Development Goals, while including new areas such as climate change, economic inequality, innovation, sustainable consumption, peace and justice, among other priorities. The goals are interconnected and require multisectoral and intersectoral action – the key to success for any one goal will involve tackling issues more commonly associated with another.



Health 2020 highlights the importance of multisectoral and intersectoral action, through whole-of-government and whole-of-society approaches, to tackling the European Region's most pressing health challenges (2). Conceptually, the Health 2020 policy framework is built on improving governance for health, which is defined as "to steer communities, whole countries or even groups of countries in the pursuit of health as integral to well-being through both whole-of-government and whole-of-society approaches" (2). The whole-of-government approach refers to "the diffusion of governance vertically across levels of government and arenas of governance and horizontally throughout sectors" (2). The whole-of-society approach extends the sphere beyond the traditional governmental decision-making by calling for increased engagement of the private sector, civil society, communities and individuals in health-related actions.

HiAP is a more recent whole-system approach that aims to integrate health considerations into policies that lie outside the health sector. The term was first used in 2006, when Finland adopted it as a theme during its European Union (EU) presidency. HiAP has been defined as an approach that “systematically takes into account the health and health-system implications of decisions, seeks synergies and avoids harmful health impacts” (15). These principles were endorsed in the 2013 Helsinki Statement on Health in All Policies at the Eighth Global Conference on Health Promotion (16). In addition, WHO has produced comprehensive training materials in order to facilitate the understanding and implementation of the HiAP approach (17).

The availability of reliable and accurate health statistics is an essential requirement to the multisectoral and intersectoral work of WHO. In addition to quantitative data, there have been increasing calls to broaden data collection efforts through the increased utilization of qualitative methods, such as the collections of case studies and narratives on successful policy interventions and initiatives; this study contributes to the latter area. For example, the WHO expert group on the cultural context of health and well-being recommended that WHO should work to enhance its current reporting “through the use of new types of evidence, particularly qualitative and narrative research” (18). The European Health Report 2015 called attention to the need to collect more qualitative data on policy interventions to help in understanding the degree to which policies implemented in one context are transferable to other cultures and communities (19).

Overview of the report

To support multisectoral and intersectoral action for health and well-being, the Division for Policy and Governance for Health and Well-being at the WHO Regional Office for Europe conducted a multisectoral and intersectoral mapping exercise from 2015 to 2017. The exercise aimed to identify examples of good practice for multisectoral and intersectoral action for health and well-being and to share lessons learned and best practices for health policy development and implementation. The aim was to inform and inspire ministries and health policy-makers to strengthen cross-sectoral collaboration for health and well-being. The first part of the exercise in 2015 involved internal consultation with 28 programme managers, unit leaders and technical officers within the WHO Regional Office for Europe to identify multisectoral and intersectoral actions for health and well-being. The second part was undertaken in 2015 and 2016 and involved external consultation with 36 Member States of the WHO European Region. From this a case story for each Member State was identified. Analysis of the findings was undertaken in 2017 and is presented in this report. The methodology used for the exercise is outlined followed by the key findings from the 36 case stories and then the case stories themselves. Annex 2 is the questionnaire used to collect the case stories.

Methodology

Table 1 outlines the two parts of the multisectoral and intersectoral mapping exercise. Part One consisted of an internal mapping within the WHO European Office. Part Two was external, with case stories or narratives of good practice, detailing multisectoral and intersectoral initiatives drafted through consultations in 36 Member States of the WHO European Region.

Table 1. Mapping exercise

| Sources | Method of data collection | Key outputs |
|---|--|---|
| Part I: internal mapping (2015): WHO Regional Office for Europe | Internal consultations with 28 programme managers, unit leaders and technical officers | Working paper Collection of multisectoral and intersectoral initiatives and mechanisms |
| Part II: external mapping (2015–2016): Member States | Consultations with WHO national focal points and Member State representatives | Summary report Subregional reports A compendium of case stories |

The methodological approach for Part Two - the external, Member State-focused, part of mapping exercise was finalized at two meetings, the first on 2 December 2015 and a follow-up meeting on 19 February 2016, held at the WHO European Office for Investment for Health and Development in Venice, Italy. The exercise focused on the collection of case stories (narratives of good practice) detailing successful examples of multisectoral and intersectoral action for health and well-being at the local, regional/subnational, national and international levels. The resulting case stories identified the structures, entry points, mechanisms and instruments that policy-makers had used to address health and well-being challenges situated between sectors across the WHO European Region.

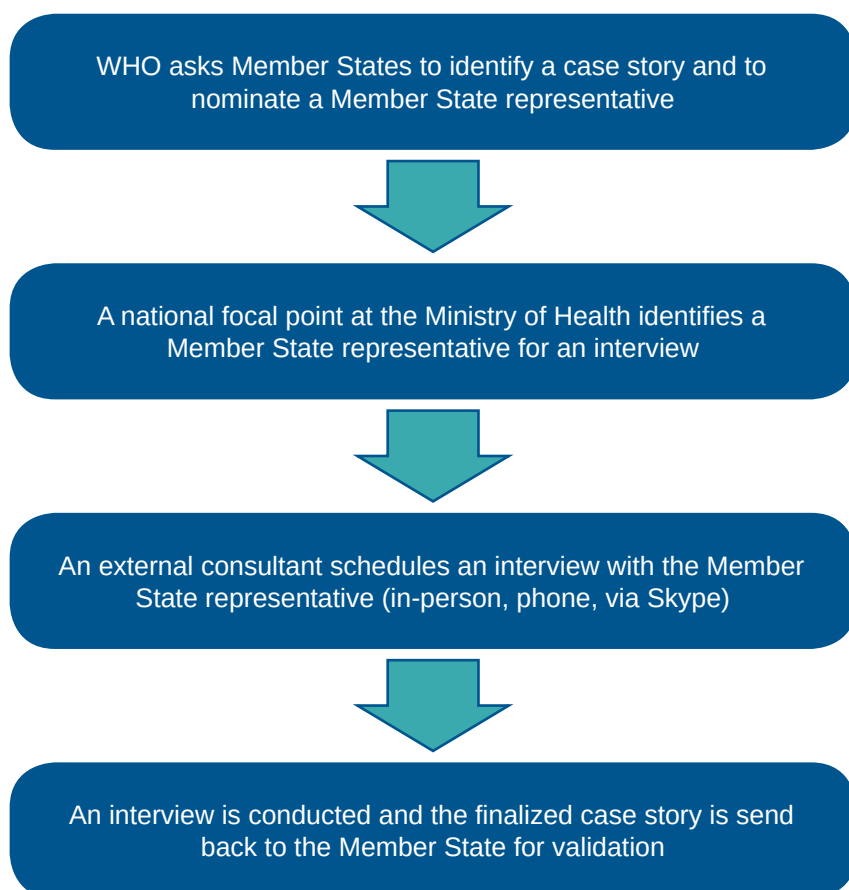
Case selection and data collection

The WHO Regional Office for Europe contacted all 53 Member States through official channels to notify them of the mapping exercise and to request that they identify an example of successful multisectoral and intersectoral action for health and well-being that met one or more of the following four criteria:

- addressed one or more of the strategic entry points for multisectoral and intersectoral action;
- showed strategic or high-level political commitment and involvement;
- demonstrated a whole-of-government approach; or
- demonstrated a whole-of-society approach, including involvement from civil society.

They also requested that Member States nominated a representative, who was familiar with the example selected. This was usually facilitated by national focal points within ministries of health of the respective Member States. Fig. 1 has an overview of the case selection and data collection process.

Fig. 1. Case selection and data collection process



To manage the data collection process, the Member States were grouped into six clusters. Three of the clusters were based on pre-existing WHO policy networks (Nordic/Baltic Policy Dialogue, South-eastern Europe Health Network (SEEHN) and the Small Countries Initiative (SCI)), and the remaining Member States were grouped geographically (central, eastern and western Europe) (Table 2). Each cluster was assigned to a consultant with previous experience with the allocated Member States. The selected examples of successful multisectoral and intersectoral action and the contact details of the nominated Member State representatives were then passed on to the respective consultant to facilitate data collection in the form of case-stories.

Table 2. Member State clusters for the external mapping

| Nordic and Baltic Member States (Nordic/Baltic Policy Dialogue) | SEEHN | SCI | Central Europe | Eastern Europe | Western Europe |
|--|---|------------|-----------------------|-----------------------|-----------------------|
| Denmark | Albania | Andorra | Austria | Armenia | Belgium |
| Estonia | Bosnia and Herzegovina | Cyprus | Czech Republic | Azerbaijan | France |
| Finland | Bulgaria | Iceland | Hungary | Belarus | Germany |
| Iceland | Croatia | Luxembourg | Poland | Georgia | Greece |
| Latvia | Israel | Malta | Slovakia | Kazakhstan | Ireland |
| Lithuania | Romania | Monaco | Slovenia | Kyrgyzstan | Italy |
| Norway | Republic of Moldova | Montenegro | Switzerland | Russian Federation | Netherlands |
| Sweden | The former Yugoslav Republic of Macedonia Serbia | San Marino | | Tajikistan | Portugal |
| | | | | Turkey | Spain |
| | | | | Turkmenistan | United Kingdom |
| | | | | Ukraine | |
| | | | | Uzbekistan | |

Notes: These clusters were formulated for this exercise and do not resemble an official categorization of WHO; Iceland is included in two Member State clusters: the Nordic and Baltic cluster and the SCI cluster but the consultant responsible for the SCI cluster collected and reported Iceland's case story.

Country level consultations were carried out by six external consultants to construct case stories of successful multisectoral and intersectoral actions for health from each Member State. The consultations consisted primarily of semistructured interviews in person or via Skype, although a few Member States expressed a preference for submitting a written response. To ensure that data were collected systematically, a template was created to guide the consultation (both the semistructured interviews and written responses) (Annex 2). The template comprised (i) background information, (ii) setting and implementation, (iii) policy considerations, and (iv) impact and lessons learned.

From the data collected, the consultants constructed the case stories, which were then verified by the individuals who provided the data (Table 3). The data gathered in the templates was also entered into NVivo, a qualitative data analysis software package, for preliminary analysis.

Table 3. List of Member State case stories by cluster

| Cluster | Member State | Case story title |
|-------------------|---|---|
| Nordic and Baltic | Denmark | Intersectoral action for health and well-being at the municipal level: implementing health promotion packages |
| Nordic and Baltic | Estonia | National Health Plan 2009–2020 |
| Nordic and Baltic | Finland | Health in all policies (approach) |
| Nordic and Baltic | Latvia | Advisory Council for Maternal and Child Health: intersectoral action with the civil society |
| Nordic and Baltic | Lithuania | State Health Affairs Commission |
| Nordic and Baltic | Norway | National system for follow-up of public health policies in Norway: a common cross-sectoral reporting system |
| Nordic and Baltic | Sweden | Promoting social sustainability through intersectoral action at the local and regional level |
| SEEHN | Albania | Introducing a smoking ban in Albania |
| SEEHN | Bosnia and Herzegovina | Mental health services at the community level |
| SEEHN | Croatia | Intersectoral Committee on Environment and Health |
| SEEHN | Israel | A Government decision to promote healthy, active living |
| SEEHN | Romania | Integrated community-based services for health and well-being |
| SEEHN | Republic of Moldova | Reproductive health strategy |
| SEEHN | Serbia | Implementation of the Protocol on Water and Health in Serbia |
| SEEHN | The former Yugoslav Republic of Macedonia | Government Committee on Environment and Health |
| SCI | Andorra | An intersectoral approach to tackle childhood overweight and obesity (the Nereu Programme) |
| SCI | Cyprus | A National Strategy and Action Plan to Fight Sexual Abuse, Exploitation of Children and Child Pornography |
| SCI/Nordic | Iceland | Establishment of a Ministerial Council on Public Health: a public health milestone for Iceland |
| SCI | Luxembourg | Get moving and eat healthier! A decade of intersectoral action to reduce obesity in Luxembourg |
| SCI | Malta | A whole-of-school approach to healthy lifestyles: healthy eating and physical activity |
| SCI | Monaco | Intersectoral collaboration to test an alert system for arrival of highly infectious diseases by sea |

Findings

This section provides an overview of the preliminary findings of the mapping exercise. Overall, high-level political support and ensuring a long-term view to the design and implementation of multisectoral and intersectoral action for health and well-being was viewed as critical for success and sustainability over time. Key factors for success included engendering a sense of ownership; fostering a strong, trusting foundation within partnerships and collaborations; and ensuring that experts and civil servants were given autonomy when creating this foundation. Furthermore, the majority of the case stories indicated that positive experiences with multisectoral and intersectoral action for health and well-being would be transferable to other Member State environments.

The findings are discussed in terms of (i) factors that contribute to the initiation of multisectoral and intersectoral action for health and well-being, including why multisectoral and intersectoral approaches were initially pursued; (ii) the scope and focus of the policies, with particular attention paid to the extent to which cross-cutting areas such as gender, equity and human rights were prioritized; (iii) implementation, including the level of implementation, the form that multisectoral and intersectoral actions took, facilitating mechanisms and the challenges and barriers identified; and (iv) the overall findings of the impact of multisectoral and intersectoral action for health and well-being and lessons identified in the case stories.

Initiating multisectoral and intersectoral action for health and well-being

Why multisectoral and intersectoral action?

Across case stories, multisectoral and intersectoral action for health and well-being was undertaken primarily for three reasons: (i) when the health sector was unable to address health and well-being challenges on its own; (ii) to improve coherence in addressing health and well-being challenges across sectors; and (iii) to increase and mobilize resources dedicated to improving health and well-being.

First, the majority of Member State representatives indicated that a multisectoral and intersectoral approach was taken in response to health and well-being challenges that the health sector was unable to address alone – a finding that aligns with the long history of WHO documents calling for multisectoral and intersectoral action for health and well-being. Often, this inability was because the health sector had neither a sufficient mandate nor the competence to address wider determinants of health and well-being; in these cases, collaboration with other sectors was viewed as essential.

While a number of case stories indicated that other sectors (e.g. education) also identified addressing health and well-being challenges as falling within their responsibilities, multisectoral and intersectoral action was viewed mostly as a mechanism through which to raise awareness of, and to achieve broader accountability and responsibility for, the achievement of goals related to health and well-being.

Second, a multisectoral and intersectoral approach was thought to strengthen coherence across sectors; within the health sector, more coherent policies were perceived to lead to better health and well-being for all.

Third, increasing the financial resources dedicated to improving health and well-being was a motivating factor. Health budgets tended to be limited by financial constraints and, consequently, the involvement of others sectors was seen in part as a means of mobilizing increased resources. In several examples it was also argued that multisectoral and intersectoral action for health and well-being improved the collective effectiveness and efficiency of financial resources used across sectors.

Triggers

The ministry responsible for health and well-being, WHO and the availability of data and evidence were cited as triggers of multisectoral and intersectoral action for health and well-being. In 12 of the 36 case stories either the minister of health or the ministry responsible for health and well-being initiated the multisectoral and intersectoral action. Noticeably, despite political support from the highest level being identified as a key facilitator, action taken by the prime minister or other ministries was rarely mentioned as a trigger of multisectoral and intersectoral action for health and well-being.

WHO was the second most frequently mentioned trigger of multisectoral and intersectoral action for health and well-being? WHO was seen to exercise levels of influence that increased gradually over decades, primarily through influential policy documents and guidance related to national health policy development?

WHO documents mentioned in the interviews included Health 2020, the World Health Reports, the final report of the Commission on Social Determinants of Health and the WHO's NCD strategies. The importance of data and evidence in triggering multisectoral and intersectoral action for health and well-being was also highlighted in several case stories, emphasizing that only knowledge of the existence and scope of a problem can lead to appropriate and needs-based action and response.

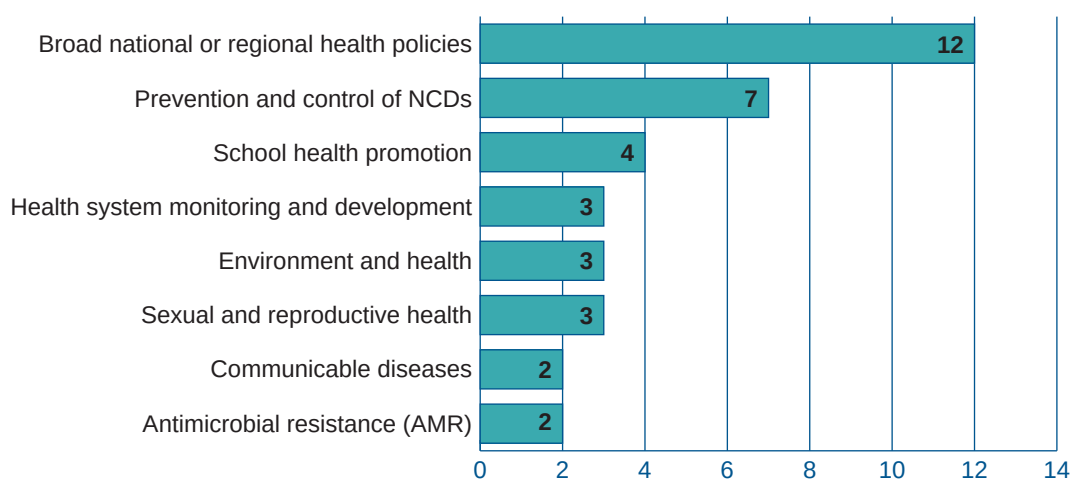
Other triggers included the introduction of national strategies or programmes, a change in government with new priorities, political will among politicians and pressure from the general public, media or nongovernmental organizations (NGOs). In some cases, specific occasions or events were also identified as triggers.

Scope and focus of multisectoral and intersectoral policies for health and well-being

Policy areas

The case stories were wide ranging and aimed to address a number of health-related challenges. The coding of the cases revealed that the case stories occurred within one of eight policy areas: (i) broad national or regional health policies, (ii) prevention and control of NCDs, (iii) school health promotion, (iv) health system monitoring and development, (v) environment and health, (vi) sexual and reproductive health, (vii) communicable diseases, and (viii) antimicrobial resistance (AMR) (Fig. 2).

Fig. 2. Policy area of the 36 case stories



Approximately two thirds of the case stories fell within the first three policy areas alone, and the following section discusses these three policy areas.

National or regional health policies

Broad national or regional health policies, including national health strategies and programmes aimed at addressing multiple health and well-being issues and their determinants, were the policy area most frequently highlighted in the case stories. The case stories of 12 Member States (Czech Republic, Denmark, Estonia, Finland, Iceland, Ireland, Israel, Lithuania, Romania, Slovenia, Sweden and Switzerland) highlighted multisectoral and intersectoral action in this area.

Planning and implementation processes engaged multiple ministries and other stakeholders. For example, the Healthy Ireland framework exemplifies a comprehensive and multisectoral and intersectoral approach to health policy-making (Box 3). Furthermore, the National Health

Plan 2009–2020 of Estonia illustrates how these broad policy frameworks can promote long-term strategies focused on improving health and well-being over the life course (Box 4).

Box 3. Case example: Healthy Ireland 2013–2025, a framework for improved health and well-being

Healthy Ireland (2013–2025) is a government-led, multifaceted framework to improve the health and well-being of the population. The broad and complex nature of the framework and the massive change agenda associated with its implementation requires that a critical focus remains on the wider enablers of implementation, such as stakeholder consultation, building a supportive culture, communication and leadership.

Healthy Ireland seeks to more effectively address the key lifestyle behaviour issues that result in ill health and chronic disease, as well as the social and environmental determinants of health and well-being, through a whole-of-government and whole-of-society approach.

The key goals of the framework include:

- increasing the proportion of people who are healthy at all stages of life;
- reducing health inequalities;
- protecting the public from threats to health and well-being; and
- creating an environment where every individual and sector of society can play their part in achieving a healthy Ireland.

Box 4. Case example: the National Health Plan 2009–2020 of Estonia

The National Health Plan 2009–2020 of Estonia is an intersectoral, long-term strategy that aims to improve health-adjusted life expectancy of Estonians. The plan is established by a government regulation, and its actions are mandated by different legislative decrees.

The National Health Plan highlights that the right to health is one of the basic human rights, and everyone must have the possibility of living in a healthy environment and an opportunity to make healthy choices. Common values such as joint responsibility for health, equal opportunities and justice, social inclusion and increasing power of civil society are priorities.

The Estonian National Health Plan for 2009–2020 has five thematic fields:

- increasing social cohesion and equal opportunities;
- ensuring healthy and safe development for children;
- shaping an environment supporting health;
- facilitating healthy lifestyles; and
- ensuring the sustainability of the health care system.

The Plan is implemented at national, regional and local levels, and its progress is monitored by an intersectoral structure, the Steering Committee, which includes representatives from all relevant ministries and departments, semigovernmental agencies and civil society. The Ministry of Social Affairs leads the Steering Committee and acts as its Secretariat.

Clear targets and indicators are set to monitor the implementation on a yearly basis and the monitoring mechanism is reviewed every four years. The yearly progress reports are opened for public feedback in an online portal (eelnoud.valitsus.ee).

Prevention and control of NCDs

The second most common policy area for multisectoral and intersectoral action was the prevention and control of NCDs. The seven case stories in this category had a more specific focus on the prevention of chronic diseases and its risk factors. Two of the case stories were specifically focused on smoking and tobacco control (Albania and Georgia).

Other areas included reduction of salt intake (Montenegro), obesity (Luxembourg), mental health services (Bosnia and Herzegovina), healthy eating and physical activity (Andorra), and a nationwide NCD prevention strategy (Azerbaijan). Montenegro's intersectoral programme to reduce dietary salt intake illustrates the benefits of intersectoral action, particularly when taken with clear targets and implementation measures (Box 5).

Box 5. Case example: intersectoral action to reduce salt intake in Montenegro

The Programme for Reducing Dietary Salt Intake in Montenegro (2014–2025), aims to reduce the daily salt intake in the population of Montenegro to below 5 grams per capita; in line with applicable WHO recommendations. This long-term goal will be achieved by increasing awareness and knowledge of the population, reducing salt content in processed foods and through a harmonized national response.

The Initiative for reducing salt in bread and baking products was launched by health sector and included the baking industry. Following the Initiative, a National Program for reducing dietary salt intake in Montenegro (2014–2025) was developed by a multidisciplinary team from the health sector setting objectives and measures to be implemented intersectorally. The Programme recommended measures that would contribute to reducing salt intake in the population by 16% relative to the baseline levels measured, during the 2014–2020 period and by 30% by the year 2025.

Specific objectives of the Programme:

- provide essential data necessary for a successful implementation of the Programme, which will be continuously updated and improved;
- upgrade awareness and knowledge within the population and professional public in Montenegro as to the importance of reducing excessive dietary salt intake;
- reduce salt content in processed food, in cooperation with the food and catering industry;
- harmonize the national response to the problem of excessive dietary salt intake with successful international solutions and experiences; and
- establish a monitoring and evaluation system for the Programme interventions.

Health promotion in schools

Health promotion in schools was the main focal area in four of the case stories (France, Hungary, Malta and San Marino). In France, the Ministry of Health and the Ministry of Education collaborate to educate children about health and also in monitoring their well-being. Hungary has developed comprehensive health promotion activities in schools that cover a wide range

of areas such as diet, physical activity, mental health, dependencies, violence prevention and personal hygiene. San Marino has highlighted the importance of nutrition and sustainable agriculture in the school setting, which has involved activities to ensure that children have access to sustainably grown and nutritious foods. Finally, Malta has initiated a whole-of-school approach to promote healthy lifestyles, with a focus on healthy diet and environments, such as playgrounds that promote physical activity (Box 6).

Box 6. Case example: a whole-of-school approach to healthy lifestyles: healthy eating and physical activity in Malta

The major health challenge affecting schoolchildren in Malta is that of overweight and obesity. The rapid increase of obesity motivated the health and education sectors to join efforts in to implement a national school-wide policy and strategy to increase physical activity and improve nutrition in schools for all children.

The highest levels of government were involved in policy and strategy development from the outset. Both the education and health sectors shared the lead in taking action forward. Many levels of society have been involved in this initiative. Parent associations were consulted during the development of the policy and in policy development through active consultation. The media also played an active role in promotion and information dissemination.

The private sector, namely school-based snack shops called tuck shops, were key players. As suppliers of snacks at schools, they were obliged to change their purchasing choices. The quality of foods sold within schools at tuck shops was examined, classifying products according to the WHO nutrient model. Tuck shop owners were given a list of permitted and non-permitted foods that could be sold.

The strategic goals of the initiative were to:

- achieve better physical activity and nutrition for all schoolchildren in Malta; and
- create a level playing field in all schools by offering equal opportunities for all children to engage in physical activity and benefit from improved nutrition in school settings.

Gender, equity, and human rights

The mapping exercise included an explicit focus on the extent to which gender, equity and rights were mainstreamed throughout the case stories provided, in line with WHO global policy (Box 7). While this focus was maintained throughout, specific questions were highlighted in the questionnaire, indicating a further focus on these issues at specific stages of the data collection.

Gender, equity, and rights were identified as being a particular focus in only a very small number of case stories and were often identified together as a group. While this suggests that they were mainstreamed in line with WHO policy when they were considered in the action undertaken, it also indicates that they were not considered often enough. This study called for examples of best practice and the lack of a focus on these issues necessitates attention and should be addressed.

Box 7. Gender, equity, and human rights in the work of WHO

At the global level, WHO released A Roadmap for Action (2014–2019) for integration equity, gender, human rights and social determinants into the work of WHO (20). The roadmap consists of three pillars: (i) institutional mainstreaming of equity, gender and human rights in WHO programmes, (ii) monitoring of health inequalities and supporting data disaggregation, and (iii) providing support to WHO Member States. The progressive realization of the right to health should entail a sustained effort to improve health for the population as a whole, but also efforts to reduce unfair and avoidable inequalities between socioeconomic groups within the population. The WHO Handbook for Guideline Development (21) states: “The planned achievements should focus not only on the average level of health, but also on how health is distributed within populations and across groups. The idea is to ensure that those of lower social position and with greater needs can benefit more than more advantaged persons. Through this progressive realization of the right to health, a levelling-up of health status is achieved across the population.”

Additional work and commitment is needed to enhance data collection and strengthen the evidence base, not only for policy planning but also for monitoring and evaluation. These data should also be disaggregated according to a number of socioeconomic variables, including gender. The case story from Norway is a particularly positive example of enhanced data collection on equity, where intersectoral action led to the development of health equity indicators that have continued to propel intersectoral action for health and well-being throughout the Member State (Box 8).

From a governance perspective, to ensure gender, equity, and rights manifest in policy outputs and implementation outcomes requires using gender, equity, and rights-based approaches from the outset of policy design, and throughout implementation, monitoring and evaluation.

Box 8. Case example: Norwegian common health equity indicators

Norway has a long history related to intersectoral action for health and well-being, which has been implemented at different levels of governance and has been supported by a wide array of tools and mechanisms. Gender, equity and human rights are cross-cutting themes in this work. For indicators, data are disaggregated according to socioeconomic variables and gender. Data are also collected for vulnerable groups.

White Paper 20 (2006–2007), National strategy to reduce social inequalities in health, highlighted public health policy as a cross-sectoral issue and first launched the cross-sectoral reporting system. The document recommended that cross-sectoral tools should be adopted to support efforts to reduce health inequalities, including establishing a review and reporting system to monitor developments in the work on reducing social inequalities in health. The reporting system is a feedback mechanism for intersectoral indicators on determinants/progress across sectors that constitutes a basis for further policy development.

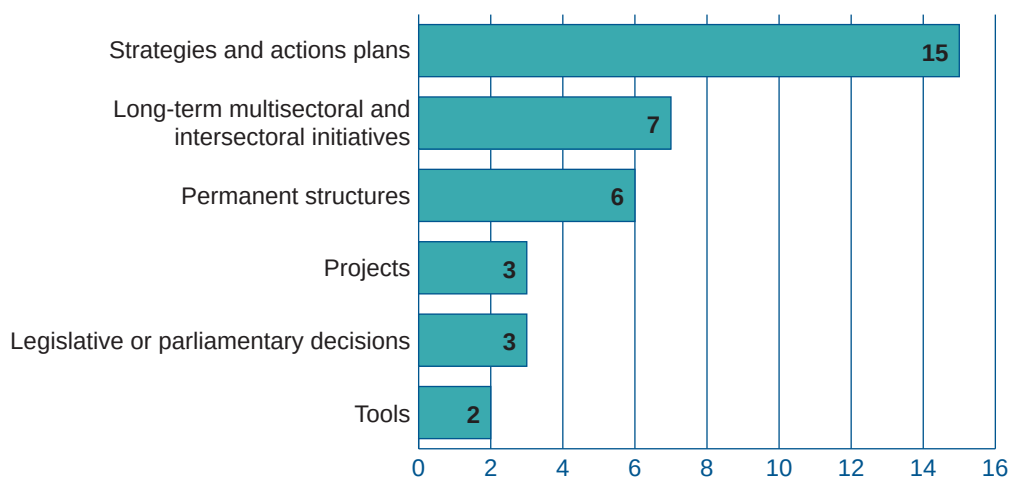
White Paper 34 (2012–2013), Public health report – good health, a common responsibility, reinforced the need for collective action on health and established a national system for the follow-up of public health policies. In order to support this work, different sectors have collaborated to create indicators across sectors to feed back to policy development. The collaboration has strengthened the focus on socioeconomic indicators and thereby stimulated the equity agenda across the Government.

Implementation of multisectoral and intersectoral policies for health and well-being

Forms of multisectoral and intersectoral action

The thematic coding of the case stories reveals that multisectoral and intersectoral action for health and well-being took one of six forms: (i) strategies and action plans, (ii) long-term multisectoral and intersectoral initiatives, (iii) permanent structures, (iv) projects, (v) legislative or parliamentary decisions, and (vi) tools¹ (Fig. 3).

Fig. 3. Form of multisectoral and intersectoral action in the 36 case stories



In the majority of case stories, multisectoral and intersectoral action took one of the first three forms: strategies and action plans in 15 (Azerbaijan, Cyprus, Czech Republic, Estonia, Georgia, Germany, Ireland, Luxembourg, Malta, Monaco, Republic of Moldova, San Marino, Slovenia, Spain and Switzerland), long-term multisectoral and intersectoral initiatives in seven (Andorra, Austria, Croatia, Finland, France, Montenegro and Romania), and permanent structures in six (Iceland, Latvia, Lithuania, Serbia, Sweden and the former Yugoslav Republic of Macedonia).

In 29 of the 36 cases stories, interministerial committees were the mechanism through which multisectoral and intersectoral action was realized. These committees involved a range of members and actors, including ministers, deputy ministers or other ministerial representatives, such as senior officials or technical experts. Several cases described the existence of a cabinet committee that was chaired by the prime minister. However the mandate and influence of these committees varied, and there are many open questions on

¹ These categories are not mutually exclusive; strategies and action plans may use legislative devices or specific tools in their implementation. However, the categories used highlight the primary form or mechanism of intersectoral action.

how these committees functioned, particularly regarding the closeness of the cooperation and the working methods.

Governance coherence

Coherence between different levels of governance is just as important as coherence across different sectors of government. In addition to promoting horizontal collaborations and partnerships across sectors, multisectoral and intersectoral action for health and well-being also takes place vertically between the international, national, subnational/regional and local levels. Table 4 groups the case stories into six types based on their vertical level of implementation. The majority were implemented solely at the national level (20 Member States). The second most common type involved a combination of national, regional and local level implementation (eight Member States) with four Member States using national-local implementation.

Table 4. Level of implementation of multisectoral and intersectoral action for health and well-being

| Implementation level | Member States |
|---------------------------------------|---|
| National | Albania, Andorra, Armenia, Austria, Azerbaijan, Croatia, Cyprus, Czech Republic, Georgia, Hungary, Iceland, Latvia, Luxembourg, Malta, Montenegro, Republic of Moldova, San Marino, Serbia, Slovenia, the former Yugoslav Republic of Macedonia |
| National–regional–local | Denmark, Estonia, France, Ireland, Lithuania, Norway, Spain, Sweden |
| National–local | Bosnia and Herzegovina, Finland, Israel, Romania |
| International–national–regional–local | Belgium, Germany |
| International–national | Monaco (with France) |
| International | Switzerland |

Ensuring that coherence extends down to the local level is vitally important, as it is at the local level that implementation occurs. For a policy or action to be most effective, coherence must be present from the international level through the intermediate levels and extending to the local level. This is necessary to ensure the implementation of WHO global and regional policies. A local dimension to the multisectoral and intersectoral action was identified far more frequently than an international dimension, with 14 case stories in total including it. While eight of these were examples of coherence between the national, regional and local levels, only two of also included coherence with the international level. This coherence from the international level could be strengthened through increased WHO support to local level implementation through existing networks such as the WHO European Healthy Cities Network and the Regions for Health Network.

Enabling and facilitating factors

Numerous factors were found to enable and facilitate multisectoral and intersectoral action for health and well-being (Box 9). Many of these factors are contextual but case stories also identified more general facilitating factors, including political will and good governance; a clear mandate; sufficient resources; data and evidence; multisectoral and intersectoral capacity; quality multisectoral and intersectoral collaboration; and civil society and media engagement, in addition to other contextual factors.

Box 9. Enabling and facilitating factors for implementing multisectoral and intersectoral action for health and well-being

- High-level political support and commitment for multisectoral and intersectoral action
- Focus on the long-term outcomes and policy changes
- Existence of a clear mandate
- High-quality evidence and information for policy planning and monitoring
- Adequate financial and human resources for implementation
- Competence of the health sector to reach out to other sectors
- Cross-sectoral relationships based on trust and shared understanding of the problem
- Clear objectives and identified co-benefits among partners
- Engagement of the civil society
- Public pressure
- Media support and involvement.

Political will and good governance

Political will, particularly in the form of high-level political support, was cited as the most important factor for the successful implementation of multisectoral and intersectoral initiatives. High-level ministerial support that transcended the health sector was reported in over 20 case stories; the involvement of the minister responsible for health and well-being was seen as essential in successful implementation. In one of these case stories, multisectoral and intersectoral action was supported by the president of the Member State and in five by the prime minister directly.

Several case stories highlighted that high-level participation influences and mobilizes other levels of governance, emphasizing that it is difficult to carry out multisectoral and intersectoral initiatives without support and leadership from the uppermost levels of government. Top-level involvement and commitment was seen as a requirement for legitimizing multisectoral and intersectoral action at other levels of government, such as the regional and local levels.

The involvement of parliaments and political parties across the spectrum was seen to be essential in addressing certain health challenges. The participation of high-level politicians

was seen as one key indication of political will and determination. Furthermore, the importance of civil servants and regional authorities was also highlighted as important in order to attain sufficient capacity and commitment for implementation. According to those interviewed, political will was expressed in the formulation of high-level committees or councils, as well as in the adoption of parliamentary resolutions or national programmes and action plans that address specific health and well-being issues.

Finally, a long-term focus was also identified as a critical success factor. Successful multisectoral and intersectoral initiatives could not focus only on short-term gains because it was clear that sustainable outcomes would usually take a prolonged period of time to achieve. In this case, political will was demonstrated by taking initiative and establishing mechanisms for planning and implementation.

Mandate

A clear mandate for action beyond the health sector was seen as essential for facilitating the successful and sustainable implementation of multisectoral and intersectoral action for health and well-being. A mandate refers to the authority to take action on a certain area. In terms of multisectoral and intersectoral action for health and well-being, the issue of mandate is important because, by definition, multisectoral and intersectoral action require that the health sector works in a manner that can sometimes be construed as extending beyond its mandated area. The majority of the 36 cases stories were supported by an identifiable mandate; there were only four cases in which a clear supporting mandate was not articulated. A clear mandate was also thought to be an indicator of high-level political support and commitment.

Most commonly, the mandate was based on government decisions, laws and resolutions. The integrity of the mandate was ensured through the clear delineation of responsibilities, sufficient resource allocation, identified outcome targets and the presence of monitoring and evaluation mechanisms. It was considered essential that the supportive legislation was in place in order to carry out multisectoral and intersectoral work effectively, and in many cases, the legislative base was supported by detailed implementation strategies, programmes and action plans.

Resources

Sufficient financial and human resources for planning, implementation and monitoring were also considered as essential facilitating factors in successful multisectoral and intersectoral initiatives. Supportive institutions were seen to facilitate multisectoral and intersectoral work through good coordination and proper organizational structures. In some cases, joint funding initiatives were used to stimulate multisectoral and intersectoral projects and partnerships.

Data and evidence

Data and evidence were seen to be driving forces, and in some cases prerequisites, for multisectoral and intersectoral action for health and well-being. Data and evidence inform an understanding of both the importance of many health challenges, and the benefits that a multisectoral and intersectoral approach can provide in addressing these. Reliable data help to set indicators and targets that can be monitored, and data collection should be disaggregated according to a number of socioeconomic variables whenever possible (e.g. by income, gender, level of education, occupation).

Additionally, data can be used to convince decision-makers and other sectoral ministries to take multisectoral and intersectoral action. Evidence and recommendations from WHO and other international organizations were also seen as facilitating multisectoral and intersectoral collaboration for health and well-being. However, several respondents cautioned that imposing health-related goals and targets on other sectors without understanding the unique challenges and policy processes of the other sector would most likely be counterproductive.

Enhanced data collection and the formation of a strong evidence base are necessary to supplement and complement good governance, clear communication and the building of strong partnerships across sectors, in order for multisectoral and intersectoral action for health and well-being to be successful.

Multisectoral and intersectoral capacity

Increasing and building the capacity of the health sector to engage other sectors more effectively was seen as a key factor in facilitating multisectoral and intersectoral action. Several case stories indicated that the use of health language could be counterproductive when seeking to establish working relationships with other sectoral ministries.

Widening the discussion to include other goals, such as development and social sustainability, was seen as a successful means of fostering multisectoral and intersectoral engagement. It was also noted that, in many cases, representatives from the health sector did not fully understand the goals and dynamics of other sectors. Attempting to impose health-related goals on other sectors without understanding the unique challenges and policy processes of other sectors was often deemed to be counterproductive.

Multisectoral and intersectoral collaboration

The quality of multisectoral and intersectoral collaboration was one of the main factors that determined the outcomes. The success factor most often mentioned was having a focus on creating good relationships based on trust and open communication. It was indicated that building these relationships often took a substantive period of time and required determined

action to overcome potential divisions. The notion that multisectoral and intersectoral collaboration helps to reach the goals of all sectors involved was a key facilitating factor, as was a consensus regarding the action deemed suitable, feasible and acceptable. Additional factors related to the building of strong relationships included effective working methods, quality and reputation of partners and ensuring an appropriate environment to facilitate the receptiveness of different partners to collaboration more broadly.

Clearly identified mutual goals and co-benefits were shown to increase the commitment of all parties involved. Early engagement with other sectors, as well as the ability to identify common ground, was described as crucial for success. The attainment of co-benefits refers to a situation where different sectors identify mutually beneficial results for themselves. For the health sector, it is important to identify these win–win situations in order to increase the commitment to health-promoting goals beyond sectoral boundaries, and to motivate actors outside the health sector to consider health and well-being goals in their activities.

The most obvious co-benefit that the health sector can bring to other sectors is that goals across most sectors are easier to attain with healthy people, in particular economic goals. Healthy people are productive people who contribute to social and economic development. Increased exchange of data and information across different sectors was also identified as a co-benefit that can lead to better evidence-informed policies and more effective implementation in all sectors involved. This is crucial in ensuring that nobody is left behind, and nobody falls through gaps in service delivery (e.g. between social, education and health sectors), which is a central element of the 2030 Agenda. More efficient and effective coordination was identified as a mutual benefit that extends beyond the health sector.

From the health perspective, the benefits of collaboration include an increased capacity to address health challenges, which sometimes includes increased financing for health-promoting activities. Moreover, strengthening equity goals was seen as a mutually benefiting development that has implications beyond the health sector. Improved monitoring and decreased duplication of work was seen as equally beneficial. In some cases, multisectoral and intersectoral collaboration had led to the development of new indicators, as well as more comprehensive multisectoral and intersectoral policies that addressed health and well-being problems through a win–win approach. These improved methods of collaboration were seen to signify increased coherence and facilitate a more systematic approach to addressing public policy challenges.

Successful multisectoral and intersectoral action for health and well-being was seen to induce health-promoting changes in other sectors, such as giving a higher priority to health concerns or the alteration of governance mechanisms to improve health and well-being. Changes in sectors besides health were reported in 27 of the 36 case stories. The nine cases that did not induce changes in other sectors were limited in their scope, and direct changes across sectors were not necessarily expected.

The emphasis on the notion that good health is good for everyone led to the integration of health goals into the activities of non-health sectors. Some of the concrete examples included minimizing the use of antibiotics in livestock (agriculture), reducing the used of salt in food production (agriculture), providing more physical activity and healthier diets in schools (education) and increasing taxes on alcohol and tobacco (finance). In the future, it is important to reach collaborators who represent sectors other than health. This could involve collecting their views on the co-benefits that can result from collaboration with health-oriented actors and health ministries.

Civil society and the media

The engagement of civil society from the planning through to the implementation and evaluation stages was seen to increase the legitimacy of action and to provide wider perspectives and concerns to governments. Creating a platform for civil society participation was in itself already a way to promote multisectoral and intersectoral collaboration. The bottom-up approach was often seen to be helpful in raising perspectives that might be lost in more high-level, top-down planning.

Cooperation with international partners such as WHO and the EU was seen also as a factor that facilitated collaboration across sectors. For example, the WHO European Healthy Cities Network and the Network of Health Promoting Schools were mentioned as existing networks that have facilitated multisectoral and intersectoral action for health and well-being. Only a few case stories in this mapping exercise indicated the involvement of the private sector. For example, a mobile phone company and a privately owned media corporation were actors with a role in two case stories.

Public pressure and media involvement were also considered as great motivators that could facilitate multisectoral and intersectoral action. A group of active citizens can hold governments accountable, particularly at the local level, and can persuade governments to create comprehensive solutions to health challenges. Similarly, the media can raise awareness and effectively disseminate information about problems that require a multisectoral and intersectoral response.

Other contextual factors

Finally, some Member State representatives highlighted the role of various contextual factors that have facilitated multisectoral and intersectoral collaboration. These included the small size of the Member State, the culture of governing jointly, an openness to learn and implement new mechanisms and having an environment that encourages creativity and innovation.

Challenges and barriers

Typical challenges and barriers to multisectoral and intersectoral action for health and well-being were negative aspects of enabling and facilitating factors; for example political will was seen as a clear facilitator and lack of political will was identified as a clear challenge. In some cases, multisectoral and intersectoral action was supported only through rhetoric, with a lack of concrete investments into implementation.

Some Member State representatives identified a lack of political leadership that values health and well-being. Lack of resources is often indicative of the absence of budget allocation and adequate human resources. Another typical challenge was the difficulty in convincing other sectors about the positive effects and financial benefits of cross-sectoral collaboration. In these situations, co-benefits and win–win situations tended not to have been clearly identified or articulated.

Communication was often acknowledged as a challenging area because of issues in finding a common language and working methods for cross-sectoral work. It was indicated that political will has to be accompanied by governance mechanisms that define both working methods and roles and responsibilities. As one Member State representative stated, “it is a great challenge to make other sectors actors, not spectators”. Several informants stated that they do not necessarily have concrete tools and ways to approach other sectors. The belief that the health sector can solve the problems of other sectors was seen to be a sign of superiority and arrogance and, therefore, counterproductive.

Siloed thinking and resistance to adopting multisectoral or intersectoral perspectives were also mentioned as challenges that apply to the health sector itself, as well as to other sectors. Conflicting interests, power imbalances and competition for the same resources were also mentioned as common barriers to multisectoral and intersectoral action. Political changes in a government or ministries were considered a challenge in terms of continuity and sustainability of actions. In addition, showing the cost–effectiveness of multisectoral and intersectoral collaboration was considered challenging because there is often a lack of clear and contextual evidence to support positive changes.

Overarching findings, insights and lessons learned

The Member State representatives shared several important findings, insights and lessons learned in relation to the initiation and implementation of multisectoral and intersectoral actions that are applicable to different cultural and political contexts. Many representatives expressed a sense that multisectoral and intersectoral action is key to achieving sustainable and substantial improvements to a number of health and well-being problems and challenges. One of the recurring statements was that high-level political participation and support at the national level are essential factors that help to achieve desired results and outcomes.

Strengthening implementation by building multisectoral and intersectoral capacity

One of the interview themes related to various ways to support and strengthen the implementation of multisectoral and intersectoral initiatives. Member State representatives suggested a number of capacity-building activities, such as training for policy-makers, civil servants and technical staff on how to coordinate and structure multisectoral and intersectoral work in practice. A main concern was that guidelines and high-level recommendations are not translated into practice if their concrete implementation is inadequately supported. Some suggested themes were related to questions such as:

- how coordination can be improved and good working relationships created with stakeholders outside the health sector;
- how health advocacy and leadership can be improved for multisectoral and intersectoral collaboration; and
- how monitoring can be improved and indicators created and used to measure progress.

Respondents commented that easy-to-use tools are needed for the planning, implementing and monitoring of multisectoral and intersectoral action for health and well-being. Additionally, there is a need for targeted and tailored engagement and mobilization strategies for different groups of stakeholders, such as vulnerable or at-risk groups, civil society and NGOs.

Case studies from other Member States were seen to be beneficial because they can work as inspiration for action in other contexts. Emphasis was placed upon developing an ability to understand the different positions and motivations of stakeholders beyond the health sector in order to facilitate the consensus-building processes necessary for effective implementation of multisectoral and intersectoral action. Methods to share common challenges, facilitating factors and strategies for approaching and engaging other sectors, as well as ways to show the economic benefits of multisectoral and intersectoral collaboration, were requested. A common form of presenting this information was through multisectoral or intersectoral policy briefs.

Several Member State representatives also suggested that there should be broader public health education on multisectoral and intersectoral action for health and well-being, with a focus on the competencies for implementing cross-sectoral initiatives. Addressing this need would require curricula development in universities and other educational institutions. Future generations of policy-makers should be equipped with an understanding of health determinants and of the capacities needed to approach health issues both horizontally across sectors and vertically at the various implementation levels.

Mobilization of resources

Member State representatives also noted that effective collaboration requires adequate time as well as financial and human resources. Often, resources can be very limited and this poses

challenges to the sustainability of multisectoral and intersectoral collaboration. Consequently, setting up permanent multisectoral and intersectoral mechanisms with adequate budget allocations was seen as important. Moreover, the existence of reliable information was considered to be prerequisite for evidence-informed decision-making because otherwise policy-makers could rely too heavily on information provided by various interest groups; for example, information might be consensual but inaccurate and so would not serve citizens' well-being. Additionally, it was hoped that there would be more support to set up permanent evaluation mechanisms and to develop new tools for citizen participation in health-related matters.

Impact and lessons learned

A number of lessons can be learned from the case stories about initiating and implementing multisectoral and intersectoral action for health and well-being. High-level political support is often one of the core requirements in order to achieve sustainable outcomes. Similarly, multisectoral and intersectoral action for health and well-being is best supported by a clear mandate, which includes strong mandates through provision within constitutions, laws and decrees or soft mandates such as institutional guidelines, strategies and action plans at the national or local level to steer affirmative action to implement multisectoral and intersectoral mechanisms.

To be sustainable, multisectoral and intersectoral mechanisms must last beyond electoral mandates, as political changes can quickly abolish initiatives and mechanisms that were established by a previous government. For this reason, permanent multisectoral and intersectoral structures for health and well-being are often looked upon favourably for their improved chance of sustainability and longevity.

Another lesson learned included having a long-term vision and commitment that is also operationalized in long- and short-term goals, measurable indicators and with a monitoring and accountability framework. Unnecessary bureaucratic procedures can act as a barrier and, therefore, engaged civil servants should be allowed reasonable levels of autonomy and independence to implement multisectoral and intersectoral initiatives. One Member State representative said that the importance of dedicated individual civil servants and decision-makers should not be underestimated, because they have the potential to attain significant success even in resource-scarce situations. Similarly, creating ownership across the sectors was considered very important. Greater ownership can be achieved by involving key actors from the start, communicating clearly by using accessible language, providing reliable information and ensuring the continuity of collaborations.

It was also considered important to find the right partners and experts to exert influence on the policy objective, and it was equally critical to identify potential or existing opposition,

barriers and challenges. Opposition was identified as stemming from private actors with vested interests and from strong interest groups. It was suggested that a useful strategy was to maintain the focus of the discussion firmly on public health arguments when engaging opposition.

With regard to transferability of lessons learned, all representatives felt that their Member State's multisectoral or intersectoral initiative could be implemented in another Member State. This implies great potential in promoting a learning-through-others approach and sharing best practice in the WHO European Region. While political, social and cultural contexts are geographically very diverse across the WHO European Region, and policy initiatives need to be modified and adapted accordingly, sharing of the practice of effective multisectoral and intersectoral initiatives can inform and inspire governments for their own actions.

Case story summaries

1. Albania: Introducing a smoking ban



Smoking is the single most preventable cause of premature mortality, increasing the risk of lung cancer, emphysema, heart disease, stroke and other diseases. Evidence from surveys in recent years has shown that over 50% of the Albanian adult population is smoking, putting the country at a very unfavourable situation regarding the future costs of illness and related complications. Motivated by such data and encouraged by positive examples of smoking bans in other European countries, the Albanian Government initiated introduction of a smoking ban in Albania and Albania became a party to the WHO Framework Convention on Tobacco Control on 25 July 2006.

The intersectoral efforts were grounded in the Health 2020 framework, which offers ample evidence on the cost–effectiveness of tobacco use prevention as a public health intervention that requires intersectoral action.

Tobacco control policy is an excellent investment in the health of a country's population. According to WHO, for less than 30 lek (approx. €0.25) per person per year, Albania will be able to pay for the four “best buys” in tobacco control policy: raising tobacco excise taxes, enforcing a comprehensive national smoke-free law, enforcing a ban on tobacco advertising and promotion, and mandating large graphic warning labels to appear on tobacco product packaging. This small investment will reap enormous dividends in health and prosperity.

2. Andorra: Tackling childhood obesity and sedentary lifestyle using a multisectoral approach: the Nereu programme



The Nereu Programme aims to promote change and maintain healthy habits in overweight and obese primary schoolchildren by offering regular opportunities for physical activity, promotion of healthy eating and working with families. Nereu seeks to reduce the prevalence of obesity in the country in line with the Andorran Health 2020 goals. The Nereu programme aims to reach 60% of overweight or obese children in the country. In Andorra, overweight prevalence is 8% and child obesity is 5.5% in children aged 11 to 12 years.

In Andorra, the health, education and sports sectors have a history of working together in an Education for Health programme and implementing actions pertaining to the National Strategy for Nutrition, Sport and Health. The Nereu programme uses an intersectoral approach involving the health, sport and education sectors and provides equal opportunities for participation, regardless of gender, income, education or fitness levels. Participation fees are waived for financial reasons.

In 2015, a pilot was carried out in seven schools in Andorra and included overweight and/or obese children with low levels of physical activity. Children attended three sessions per week of extracurricular physical activity lessons, practised new sports and received healthy eating and active lifestyles information. Families received two behavioural counselling sessions per month covering healthy eating and physically active lifestyles.

The Nereu programme is led by the Ministry of Health and promoted in partnership with the Ministry of Education and the Ministry of Sport. Main triggers for the programme were data from the first National Nutritional Survey in 2004 that showed increasing levels of overweight and obesity in Andorran children, the WHO overweight and obesity recommendations and the 2007 the national strategy for Nutrition, Sport and Health.

The health sector leads and coordinates the programme and is responsible for managing user data, monitoring and evaluating the pilot phase and making necessary adjustments. The NGO Associació Nereu will coordinate, monitor and supervise implementation. Dieticians will provide counselling sessions to families in the programme. The Ministry of Education will manage the sport extracurricular activities and report progress to all involved sectors. The State Sport Secretariat has engaged sports clubs and informed sports facilities about the Nereu programme. The Andorran School for Training on Sport and Mountain Professions will provide sports counsellors for the extracurricular activities. The media has been involved through a press conference presenting the programme and an interview on Andorran television.

An intersectoral committee was set up between the Ministry of Health, the Ministry of Education and the Nereu Association and holds regular meetings. The Ministry of Education used its intranet to keep internal stakeholders informed and a Nereu web-based platform was also set up for coordination.

The Nereu programme brings primary health care benefits in terms of preventive action to reduce obesity and increase physical activity and reduce NCD burden in the long term. While the project is primarily funded from the Ministry of Health's budget, physical activity sessions are funded by the Ministry of Education.

The involvement of primary care professionals is essential for programme success. Their role in the community as the first contact with the health care system and in identifying families with children who could benefit from the Nereu programme is key.

Main challenges or barriers encountered to programme performance are the work schedules of families, many being employed in the tourism sector and having shift work schedules that does not permit them to attend family counselling sessions. The existence of extracurricular sports programmes, good working relationships with the Ministry of Education and their willingness to take an active role in the programme have been facilitating factors.

The Nereu programme was very well perceived and accepted by the population at first, but full family participation dropped possibly through fear of child stigmatization or work schedule conflicts. The full involvement of primary care professionals in the project will help to improve programme performance as they are the common thread that will link families with other sectors and initiatives such as the Nereu programme.

The pilot programme ended in 2015. Full implementation of the programme will begin in September–October 2016.

3. Armenia: National campaign to raise public awareness of AMR



The Ministry of Health of Armenia conducted a national campaign to raise public awareness of AMR on 16–22 November 2015, coordinating efforts and support from a wide range of stakeholders:

- other governmental agencies and public institutions, such as Drug and Medical Technology Agency, NCDC Armenia, Food Security Agency, medical education institutions, public hospitals and other health care providers;
- market actors such as mobile operators, pharmacies and companies working in the agriculture and food production sectors; and
- mass media and civil society.

The ultimate goal of the campaign was behavioural change towards rational use of antibiotics through raising awareness of AMR among the general population, health care providers, pharmacists and veterinary service providers.

The campaign was planned under the National AMR Prevention Strategy, which was adopted in 2015 but was triggered by the invitation from WHO to join the World Antibiotic Awareness Week.

An inter(ministerial) board established by the Ministry of Health served as a coordination mechanism. Four group leaders were identified to target specific audiences and use

appropriate methods for information sharing or knowledge transfer. The board approved common key messages and a campaign logo and oversaw campaign implementation.

Financial resources were not earmarked in the 2015 state budget; however, WHO provided a grant of US\$ 5000 for the production and dissemination of information on electronic and printed media; and the Drug and Medical Technology Agency co-financed the campaign.

There was no formal mechanism for the evaluation of the campaign outcomes. However, the results surpassed the expectations in terms of the interest and active involvement of private actors and mass media, and in the feedback received from the population.

The main lessons learned (e.g. support from the private sector and the mechanism of engagement) can be generalized in countries in the region with the same context and AMR challenges. Other operational and organization experience gained during the campaign will help to plan and implement the campaign more effectively in the future.

The country plans to conduct a further AMR awareness-raising campaign in 2016 based on the lessons learnt.

4. Austria: Austrian health targets



In 2011, the Ministry of Health and the Federal Health Commission in Austria initiated a widely participatory intersectoral process of preparation for national health targets in line with an HiAP approach, with more than 40 key political and societal stakeholders. The general public was consulted through an online platform. In 2012, the 10 national health targets were adopted by the Council of Ministers and the Federal Health Commission. They are part of the current government programme and represent a basis for health reform. Currently, different intersectoral working groups work on each health target and define subtargets and implementation actions; these will be monitored and evaluated by the Austrian Public Health Institute. A clear implementation structure was set up in order to support the implementation of the targets. The targets are based on a number of guiding principles. The most relevant are focus on health determinants, a HiAP approach and promoting health equity. In addition they relate to both living conditions and individual behavioural factors.

A broad governance approach is seen a key to generate joint ownership and to advance health in general. The challenge, however, is to communicate the win–win situation to different stakeholders and political players. At the beginning of the process, a policy dialogue was organized and “motivational fact sheets” highlighting potential win–win situations of the health

targets; policy priorities of the respective sector were produced for each ministry involved. The intersectoral process and coordination is a priority for the Ministry of Health, with the clear objective to keep the process moving and to offer a space for debate. In addition, the Austrian Public Health Institute is supporting the process and its implementation. Plenum (platform of more than 40 stakeholders) meets two to three times a year; different intersectoral working groups meet several times a year to formulate subtargets, implementation actions and indicators, while the leaders of all intersectoral working groups come together at least twice a year to exchange experiences and lessons learnt, coordinate further steps and enhance commitment. Each action has a focal point, with someone who is responsible for the implementation. When a concrete action is defined within the intersectoral working groups, it is crucial that the funding is secured. There is no joint budget for the process.

An intersectoral way of thinking/planning has been established. Furthermore the awareness for health determinants, health equity and HiAP has greatly increased within different sectors. Key lessons are that it is crucial to promote intersectoral cooperation, to empower relevant stakeholders and to create ownership of the process. It is central to have a ministry leading the process. By formulating a number of concrete actions and activities within (so far) five national health targets, cooperation between sectors has become an intrinsic part of the whole process. Challenges and barriers include resistance of old-fashioned/hierarchical structures, keeping the momentum, finding the balance between a highly participatory approach and leadership, lack of structures/processes regarding intersectoral cooperation with a focus on HiAP in most of the Austrian provinces, and the challenge of ensuring common knowledge and understanding with changes in plenum members. Capacity building (leadership, partnership, organizational and workforce development, resource allocation) during the process and strong leadership from the Ministry of Health have been major facilitating factors. Further facilitating factors include strong political support; the participatory process, which fosters partnership and commitment/ownership; a good combination of top-down and bottom-up approaches; enough leeway to allow for creativity (no overregulation); and good team work.

5. Azerbaijan: National Strategy on NCD Prevention and Control 2013–2020



The President endorsed the National Strategy on NCD Prevention and Control in Azerbaijan 2015–2020 and the Operational Plan. Strategy preparation was preceded by a series of studies conducted by the Public Health and Reform Centre of the Ministry of Health in 2008–2011; these generated sufficient evidence for decision-making. Advocacy from WHO regional and country offices was critical to initiate the national policy development on NCD prevention and control.

A working group composed of specialists from the Public Health and Reform Centre and the Ministry of Health worked closely with the representatives of development partners (WHO, the United States Agency for International Development and the World Bank) to draft the strategy. The Ministry of Health submitted the draft strategy to the Cabinet of Ministers, and the document was reviewed and endorsed by the relevant line ministries. Specialists from the Public Health and Reform Centre carried out consultations with their colleagues at the sectoral ministries to incorporate their feedback. Civil society and the private sector were not engaged in the national policy development, which is common practice in Azerbaijan for the development of national policies.

The strategy goal is defined as to “improve the health of the population in Azerbaijan, by reducing premature mortality from noncommunicable diseases by 15% by 2020 through integrated and collaborative interventions.”

Under objective 1, the national strategy envisages the establishment of a high-level national intersectoral coordination mechanism for planning, guiding, monitoring and evaluating enactment of the national policy, with the effective involvement of sectors outside health: social, agriculture, finance, trade, transport, urban planning, education and recreation. Close interaction with civil society and private sector as well as the mass media is intended for raising awareness and for behavioural change interventions.

The Operational Plan provides a framework of results (outputs and outcomes) with indicators and targets that will be used to assess achievements.

There is no dedicated budget for the implementation of the national strategy. The Ministry of Health will be the main source of funding in the beginning; the line ministries have already developed relevant sectoral work plans that will be translated into sectoral budgets in the next budgetary cycle. Finally, the strategy objective 1.3 calls for ensuring “sustainable financing and appropriate budgetary allocations to support equity-sensitive cost-effective NCD interventions.”

6. Belgium: Response to Ebola crisis



The most widespread Ebola epidemic began in December 2013 in Guinea and continued with significant loss of life for over two years. Since spring 2014, the Federal Public Service for Public Health in Belgium provided information on Ebola virus and led consultations with all concerned sectors, including the Federal Foreign Affairs, the Ministry of Defence, the Scientific Institute of Public Health, the Federal Agency for the Safety of the Food Chain,

Fedasil (federal agency for the reception of asylum seekers), SN Brussels Airlines, Brussels Airport, the Port of Antwerp, the communities and regions, trade unions, customs, police authorities, Institute of Tropical Medicine in Antwerp, Médecins sans Frontières, hospitals and doctors, and so on.

In October 2014, a specialist in infectious diseases from the Antwerp Institute for Tropical Medicine, Dr Erika Vlieghe, was appointed as Ebola coordinator. Dr Daniel Reynders from within the Federal Public Health Services was named as her deputy. Dr Vlieghe drafted, evaluated and fine-tuned a set of procedures in close consultation with all relevant departments and institutions involved in the field and with the different regional authorities.

At every instance, Belgium tries to align its assistance to disasters as transversally as possible across the disaster management cycle. The scope of its response to the Ebola outbreak included research on vaccines; sending logistical support and means as well as provision of a mobile laboratory in Guinea (blood tests to diagnose Ebola); continued flights by Brussels Airlines to the affected countries; and support from Médecins sans Frontières and United Nations Children's Fund within the same framework (linked to laboratory activities in Guinea and that notably aims to raise municipalities' awareness and is linked to the construction of communal medical centres).

Belgium has a complicated multilevel political and administrative structure: the Federal Services of Public Health, Food Chain Safety and Environment; the Agency for Care and Health of the Flemish Community; the Common Community Commission of Brussels-Capital; the Walloon Region; the German-speaking Community.

The Ministry of Interior hosts the Governmental Coordination and Crisis Centre, a 24-hour operational centre that provides infrastructure, interdepartmental management, expertise and coordination. The first national meeting on Ebola was held the Crisis Centre in October 2014 and brought together interior, public health, transport and mobility, defence, police and foreign affairs officials and all levels of government.

The Federal Ministry of Health's response was led by their Public Health Crisis Centre, which was expanded from five people to 25 and an Ebola Crisis Centre established.

In addition to liaising with health care institutions and professionals at all levels of government, the Ebola coordination cell cooperated with NGOs on the drafting of the national plan, training sessions, follow-up of returning humanitarian health workers and scientific contributions. There was also engagement with the private sector on procurement of materials (e.g. cleaning equipment).

The Belgian government allocated up to €40 million for the response to the Ebola crisis.

Belgium held a national conference to evaluate the response to the Ebola crisis and to integrate lessons from the peer-learning delegation of the European Centre for Disease Prevention and Control. This peer review praised good collaboration across government and welcomed the concise arrangements for the organization and governance of the Ebola response. It also highlighted the intensive collaboration between key stakeholders, including clear coordination and collaboration with organizations outside the health sector. This resulted in guidelines and standard operating procedures being drafted or amended with contributions from professional experts, scientific collaborators and NGOs.

The Ebola crisis identified that expert resources (scientists, communicators, medical specialists) were available but the existing workload would make it difficult to respond effectively at primary, secondary or tertiary levels of health care if more than one person with Ebola infection needed to be treated. To build on the legacy of the Ebola crisis response, generic preparedness and response plans are being strengthened and updated.

7. Bosnia and Herzegovina: *Mental health services at community level*



Mental health gained prominence as a public health issue on the international agenda during the last decade of the twentieth century. There was growing consensus that major reforms were needed, including a shift to community-based care. WHO strongly advocated this new approach, dedicating the 2001 World Health Report to mental health (1).

In general terms, this involves a greater focus on care near where people live, care that enhances recovery and care that is based on the evidence of what works best; this requires the involvement of multiple services through engagement of a number of sectors in ensuring coordinated care.

Intersectoral action of improvement of mental health at community level in Bosnia and Herzegovina is part of the long-term continuing commitment of the health authorities in Bosnia and Herzegovina and the ministers of health in the South-eastern Europe Health Network to continue with the process of mental health reform in the region.

The overall strategic goal of this intersectoral action is to improve mental health of the population in the countries of south-eastern Europe as well as to increase respect for the human rights and dignity of persons with mental disorders. Specific objective is provision of integrated community-based mental health services with greater focus on care near where people live, care that enhances recovery and care that is based on the evidence of what works best.

The intersectoral action was initiated in 2002 as a result of the 2001 World Health Report dedicated to mental health and as commitment to the regional development of health and well-being within the South-eastern Europe Health Network. The action was oriented to providing integrated mental health care through community-based centres; the initial stage was piloted at two centres, with growing network of centres throughout the country.

Beyond the initial two-year period of activities implemented with donor assistance, success led to continuation for an additional four years; thereafter, the commitment and political will, jointly with the dedication of the public health professional community, local government units and civil society, have ensured that this initiative is a long-standing one, remaining active and contributing to the health and well-being of citizens.

8. Croatia: Intersectoral Committee on Environment and Health



Health is more than just the health sector itself; the complexity of factors influencing this public good requires intersectoral action in which multiple sectors join their expertise, capacities and resources in effective, efficient, timely and consistent provision of services to the citizens.

One such example of intersectoral action is the initiative of the Croatian Ministry of Health to establish an intersectoral committee for environment and health, which would cover the dimensions of health and well-being particularly with regard to issues related to the environment, in line with ample evidence of the effect of environmental factors and conditions on health and well-being.

In 2014, Ministry of Health of Croatia established the Intersectoral Committee on Environment and Health; this involved health, environment and science sectors, alongside related agencies in these sectors, to assist with issues of environmental health and any other expertise requested by the Ministry of Health or other higher governance structures, such as the parliament.

The successes of the Committee are predominantly in the area of policy advice to the Minister of Health; however, because the Committee has only recently been established, other functions have not yet been established: monitoring is planned to measure the level of achievement of the objectives set for the work of the Committee, as well as for the Ministry of Health programme.

Some of the key assets to the initiative are the political will and commitment to address issues of intersectoral nature in an intersectoral manner, although political changes may well affect the process. The initiative has encouraged other sectors to initiate joint programmes

and intersectoral actions, both at national and local levels, and has served as a matrix for comprehensive and timely intersectoral collaboration, which is so important for the holistic improvement and promotion of health and well-being in Croatia, and possibly in other countries.

9. Cyprus: National Strategy and Action Plan to Fight Sexual Abuse, Exploitation of Children and Child Pornography 2016–2019



Child sexual abuse is a problem worldwide and that persists in the WHO European Region. Analyses of community surveys from Europe and around the world have estimated a prevalence rate for sexual abuse of 9.6% (13.4% in girls and 5.7% in boys). Child sexual abuse, exploitation and child pornography is also an issue of concern to Cyprus. In 2015, the Cypriot Council of Ministers decided to tackle this issue by establishing an ad hoc ministerial committee with Ministers of Labour, Education, Health and Justice to coordinate preparation of a National Strategy and Action Plan to Fight Sexual Abuse, Exploitation of Children and Child Pornography.

The Strategy's goal is to protect children in Cyprus from all forms of sexual abuse, exploitation and pornography. The initiative received high-level political commitment and was triggered by the need to enforce existing legislation (2014) based on the Lanzarote Convention. Intersectoral action was chosen to ensure coordination with regard to addressing specific cases as well as for application of a coherent, systematic approach to dealing with the issue. The media broke the silence and raised awareness among the public. This coupled with the introduction of the new law supported by the ongoing "ONE in FIVE" campaign provided momentum for action.

The Ministry of Labour took the lead since social issues fall under its mandate. The Ministry of Health provided technical expertise and assumed an advisory role providing the scientific evidence. Within the context of strategy development, the Ministry of Justice and Public Order ensured that a specialized police group would be educated on how to conduct video-recorded statements investigate sexual violence offences against children according to location (rural or urban). The Ministry of Education offered seminars in schools for teachers on sex education, prevention of sexual abuse, diversity in school, anti-racist policies and actions, sexual and reproductive health of adolescents and other topics. NGOs put pressure on the Government to act on this issue, prepared the National Strategy's Action Plan and provided funding. The private sector, psychologists and social workers offered their specialized services. The media ensured wide coverage of the issue throughout.

Information sharing came naturally through enforcement of existing legislation. Parliament encouraged sectors to work towards a single strategic plan. Parliamentary hearings facilitated the process. Bureaucracy-free working and open communication facilitated the intersectoral working group's job.

The main financial leader of the initiative is the Government of Cyprus. The Hope for Children NGO provided €300 000 for the project and a house for the victims. This programme has led to better links and collaboration being established with other sectors.

Creation of an intersectoral working group with accountability for the plan and open communication were the keys to success. Initial resistance to intersectoral working and "thinking out of the box" was overcome once work began. The small size of the country, and thus proximity, made for easy dissemination of information. Existing legislation meant that a legal framework was available to build upon, with international commitments supporting this. Support from NGOs and private practitioners by means of funding and person time were also key enablers.

Health of all children in Cyprus and future psychological well-being, as a human right, is the foundation for this plan and its strategic goals. Wide sector involvement, including a strong NGO presence and media pressure, helped to develop the best plan for the benefit of children. Cyprus has recorded significant achievements in the fight against sexual abuse and sexual exploitation of children since 2014 as a result of this well-coordinated effort.

The National Strategy and Action Plan were approved in March 2016 by the Ministerial Council.

10. Czech Republic: Action plans for implementation of Health 2020: National Strategy for Health Protection, Promotion and Disease Prevention



The Health 2020 National Strategy for Health Protection, Promotion and Disease Prevention adopted in 2014 is an umbrella document for the Czech Government, with key priorities in those areas and for the development of an integrated people-centred health system. A set of horizontal targets defines specific areas in which action can be taken jointly with other sectors to target the main causes of ill health and deaths in the population. Equally important are the vertical targets, primarily the improvement of health literacy and reduction of health inequalities. These need to be taken into account across all measures in order to strengthening the role of individuals and communities in taking care of their own health. The

Strategy also aims to develop the public health system for the long term and to stabilize a system of disease prevention, health protection and promotion.

Action plans are the implementation tool for the Strategy. A working group was established for each action plan and relevant stakeholders, including nongovernmental actors, were invited. Their contributions ensured that the strategy remained impartial. Dialogue has started with all government departments and representatives of non-profit-making and private sectors, scientific and research institutions, professional associations and other stakeholders in order to prioritize actions in the action plans and start implementing projects. Significant considerations have been undertaken in order to secure effective implementation of the action plans, which include different tools and mechanisms for effective health promotion, primary prevention and health literacy improvement. The action plans are at interministerial level and are coordinated by the Government Council for Health and Environment. A managing committee has been established at the Ministry of Health that is mandated with preparation and coordination of implementation of action plans according to strategic objectives and priority areas.

Government Resolution 671 supporting the implementation process of action plans was adopted on 20 August 2015. The Parliament of the Czech Republic, Chamber of Deputies, adopted Resolution of Committee on Health No. 99 on 2 September 2015. The action plans were prepared with the broad participation of the general and professional public. The working groups for preparation, implementation and evaluation consisted of various stakeholders. The managing committee consists of deputy ministers from different departments of the Ministry of Health. The working groups' members include stakeholders from various departments/ministries.

The implementation of the action plans is a work in progress and, therefore, it is too soon to judge the lessons learnt. However, at this point, it is clear that political support played a key role in the process of preparation of the strategy and the action plans as implementation tools. A strong focus on implementation from the beginning was important in engaging a wide range of stakeholders and the general public.

11. Denmark: Intersectoral action for health at the municipal level: implementing health promotion packages



In the structural reform of 2007, municipalities in Denmark were delegated the responsibility of health promotion in accordance with the Health Act of 2005. The main goals of the reform were to improve the welfare of citizens, to bring decision-making on health closer to the citizens and to integrate health with other policy areas at the municipal level, thus saving

costs related to health promotion. Since then, many municipalities have adopted intersectoral policies to promote health and well-being. Although municipalities have independently adopted and implemented these policies, some national level guidance has been created to support these efforts.

The “health promotion packages”, introduced by the Danish Health Authority in 2012, are an example of national level guidance created for supporting health promotion and intersectoral action at the municipal level. These packages comprise an evidence-informed tool to assist municipal decision-makers and health planners in setting priorities, planning and organizing local health promotion initiatives. The 11 packages – focusing on different risk factor areas such as alcohol, tobacco and physical activity – aim to contribute to municipalities’ efforts to work across administrative sectors and to integrate health into all municipal policies. A study by the University of Southern Denmark on the health promotion packages in 2015 found that, in the absence of (numerical) evidence of the effectiveness of intersectoral action for health, having knowledge-based guidelines emanating from the national level can create legitimacy for municipal intersectoral action for health. Although the health promotion packages have been criticized as being rather vague and abstract (lacking specific guidance on topics), they were found to have functioned well for the health sector for the purpose of initiating dialogue with other sectors. Support from national level institutions or organizations was seen as a clear facilitating factor for local level intersectoral action for health. Local Government Denmark (association of the 98 Danish municipalities) has also supported intersectoral initiatives at the municipal level.

Support may also be offered in the form of funding. Although not described in detail in this study, the central Danish Government has created incentives for intersectoral action by offering some funding for specific, temporary intersectoral projects at the municipal level. Public–private partnerships are also encouraged through the “partnership initiative for health promotion” where funding is available for intersectoral projects. Some municipalities have also increased incentives for intersectoral action for health through establishing joint funding for intersectoral initiatives. Public participation has been organized at the local level through public dialogue hearings and, in some cases, through web-based feedback opportunities.

Although progress has been made and intersectoral action is generally better recognized in Denmark, several challenges remain. More thought needs to be given to the role of the health sector in intersectoral action for health – it may not always be the best leader. Moreover, specific capacity-building activities would be needed to support the implementation of existing guidelines and recommendations. This case story demonstrates that, although municipalities offer an excellent arena for intersectoral action, particularly because they are closer to the citizen, such efforts at the local level benefit from national level guidance and support. The Danish health promotion packages and other tools are an excellent example of such support.

12. Estonia: National Health Plan 2009–2020



The National Health Plan is an intersectoral, long-term strategy, which aims to improve health adjusted life expectancy of Estonians. It is established by a government regulation, and its actions are mandated by different legislative decrees. The Plan details five thematic fields: increasing of social cohesion and equal opportunities, ensuring healthy and safe development for children, shaping an environment supporting health, facilitating a healthy lifestyle and ensuring the sustainability of the health care system. It highlights that the right to protect one's health is one of the basic human rights, and that everyone must have a possibility to live in a healthy environment with the opportunity to make healthy choices. Common values such as joint responsibility for health, equal opportunities and justice, social inclusion, and increasing power of civil society are priorities.

The National Health Plan is implemented at national, regional and local level, and its progress is monitored by an intersectoral structure, the Steering Committee, which includes representatives from all relevant ministries and departments, semi-governmental agencies and the civil society. The Ministry of Social Affairs leads the Steering Committee and acts as its Secretariat, coordinating its implementation. The activities of the Plan are funded from the state budget. The yearly progress reports are opened for public feedback in an online portal (eelnoud.valitsus.ee) – an excellent example of how public participation can be organized. Another good practice of the Plan is that regular overviews of activities are conducted, and clear indicators, baselines and targets related to risk factors and health outcomes are set, monitored on a yearly basis and reviewed every four years. Having such data may facilitate communication with other sectors. An evaluation of Plan implementation (2009–2015) is also to occur.

Lack of human and financial resources is still a challenge for implementation of the National Health Plan. Lack of high-level awareness and political will on HiAP was also seen as a challenge to collaboration between sectors. The fact that the Plan is mandated by legislation was highlighted as a facilitating factor. The intersectoral Steering Committee offers a forum for discussion of issues of common interest, and it operates within clearly set, measurable targets. As its activities are also open for public review, it is a good example of a national intersectoral body that is accountable, transparent and has the potential to foster ownership of intersectoral action across sectors, including civil society.

13. Finland: Health in all policies (approach)



Intersectoral action for health initiatives have been implemented in Finland since the 1970s and have been strongly impacted by international milestones, such as the Alma-Ata Declaration in 1978 (4) and the Ottawa Charter in 1986 (6). Initially, this approach was taken as a response to apparent health inequities and poor overall health in the country. The concept and approach have been developed over decades, in collaboration with WHO. The term “health in all policies” was first used in 2006 when Finland adopted it as a theme during its EU presidency.

HiAP is a long-term approach that aims to ensure that health and well-being are taken into account in the policies and actions of all sectors, at all levels of governance. Gender, equity and human rights considerations are central in this approach. In Finland, the Constitution, the Public Health Act, and the Health Care Act mandate HiAP at the municipal level. At the national level, action is coordinated by the Ministry of Social Affairs and Health. The Advisory Board for Public Health is an intersectoral national level body that aims to promote health and well-being, including HiAP. Ministries, local authorities and the civil society are represented on the Board. Other mechanisms that have been used to support HiAP include human impact assessment, networks of HiAP focal points in all ministries and various intersectoral working groups such as the National Board for Nutrition.

Although HiAP has gained recognition and has been increasingly accepted as an approach in Finland, there are still challenges in its implementation. For example, lack of resources for HiAP is an issue, and approaching other sectors with health arguments has remained challenging. Capacity for advocacy still needs to be built. In terms of terminology, “well-being and health” has been increasingly used instead of simply the word health. Moreover, lack of a broad approach to health in education impedes HiAP work. This is particularly true for education of doctors and other health professionals, which has remained too focused on health care.

Given that Finland had a long history in HiAP and intersectoral action for health implementation, many lessons learnt can be drawn from its experience. For example, laws that obligate intersectoral action have worked well in Finland and have been considered a facilitating factor in mandating sector collaboration. Institutions that support HiAP are key to success. In Finland, the National Institute for Health and Welfare has been strong in promoting HiAP, for example by developing supportive tools such as a model for municipalities for “reporting for well-being”, a human impact assessment and the TEA-viisari online service, which enables follow-up of municipal HiAP activities. Municipalities have successfully used existing structures, such as the Healthy Cities programme, to initiate HiAP. Most importantly, the Finnish experience

demonstrates that HiAP is a systematic, long-term approach. It requires long-term vision, commitment and permanent structures to be effective.

14. France: Improving the health of school-age children



Each ministry in France has a senior official designated as the nominated contact person for health. Intersectoral action in health has a long history in France: for example agriculture and health departments (French National Nutrition and Health Programme since 2001), and education and health departments (Health Education Programme 2011–2015). The 2014 Health Act established a new mechanism, an Interministerial Committee for Health, to be chaired by the Prime Minister and bringing together all of the relevant departments (whole of government). The Committee has not yet been convened but a first meeting is due in 2016 on the topic of AMR.

The Ministry of Health promotes a “health democracy” concept, with health stakeholders invited to co-create public health policy at all levels. This is not yet a whole-of-government approach because it is initially designed to create closer relationships between the regional health agencies and local authorities.

Most ministries have representatives in the regions who are accountable to the prefect, the Prime Minister’s representative at regional level. Three ministries (education, health and justice) have their own territorial configurations who do not report to the prefect. The Department of Health works through regional health agencies. There are also regional public policy coordination commissions that include all public entities with an impact on health, such as local branches of health insurers.

As part of the intersectoral activities for health in school-aged children, there are some shared budget mechanisms; for example, the Ministries of Agriculture and Health co-finance activities related to obesity prevention in children.

A new concept of the *parcours éducatif de santé* or educational pathway of health is designed to support well-being in schools. The Ministry of Health sets the child health goals and the Ministry of Education is responsible for the health outcomes.

It has been challenging to get other ministries involved. There are legal agreements between Departments of Health, Education, and Social Affairs and this makes collaboration easier.

15. Georgia: Tobacco control: whole-of-government approach



The Government of Georgia established the State Committee on Tobacco Control to strengthen tobacco control interventions and, to ensure the effective implementation of the respective law on 15 March 2013. The Committee is chaired by the Prime Minister, and its Deputy Chairperson is the Minister of Labour, Health and Social Affairs. This intersectoral Committee unites the key decision-makers from the Ministries of Education and Science, Justice, Internal Affairs, Sport and Youth Affairs, Finance, Economy and Sustainable Development, Regional Development and Infrastructure, and Agriculture, plus with the members of the Parliament (the Patriarchy), mass media, the Georgian Public Broadcaster, and relevant international and local NGOs. The National Centre for Disease Control and Public Health serves as the Secretariat of the Committee.

The Tobacco Control National Strategy and the Action Plan 2013–2018 were developed by the working group of the Committee and further approved by the Government of Georgia on 30 July 2013 (Strategy) and 29 November 2013 (Action Plan). The process was continued with elaboration of amendments to the five relevant laws (Administrative Offences Code of Georgia, Tobacco Control Law of Georgia, Law on Advertisement of Georgia, Broadcasting Law of Georgia and Tax Code of Georgia). Approval and mainstreaming of these amendments are expected shortly.

The Tobacco Control National Action Plan includes measures aligned with the Framework Convention on Tobacco Control, with a focus on the prevention of smoking among young people. This includes a comprehensive ban on tobacco advertisement, promotion and sponsorship; an educational campaigns on tobacco-related harm that is run within the secondary and graduate education systems; strengthening the penalty mechanism for selling tobacco to minors or near educational facilities; awareness-raising campaigns in collaboration with the Ministry of Sport and Youth, the Georgian Public Broadcaster and other relevant agencies; annual increases in tobacco taxation; and enforcement of a partial smoking ban in public premises with preparation for a total ban after 2015.

Bilateral cooperation mechanisms were also used between the health and finance sectors in order to strengthen specific policies such as tobacco taxation.

The national Health Promotion Programme is used as a major financing source but a funding gap within joint financing from different sectors still needs to be addressed. International assistance mechanisms have contributed significantly to the attainment of the national strategy goals through intersectoral approach.

There is close collaboration with media in order to ensure transparency of the process.

16. Germany: AMR strategies (DART 1 and 2)



AMR has become an important issue in Germany, moving from a regional to national priority and then championed globally during Germany's leadership of the G7. This prioritization is driven by data. In 2006, more than 40 000 people died because of an infection. Death rates rose by 14% between 2002 and 2006. Hospital-acquired infections are a particular challenge; rates of methicillin-resistant *Staphylococcus aureus* (MRSA) have increased from 2% to approximately 23% in a 10-year period. However, in neighbouring countries such as the Netherlands and Scandinavia, MRSA rates remain below 5%.

A pilot project EUREGIO MRSA-net, financed with EU funds, in the Dutch–German border region Twente/Münsterland sought to improve the implementation of MRSA prevention and control strategies by exchanging knowledge and technology. The EUREGIO model was promoted by a decision of the regional ministers of health and recommended as a model for regional networks on AMR, which now exist in almost all German states.

In 2008, the first national AMR strategy (DART) was published jointly by the Federal Ministry of Health, the Federal Ministry of Food and Agriculture and the Federal Ministry of Education and Research. The strategy has 10 core goals with actions, actors and milestones identified for each goal. A total of 42 interconnected actions were set out.

In 2015, an updated strategy, DART 2020, was published with an explicit focus on a “One Health” approach encompassing human and animal health. DART 2020 sets out six objectives that apply equally to human and veterinary medicine and should be implemented appropriately in both contexts (see Case story 9). This second strategy is shorter and more political.

The role of the media in raising public awareness about AMR has been critical to maintaining political will. Tackling AMR effectively will also require a shift in the mindset of consumers. Improving the conditions for animals and using fewer antimicrobial agents in veterinary practice requires fewer animals to be in the food chain, consumers to eat less meat and pay more for it.

DART was drafted by the Ministry of Health after interviews with a range of experts that identified gaps. It was also subject to extensive public consultations and featured separate aims for human and animal health sectors. By DART 2 there were joint aims under the “One Health” banner. This represented a step change in terms of integrated working. Civil servants stopped thinking in terms of “silo budgets” to find ways to do more than before and scale up their activities.

Precise, measurable indicators linkable to project activities are useful, for example rates of resistant bacteria in blood cultures. After a decade of efforts, the levels of resistant bacteria in blood culture show a significant decline in 2014. Pilot projects can test out approaches that generate the evidence to convince politicians to scale up activities.

The process of building working relationships between the federal ministries was slow and sometimes challenging to bring different actors together. One useful lesson has been to inform people early, keep them close to the process and involved them in the follow-up. Each ministry has now designated contact people for the DART strategy.

Efforts to combat AMR are a natural choice for intersectoral action because of the key connection between human and animal health. Three ministries were initially involved, health, agriculture and research, and these were joined by environmental health.

The sustainability of the efforts to tackle AMR is uncertain. Local public health officers are needed for quality audit in hospitals. Funds are needed to train medical professionals and to ensure a good ratio of staff to patients in intensive care environments, which are key sites for infection. This is largely a financial issue but is critical for prevention and quality assurance.

17. Hungary: Comprehensive health promotion in schools



The 2011 modification of the Act on Healthcare set the background for comprehensive health promotion in schools. High priorities were the diseases affecting young people, disease prevention and health promotion, raising awareness of health issues among the Hungarian population as a whole and implementation of regular screening programmes for specific age groups. The Act outlined comprehensive health promotion in schools with the aim of ensuring that all children participate in health-promoting activities that would effectively improve physical and mental health and their well-being. The key action points included healthy diet, daily physical education, physical activity, physical and mental health development, prevention of behavioural dependencies and consumption of products causing dependency, prevention of school violence, and personal hygiene. The schools cooperated with the school health service to develop and implement local health promotion programmes. Adoption of relevant legislation was the first step towards the goals of comprehensive health promotion. In order to support implementation of these goals, three EU-funded projects were launched. The initiative was triggered by the launch of “Healthy Nation – National Public Health Programme” in 2001 and further supported by the decisions of the Public Health Interministerial Board in 2003.

School health promotion is seen as an intersectoral responsibility, not just one for the health sector. Comprehensive health promotion is, therefore, a shared goal between the Departments of Health, Sport, and Education. Support from the prime minister has been very important for the promotion of daily physical education. The organization of the Ministry of Human Capacities, which is responsible for health, education, sport, higher education, youth and family, social integration, culture, church and civil society, provides at present an important intersectoral mechanism for joint action since it brings often conflicting governmental sectors under the same roof. Effective intersectoral coordination was secured by involvement of all key players.

The achievement of co-benefits has been considered from the viewpoint of different sectors. For the health sector, it was most important to secure primary prevention of most NCDs and better physical and mental health for all children. For the education sector, better health for all children has been seen as prerequisite for better academic achievements, more effective work for teachers, less absenteeism and less aggression. For the sport sector, fit and healthy children had better chances in junior education and competitive sports. Higher education connected better health with better academic achievements. Social integration has been a concern with children from the most disadvantaged groups, who have worse socioeconomic background and may have a poorer health status; these children can easily be reached in school. Comprehensive health promotion aims at better health and equal opportunity for all children. The culture sector has seen art classes at school as significant factor in the mental health promotion of the children.

There were several NGOs involved in the process. Long-term and stable commitment in the health sector from 2001 onwards was the most important facilitating factor. Long-term and persistent civil work from the medical societies, in good cooperation with the NGO's representing teachers, was the second most important.

Based on the legislation adopted in 2011 and on its gradual implementation, all pupils do have physical education classes every day from the academic year 2015/2016, which equals five sessions of 45 minutes of physical education a week.

18. Iceland: Establishment of a Ministerial Council on Public Health: a public health milestone for Iceland



Iceland faces demographic changes and other major challenges that call for effective solutions to preserve and improve health and well-being at all life stages. One of the priorities of the current coalition government's (2013–2017) platform is to ensure equality for all citizens by means of public health and preventive measures. In 2014, the Prime Minister of Iceland

established, with the approval of the Government, the Ministerial Council on Public Health. The main role of the Council is to promote dialogue and cooperation between ministers and ministries, harmonize overlapping thematic areas and prepare a comprehensive public health policy and action plan for submission to the Government.

Through intersectoral work, the Council aims to improve health, well-being and equity at all stages of life, with special emphasis on children and adolescents. To reach these goals, a comprehensive public health policy and action plan will be published in 2016. One of the actions in the plan's draft is implementation of a health-promoting community project in all communities in Iceland. This project will assist communities at the local level to work across sectors to create environments that promote the health and well-being of all inhabitants, emphasizing HiAP.

The Ministerial Council comprises the Prime Minister (chairperson), the Minister of Health, the Minister of Education and Culture and the Minister of Social Affairs and Housing plus representatives from their ministries. A Public Health Committee, also established in 2014 under the authority of the Minister of Health, also involves stakeholders from a wide range of sectors. The Committee's main role is to advise and support the work of the Ministerial Council by drafting the public health policy and action plan and consulting regularly with the Council. Apart from the sectors represented in the Ministerial Council, the Public Health Committee engages representatives from unions, public health centres, universities and associations.

Participatory mechanisms have brought together stakeholders from different sectors through the work of the Ministerial Council and the Public Health Committee, thereby facilitating communication, joint understanding and a sense of ownership among those involved; all stakeholders in the Public Health Committee were invited to contribute to the draft strategy. The Ministerial Council of Public Health has earmarked funding from the state budget for the health-promoting community projects in 2016. An evaluation plan is included in the Public Health Strategy and some suggested actions are being assessed.

Lessons learnt emphasize the importance of using language and concepts that everyone can relate to. Work should be founded on a common ground and understanding so that everyone can see the benefits of participating and contributing. Being able to show other sectors how public health, well-being and reduced health inequalities are also important and relevant to their needs and helps them to reach their goals and facilitates the work of the Ministerial Council. Challenges relate to limited resources, such as time, human resources and funding. To ensure sustainability of this work, it is essential to maintain its continuity despite possible changes in government at national and/or local level.

The establishment of the Ministerial Council is an important milestone for public health work in Iceland, bringing together ministers from different sectors to find common ground to work towards improved health, well-being and equity.

The Ministerial Council is currently in place and working on the comprehensive health policy and action plan. They have discussed, among other things, determinants of health, HiAP, health tourism, a comprehensive public health policy, an action plan to improve public health in all age groups with a special focus on young people, and public health indicators.

19. Ireland: Healthy Ireland



The Healthy Ireland framework for improved health and well-being 2013–2025 is a strategy based on the determinants of health. Inspired by Health 2020, it has four central goals.

- increasing the proportion of people who are healthy at all stages of life;
- reducing health inequalities;
- protecting the public from threats to health and well-being; and
- creating an environment where every individual and sector of society can play their part in achieving a healthy Ireland.

Healthy Ireland sets out a framework of 64 actions for public and private sector organizations, communities and individuals across six themes:

- governance and policy
- partnerships and cross-sectoral working
- empowering people and communities
- health and health reform
- research and evidence
- monitoring, reporting and evaluation.

The Healthy Ireland framework draws on existing policies but proposes new arrangements to “ensure effective cooperation and collaboration and to implement evidence-based policies at government, sectoral, community and local levels”.

Implementation of the actions will be managed through an outcomes framework, with key indicators such as health status, weight, diet and activity levels plus measurable targets. Health inequalities measures and the broader determinants of health will be assessed, such as the proportion of young people completing second-level education, access to green spaces and indicators measuring the extent to which the population’s health is protected (e.g. uptake of immunization programmes).

The changing demographics of Ireland was the trigger for the initiative. Life expectancy had

increased but overall health status had not. A growing population of older people will also result in a higher chronic disease burden with associated costs.

The Health Service Executive recently published its implementation plan for Healthy Ireland in the Health Services with three priorities: reforming the health system, reducing chronic disease and improved staff well-being.

A choice was made to create few new structures that need servicing. The Cabinet Committee on Social Policy and Public Sector Reform (chaired by the Taoiseach (Prime Minister)) has responsibility for overseeing implementation. A cross-sectoral group comprised senior officials from government departments and relevant national agencies. External stakeholders are convened via the Healthy Ireland Council, a platform to connect and mobilize communities, families and individuals.

The focus is on implementation science and building cross-sectoral relationships and links to develop an enabling environment for collaborative implementation. The goal is cultural change, operational change and mind-set change so that health and well-being is on everyone's agenda in a meaningful way.

The Healthy Ireland framework has political support at the highest level of the Irish Government but it is too early to evaluate progress. The long-term time scale of the initiative (to 2025) gives time for governance processes to mature and the activities to bear fruit. In 2015, a baseline survey of more than 10 000 people was made and annual surveys will continue.

20. Israel: A government decision to promote a healthy and active lifestyle



In December 2011, Israel launched the National Programme to Promote Active, Healthy Lifestyle, an interministerial and intersectoral effort to address obesity and its contribution to the country's burden of chronic disease.

The initiative was triggered by ample evidence of rapidly increasing rates of obesity among Israelis, and it was further supported by existing research on the correlation between obesity and NCDs, which were also increasing in incidence in the country; rates of diabetes mellitus are twice as high as the average in western Europe, and the number with hypertension has increased by more than 250% in 25 years.

Pressure from the expert community and the political will of high officials, channelled through the Healthy Israel 2020 policy adopted in 2008, have led to the establishment of an

intersectoral policy and implementation mechanism that involves the health, education and agriculture sectors and will be extended to other sectors including the Ministry of Finance, local governance units and health management organizations. The initiative consists of joint efforts to limit access to unhealthy food in schools and to promote healthy school meals and physical activity. The success of the initiative is indicated by evaluations that have shown obesity levels stabilizing at a plateau; and in coming years it is expected that the desired outcome of reduced obesity will be observed.

Changes in government and achieving stable financing have been challenges, but the continuation of the initiative shows unanimous commitment to reaching this universal goal.

This case study exemplifies intersectoral action including joint planning, implementation and, to a limited extent, budgeting between the Ministries of Health, Agriculture, Education and Culture, and Sport, reflecting the Health 2020 and HiAP approaches through integrating health into the policy-making of other sectors and line ministries.

21. Latvia: Advisory Council for Maternal and Child Health: *intersectoral action with civil society*



The Advisory Council for Maternal and Child Health is a permanent intersectoral body that engages various stakeholders including professional associations and NGOs in the development and implementation of mother and child health policy in Latvia. The Advisory Council was established by regulation of the Ministry of Health in 2008 with the aims of decreasing maternal and infant mortality and facilitating the exchange of information and cooperation between the Ministry of Health, NGOs and state and local government institutions in this field. It has 18 members, and its work is coordinated by the Department of Health Care of the Ministry of Health. The head of the Advisory Council is the main specialist of the Ministry of Health on maternal and child health issues.

The Advisory Council offers an arena for the civil society to participate in maternal and child health policy planning and implementation at the national level. The sector collaboration is primarily vertical (i.e. between the Ministry of Health, associations representing local and regional governments, and NGOs). The Advisory Council's meetings are also open to the public, and information about the Council's meeting is available on the Ministry's website (in Latvian). Questions and proposals for the Council may also be sent via the website.

Although sector collaboration in the area of maternal and child health has improved in Latvia, challenges remain. For example, engagement of some sectors has been easier than

others. Tools are needed, for example for negotiating or communicating financial implications (including savings) related to intersectoral action.

Regarding the facilitating factors, ownership was improved by engaging NGOs from the beginning and ensuring that they participate as full members of the Advisory Council ('NGOs feel like they are a part of the political process'). In offering a platform for civil society participation, the Advisory Council is also a good example of a mechanism through which bottom-up input for national initiatives can be ensured and government accountability improved.

22. Lithuania: State Health Affairs Commission



The State Health Affairs Commission is a permanent intersectoral structure that was established in 1996. It is responsible for health promotion, including the promotion of HiAP in Lithuania. It is chaired by the Minister of Health and has 21 members, representing all ministries and one NGO. The activity of the Commission has been revived since 2013. The Commission is an institution coordinating the planning of health policy measures and the implementation of these at the ministries and other government institutions, as well as implementation of the laws and other legal acts on health activities. Promotion of HiAP is a key strategic goal. Equity, gender and human rights issues are discussed at the Commission but they are not explicitly in its mandate.

There has been widespread acknowledgement that the health sector alone cannot take care of health and well-being of the population. Even though other sectors have increasingly participated in the work of the Commission, it has been somewhat challenging to "make other sectors actors, not spectators". There have also been some political barriers and it has been challenging at times to gather together vice-ministers, who are members of the Commission. Political changes are also difficult; changes of ministers may impact the agenda of the Commission. Against this, the high participation of high-level politicians has made it easier to take decisions and to implement intersectoral policies. Furthermore, participation of vice-ministers in the Commission has meant that politicians have become overall more aware of health issues. This high-level participation in the Commission has, therefore, increased the legitimacy of intersectoral action for health.

23. Luxembourg: Get moving and eat healthier! A decade of intersectoral action to reduce obesity in Luxembourg



According to the 2013–2014 Health Behaviour in School-aged Children survey data for Luxembourg, 26% of boys and 14% of girls aged 11 years are overweight or obese. Data from the national medical school surveillance system (2014/2015 school year) showed that 14.1% of boys and 14.3% of girls in primary schools are overweight or obese. Growing levels of overweight and obesity in Luxembourg triggered action to:

- increase awareness among the population and provide information on the importance of healthy lifestyles for physical, mental and social health;
- promote balanced nutrition; and
- increase the quantity and quality of physical activity in the population, including children and adolescents.

This case story describes a project and a national strategy, called “Gesond iessen, mei bewegen” (healthy diet, more movement), on increasing physical activity and promoting balanced diets for all residents of Luxembourg that was launched in 2006 and is ongoing. While its initial focus was primary schoolchildren and adolescents, today the project targets the entire population. The initiative is now nationwide and has been adopted by approximately 1000 communities, which offer sports opportunities of all types and for all ages.

Intersectoral action was chosen since the Ministry of Health realized that it could not act on this issue alone. This triggered a national debate in Parliament on the problem of obesity and four ministries, in charge of health, sport, family and national education, decided to work together.

The Ministry of Health and Ministry of Sports took the lead from the outset with the former maintaining its coordination role throughout. They later engaged the private sector (sports clubs and school canteen suppliers) in local communities. School catering services also started offering healthier foods. The media played an important role promoting sport and balanced diets.

Initially, parliamentary hearings were held and the four ministries established an interministerial group to plan the project and strategy jointly. They drafted a national plan to fight obesity with a focus on increasing physical activity and promoting a balanced diet. The interministerial group is still active and coordinated by a staff member working in the Health Directorate. This person regularly liaises with all other stakeholders on the project. Funding for this project is shared between cities and ministries.

Prevalence of obesity in Luxembourg has remained stable across the population in the initiative's 10-year period. Each of the four sectors reaped benefits from involvement in this project. The general public has increased awareness that balanced nutrition and physical activity result in better quality of life. A first evaluation is planned for 2016.

Factors that facilitated work were the easy engagement of sectors once the decision was taken by the Prime Minister to support this project. As a result, it is now easier to contact the Ministry of Sport and get support when initiating sports activities in communities. The small size of the country was also a great advantage since it made it easier to reach everyone equitably. An initial challenge was to engage sports federations or fitness clubs, which were not keen on promotion of low-priced fitness options, but they now understand that the promotion of sport for everyone is good for the whole population. The programme has led to an increase in demand for people who can professional teach sports, which cannot always be met. The programme is still currently being implemented.

24. Malta: A whole-of-school approach to healthy lifestyles: healthy eating and physical activity



The major health challenge affecting schoolchildren in Malta is overweight and obesity; almost 47% of 11-year-old children in 2012 were either overweight or obese, with boys showing increasing trends and girls' levels of obesity on the downturn. This rapid increase motivated the health and education sectors to join efforts to implement a national school-wide policy and strategy to increase physical activity and improve nutrition in schools for all children.

The strategic goals of the initiative were to:

- achieve better physical activity and nutrition for all schoolchildren in Malta; and
- create equal opportunities for all children in all schools to engage in physical activity and benefit from improved nutrition in school settings.

The national policy and strategy aims to increase opportunities for physical activity and improve nutrition in schools while allowing the schools to propose locally appropriate actions. One of the initiatives so far has been increasing physical activity among adolescents in secondary schools. To achieve this, a health, education and sports working group was set up and dance sessions offered to students during class breaks. Active changes in foods being sold in school-based snack shops (tuck shops) have also taken place.

The policy and strategy, jointly implemented by the health and education sectors, was triggered by the growing prevalence of obesity among children and the intersectoral action was built on existing relations with the education sector; this was an opportunity to identify common goals and work towards them.

The highest levels of government were involved in policy and strategy development; education and health sectors shared the lead. Many levels of society were involved. Parent associations were consulted during the development of the policy. The media played an active role in promotion and information dissemination. The tuck shops changed their purchasing choices. Cereal companies were informed of the mandatory nutrient levels and sought to promote healthy cereals.

Mechanisms to facilitate the initiative included the establishment of an intersectoral working group by the ministers themselves. They also launched events emanating from the policy such as a “lunch box” campaign using television, radio and social media. School-based initiatives such as cooking classes on healthy meals for children and parents were offered. Preparatory work for the initiative was facilitated by a SWOT analysis (strengths, weaknesses, opportunities, and threats) and policy reviews to assess feasibility.

No additional funding was required for policy and strategy. Each sector used its own budget and staff time. Positive impact of intersectoral collaboration is apparent in other sectors. The sports sector, previously promoting “elite” sports, now promotes “health-enhancing physical activity” at schools. During the summer, children can enrol in non-competitive swimming classes.

To have successful intersectoral collaboration, the goals of each sector need to be complementary; conflicting goals impede smooth working. The action needs to be logistically feasible. Building up personal relations and identifying a champion from each sector is key. Commitment of people working in the field and at policy level facilitated this process. The fact that schools were involved in developing the policies supported their ownership of the initiative.

This initiative had equitable strategic goals; both policy and strategy sought to ensure that all children would be equally exposed to opportunities for physical activity and good nutrition. With regard to public participation, parent associations actively provided input to the process. The media were also involved at various stages, promoting and disseminating information to the public.

The whole-of-school approach to healthy lifestyles policy was launched in January 2015 and is currently being implemented.

25. Monaco: Intersectoral collaboration to test an alert system for arrival of highly infectious diseases by sea



Work on development of an alert system for dealing with the arrival of highly infectious diseases in Monaco by sea started in 2013, with a first test carried out using the hypothetical case of pneumonic plague. The alert system developed aims to ensure a coordinated approach of highly infectious diseases arrive in Monaco by ship. The system should ensure that affected people receive appropriate care, health workers are protected and the spread of the infectious disease is halted.

The core of the alert system is the crisis unit, which relies on a set of intersectoral stakeholders and procedures to activate if someone with a highly infectious disease arrives in Monaco by ship. Close cross-border collaboration takes place with France; an international convention exists since Monaco does not have sufficient infectious diseases specialists. The alert system includes protocol for health workers, care of affected people and the required infrastructure.

The alert system relies on International Health Regulations, which require every ship entering a foreign country to submit a Maritime Declaration of Health to the port authority within 24 hours of arrival. If a highly infectious disease is identified on board, the police are notified and then the Ministry of Health. The crisis unit is convened with relevant sector officials, who divide up tasks according to expertise.

Intersectoral action for health was a natural choice since emergency operations call for assistance from health and non-health actors. Monaco needed a system that could be effectively activated since the Government knew that if an epidemic was to take place, the country did not have the capacity to address it.

This initiative received ministerial support from many government sectors. The Interior Ministry (police) receives the Maritime Declaration of Health, the Ministry of Health (ministry staff) informs hospitals upon receipt of the alert and hospitals provide care to the affected person. Firefighters (armed forces) provide rescue services, logistics for citizen protection and organization of transport to the hospital by protected ambulance. The Maritime Affairs Department, with the Port Authority, facilitates the docking of the ship to evacuate sick people while limiting ship crossings at that moment. A cruise ship (private sector) was engaged to increase preparedness through training offered. The media was involved in disseminating general information about the test locally.

Cross-border collaboration with France is unique to this case story; the French Maritime Department is involved and infected people are sent to French hospitals for care. The crisis

unit collaborates with the French medical system and emergency medical services in the Alpes Maritime Department. The French Navy Prefect and the Maritime Medical Consultation Centre, comprising doctors who can treat problems that happen at sea, give advice and arrange care for passengers.

Work was facilitated by abundant sector-specific expertise. During planning there were meetings with firefighters to learn from their experiences in crisis situations. In infectious disease emergencies, the crisis unit can ask France for personnel support, relief equipment and for care of the sick in French hospitals. The crisis unit also proposes public information messages.

The test of the alert system has led to several adaptations to ways of working, such as changes in doctors' behaviours and recognition of the need for increased and continued training to maintain knowledge. Hospitals need to buy more appropriate materials and health workers must have better training on materials use, contact with infectious persons and protection of themselves while caring for the patient. Monaco's size means proximity fosters close working relationships. No additional funding was needed as each ministry provided financing and person time from its own budget. Lack of time and human resources are a challenge for Monaco; people often carry out multiple functions.

The test of the alert system on the cruise ship confirmed the need to train all sectors to coordinate and follow established procedure. Firefighters need to have appropriate clothing and materials. The Ministry of Health needs health information and techniques for dealing with highly infectious diseases. Regular training of health workers on care of patients and appropriate materials on ships to protect passengers are essential. The fact that ministers facilitated this exercise was very positive. Intersectoral collaboration worked smoothly for Monaco and the experience has been positive for all sectors involved. The test of the alert system has been concluded and there is a plan to repeat this exercise with a staged chemical threat situation.

26. Montenegro: Intersectoral action to reduce salt intake in Montenegro



In 2008, the Ministry of Health Montenegro developed a Strategy for Prevention and Control of NCDs with a framework for action until 2013. Estimates of circulatory system disease at approximately 50% (2010–2012) warranted population-wide action to reduce salt intake. A midterm NCD Action Plan (2014–2015) with intersectoral activities was developed with priority given to prevention of NCDs and education of food industry staff on reduce salt content in

foods. The Programme for Reducing Dietary Salt Intake in Montenegro (2014–2025), aims to reduce salt intake to below 5 g/day per capita, by raising awareness, reducing salt content in processed foods and through a harmonized national response.

An initiative for reducing salt in bread and baking products was launched by the health sector and included the baking industry prior to development of the Programme. It is closely linked to activities from the NCD Strategy and has WHO support from a 2012–2013 Biennial Collaborative Agreement for implementation of the NCD Framework for Action 2008–2013. The Programme recommends a reduction in salt intake by 16% during 2014–2020 and by 30% by 2025.

Intersectoral action involving health, agriculture and the private sector was promoted from the outset, the health sector recognizing that sustainable action was needed with a wider alliance with other sectors. The Biennial Collaborative Agreement with WHO supported development of the NCD Action Plan, the Initiative on Salt Reduction and the National Programme for Reducing Dietary Salt Intake. This policy framework, the NCD morbidity and mortality burden in the country and comparative transferable experiences on reduction of salt intake were main triggers for action.

The initiatives had high-level political support and involved diverse stakeholders including community, civil society and local municipalities. A national council to support the implementation of the NCD strategy will be established with the Prime Minister acting as council chair. The main sectors involved in the initiative and programme were health and agriculture. Other sectors were the chamber of commerce and the private sector, namely the bakery industry. The media was also instrumental in promoting the programme. They were invited to events and were provided with information for accurate reporting. The health sector shared epidemiological data with the agriculture sector to communicate that excessive salt intake is a health risk factor. An analysis of bakery products revealed high salt content, and bread became the food vehicle for salt reduction as it is consumed at every meal. An agreement was reached on the maximum content of salt that would be allowed in bread, which would be implemented at the local level. A link was made between health and tourism in the capital, Podgorica, where local authorities and the hospitality sector will offer low salt options in restaurants in the near future.

A multidisciplinary core group was established to draft the Programme. Continuous dialogue by means of consultations took place during the Programme's infancy, such as with the bakery industry to assure them that business would not suffer. Technical consultations between health, agriculture and the bakery industry helped to achieve expert consensus, policy-maker commitment and agreement on maximum salt thresholds. Once legislation passes, the Ministry of Agriculture will regulate food item labelling to conform to agreed salt levels. An estimate of 24-hour urinary sodium excretion will be carried out to establish a baseline and measure progress. The United Nations development framework for Montenegro (2017–2021)

includes salt intake as an indicator to measure progress in addressing health risk factors.

This experience reaffirms the importance of engaging different sectors from the start and for regular information sharing. Governance arrangements need a sustainable lifespan covering the implementation period and should be integrated into existing policies or programmes. Capacity building for health advocacy is needed so that benefits beyond the health sector can be reaped. Despite ample evidence supporting salt-reduction programmes, health advocates do not use it to engage other sectors.

Challenges were lack of budget allocation and knowledge of how to use financial language and evidence to show positive financial benefits of investing in prevention. International commitments and global or regional policy frameworks helped to promote intersectoral collaboration. The existence of subregional technical networks facilitated the exchange of knowledge, lessons and experiences.

Other sectors such as agriculture now consider health risks of high-salt content when drafting regulations that deal with labelling. Overall, the intersectoral collaborative process ran smoothly and transparently with information shared freely among stakeholders. This case study is just one of several examples of intersectoral action that Montenegro has embarked upon, showing that the country has embraced accountability across sectors to improve health.

The Programme for Reducing Dietary Salt Intake will be officially adopted in 2016.

27. Norway: National system for the follow-up of public health policies: a common cross-sectoral reporting system



Norway has a long history of developing and implementing intersectoral action for health at different levels of governance. A wide array of tools and mechanisms has been developed to support these efforts. In this case story, the Norwegian national system for follow-up of public health policies and the common cross-sectoral reporting system are discussed, with a focus on the cross-sectoral indicators that were developed to support this work. These systems derive their mandate from government white papers.

White Paper No. 20 (2006–2007; National strategy to reduce social inequalities in health) highlighted public health policy as a cross-sectoral issue and first launched the cross-sectoral reporting system. White Paper No. 34 (2012–2013; Public health report: good health, a common responsibility) reinforced the need for collective action on health and established a national system for the follow-up of public health policies.

The main strategic goal was to improve public health and reduce social inequalities in health. In order to support this work, different sectors have collaborated to create indicators across sectors to feed back to policy development. For the indicators, data is disaggregated according to variables such as socioeconomic situation, gender and vulnerable groups. An interministerial committee with representatives from 12 ministries has worked on developing these common indicators, and cross-sectoral teams have separately worked on creating indicators for specific topics such as economic living conditions, social support, safe and health-promoting environments, health-related behaviour, early life living conditions, work environment and inclusion, and local public health work.

Collaboration to create the common reporting system and the development of common indicators has been challenging at times. Getting accurate data is challenging. Not all sectors routinely collect data, or they have not collected data on socioeconomic variables. The perception of challenges also varies from one sector to another, as each sector has different societal goals. In many intersectoral projects and programmes, the health sector has partly a history of pushing a ready-made prescription of solutions to other sectors, when the right approach should be negotiated. The determinants approach and reporting system seems to nurture collaboration. In developing the national system for follow-up of public health policies, other sectors have been involved from the beginning. Sectors have commonly decided on the indicators to use in this work. Having data on health-related inequalities, rather than traditional health data, makes it easier to approach decision-makers in different sectors. Ensuring that other sectors participate in creating these data will also ensure ownership. Other factors that have facilitated this work include high-level political commitment and building the capacity of the health sector in negotiation and in understanding power, process and policy development.

This Norwegian experience demonstrates how intersectoral action on health equality can be supported through development of common indicators and, more broadly, through joint reporting and follow-up systems.

28. Romania: Integrated community-based services for health and well-being



Community-based services have initially been established as pilot activity within field-based projects funded by different development partners. These started from an initiative for addressing the health issues of vulnerable population groups in the Roma communities at local level through establishment of the Roma health mediators. The main objective was to provide access to health services for the Roma population in the country, and in particular in several regions with identified lack of services and poor health.

The activities were in line with the ongoing health reform and the draft National Health Strategy 2014–2020; by far and foremost, activities were based on evidence and best practices provided by development partners and the Centre for Health Policies and Services during the 2012–2013 implementation of the model project. Furthermore, in order to achieve expected results by 2020, collaboration with other initiatives in this field was considered in order to build up a sustainable and coherent framework for further developing integrated community-based services.

The intersectoral action has grown from a field-based project into a whole-of-government and whole-of-society initiative addressing health inequalities of some of the most vulnerable groups at local level; along with this strategic objective, the Ministry of Health has integrated the community services and continued and formalized the two field professions (community nurses and Roma health mediators) into the system to work together with the line ministries, local government, civil society and development partners. Technical expertise and assistance from WHO, the EU and bilateral cooperation partners has allowed the initiative to move beyond child survival and to contribute to greater child well-being and increased social and economic capital in Romania.

This intersectoral action is noted for its prospects of providing better access to health services for marginalized groups while also improving access to other services (e.g. social, education) that are prerequisites for better health and well-being. It has thus contributed to reducing health inequalities through joint action and through addressing multiple social determinants of health, with the aim of providing equal opportunity for prosperity for everyone.

29. Republic of Moldova: National Reproductive Health Strategy 2005–2015



Reproductive health has been a long-standing priority in the Republic of Moldova. With history of long-term collaboration with international partners in provision of free contraceptives and reproductive health services, in 2005 the Ministry of Health moved forward into the process of providing sustainable reproductive health services and initiated the development, endorsement and implementation of the National Reproductive Health Strategy 2005–2015.

The initiative has built upon the previous efforts of the Ministry of Health, supported by other line ministries, intergovernment agencies and development partners to address the issues of reproductive health, in particular mother and child health, in order to efficiently reduce the infant and maternal mortality rates in the country. Upon successful development, endorsement and implementation of the Strategy, the Ministry of Health, together with its development partners

and with technical support from WHO, has initiated a process of evaluation of the Strategy with a view to development of a new Reproductive Health Strategy for the next five-year period. The evaluation revealed important issues to be addressed in all of 11 priority areas assessed within the strategy, and currently the country is in the process of development and endorsement of the new strategy, based on the lessons learnt. The key supporting factors are the political will and the set priorities of the Moldovan Government, together with the strong leadership role of the Ministry of Health; among the key challenges are the funding and monitoring, for which the country has already set new goals for the upcoming strategic document. The process of development of the new National Reproductive Health Strategy involves multiple sectors and stakeholders because the evaluation of the 2005–2015 programme emphasized that the key to its successes was coordinated joint actions across government and society.

30. San Marino: EXPO 2015: an opportunity to highlight the importance of nutrition and sustainable agriculture in school settings



According to data from the WHO COSI study (2), 31% of primary schoolchildren in the Republic of San Marino are overweight or obese. This case story reports on the incorporation of nutrition and agricultural components in an existing nutrition in schools project. It shows how intersectoral action and an international event (EXPO 2015) can promote balanced diets and food-quality standards that prevent overweight and obesity among children.

The strategic goal was to ensure that all children in San Marino had access to sustainably grown nutritious foods in school and educational opportunities to learn about these foods. Equity, gender and human rights were implicitly considered; all children in San Marino are offered these foods at school. EXPO 2015 provided an opportunity strengthen the nutrition in schools project already in place while providing education to children on the importance of food quality.

Two congressional resolutions backed this process. A 2013 congressional resolution was passed calling for the establishment of a multidisciplinary and intersectoral working group for planning and coordination of the health promotion and education interventions in schools. Another congressional resolution on EXPO focused on promotion of balanced diets and food-quality standards was also passed.

Sectors took turns in leading the initiative. The Ministry of Health, with the support and coordination of the Health Authority, provided guidelines on health education in school settings

and guidance to dietitians and paediatricians on menu development and special diets. The Ministry of Education ensured a link was made between school science lessons and off-campus workshops. The Ministry for Tourism, responsible for EXPO, highlighted agricultural production in San Marino to the outside world. The agriculture sector (Terra di San Marino agricultural consortium) organized workshops for schoolchildren on their different products. They agreed to follow a number of integrated agriculture standards that would help to ensure sustainable production of the six main food products. The media highlighted and promoted best practices and broadcast programmes highlighted food quality and healthy diets.

While the consultative committee for EXPO had a time-specific mandate, the education for health working group will ensure sustainability. EXPO 2015 had its specific funding and the initiative built on activities already in place.

While it is early to see the health effects or decreases in obesity, indirect evaluations carried out every two years, such as “Occhio alla salute”, will provide indications of change in overweight and obesity. Intersectoral work was successful with an indicator of interest being high attendance at nutrition workshops organized by the agricultural consortium (1500 children). Other elements to be evaluated are the effects of direct training of cooks by dietitians from the Institute of Social Security, knowledge passed on to children by teachers in science lessons and the results of a dietary assessment of children in third grade.

If there is strong government support, a mechanism such as the education for health working group can be activated. Using a major event such as EXPO 2015 provides an opportunity for the country to bring together all its skills to work on a common project. An understanding by all stakeholders of integrated work helped to streamline work and led to better coordination. Finding a common language between schools and the health sector as well as identifying goals that were of mutual benefit were also challenges that were overcome.

Despite the fact that EXPO 2015 is finished, the education for health working group remains intact and the agricultural consortium continues to supply school cafeterias with sustainability grown healthy foods.

31. Serbia: Implementation of the Protocol on Water and Health



The Republic of Serbia ratified the Protocol on Water and Health and in April 2013. Article 1 of the Protocol states that its objective is “to promote at all appropriate levels, nationally as well as in transboundary and international contexts, the protection of human health and well-being, both individual and collective, within a framework of sustainable development, through

improving water management, including the protection of water ecosystems, and through preventing, controlling and reducing water-related disease”.

According to the Law on Ratification of the Protocol on Water and Health, ministries responsible for health, water management and environmental protection ensure Protocol implementation. The “Agreement on the Establishment of the National Working Group in Order to Undertake Joint Measures and Activities Important for the Implementation of the Protocol on Water and Health to the Convention on the Protection and Use of Transboundary Watercourses and International Lakes” was signed between the Ministry of Health, the Ministry of Energy, Development and Environmental Protection and the Ministry of Agriculture, Forestry and Water Management. The ministerial agreement resulted with the establishment of the National Working Group.

In order to systematically review the legal framework (national and international) and the water, sanitation and health situation in Serbia, a baseline analysis was performed as the first technical step and to support a tool to facilitate drafting targets and target dates. This analysis was essential for the setting of priority issues and actions under the Protocol and resulted in targets and target dates being set.

Beyond the whole-of-government approach, other stakeholders involved have broadened the scope to the whole of society; NGOs and the media were actively involved, and activities for collaboration with the private sector were initiated.

To date, no funding mechanism has been established, and the work of the National Working Group is on voluntary basis. However, to ensure sustainability, financial support is needed for further implementation of the Protocol and increased capacity is required for developing a tool for performing cost–benefit analysis for Protocol targets.

32. Slovenia: Development of the Active and Healthy Ageing Strategy



Slovenia has adopted and with some success implemented the Active and Healthy Ageing Strategy 2006–2010. Because of the enormous challenges from demographic trends in the country, two attempts to prepare the new Strategy in the period 2010–2013 were not successful. It was very clear from the two unsuccessful attempts that an intersectoral approach with engagement and participation of stakeholders, even mobilization of society, would be necessary for successful preparation of the Strategy. The Strategy SI project was finally launched and implemented in March 2014 to February 2016, resulting in a governmental decision in January 2016 to prepare a comprehensive national strategy to respond to the

longevity challenges in Slovenia society. The Ministry of Health and the Ministry of Labour, Family and Social Affairs were highly interested in participating in the preparation of the proposal of measures for the Active and Healthy Ageing Strategy for Slovenia.

This initiative was triggered by several parallel processes. The European Commission adopted the Social Investment Package in the beginning of 2013 and the Directorate-General for Employment, Social Affairs and Inclusion was interested testing the implementation potential of the Package in one of the EU Member States; because the country-specific recommendations for Slovenia in the EU Semester 2016 included structural reforms, in particular on pensions, health, long-term care, the Ministry of Health proposed that its Active and Healthy Ageing Strategy should become the testing area. The Ministry of Health approached the Ministry of Labour, Family and Social Affairs to initiate the intersectoral process. The latter ministry involved the Ministry of Education, Science and Sport because of its role in lifelong learning initiatives.

The evaluation tools (questionnaires, interviews, meetings and conference participation) have showed that an important momentum of engagement was created. This involved not only different stakeholders but also policy-makers from government level (the three ministries). The commitment of the Slovene Government to the outcomes is noticeably high, as evidenced by the participation of ministers and state secretaries at events and conferences in addition to their involvement in strategic decisions. Most importantly, on 21 January 2016, the Slovene Government adopted the decision on preparation of holistic policy response to demographic change in Slovenia. The project has increased the awareness and understanding of healthy and active ageing principles and addressed the challenges posed by financial constraints, existing systems and regulatory frameworks.

The main challenge at the initiation of the process was the relatively low multisectoral competence of the project partners. For first six months, definitions and understanding of common issues were developed. Modes of action also varied within the social, economic and health partners' organizations and some time was needed for adaptation to the common working procedures. In the implementation stage, high sensitivity for simultaneous political processes was needed and fine-tuning of the processes was an absolute for the project. The EU country-specific recommendations for Slovenia in the area of prolonged employment and postponed retirement and in the area of long-term care were the main facilitating factors for the SI process. High political will and determination to create results at the Ministry of Health and the Ministry of Labour, Family and Social Affairs were important driving forces. Involvement of all relevant stakeholders, participatory research, targeted engagement and mobilization of different groups of stakeholders, understanding of different positions and needs of stakeholders, testing proposed political measures in local environments and consensus-building processes, all with focus on health equity, were important success factors in the project.

33. Spain: National Strategy on Patient Safety



A national Strategy on Patient Safety was adopted in Spain 2005 and formed a key element in the Quality Plan for the health service. The Strategy was updated and renewed for 2015–2020. It is based on international recommendations from the WHO, EU and national experts. The Strategy is implemented by a Network for Patient Safety led by the national Ministry of Health and made up of the 17 regions and two autonomous regions that have responsibility for the delivery of health care.

At national level, there are coordinators for each working group of experts and ministry officials. At regional level, the framework includes staff from regional bodies and health care specialists. The Strategy on Patient Safety is coordinated locally in hospitals or within primary care, with data being aggregated regionally and nationally. Each of these working groups has regular teleconferences and annual meetings. The full network is convened once or twice a year to agree the objectives and actions for the year and review progress.

At the request of the regions, the national Strategy on Patient Safety was updated. Stakeholder involvement was ensured by contributions from a group of multidisciplinary experts, all regional authorities and 70 scientific societies and patient organizations.

The new focus in the updated Strategy is on making surgery safer, bringing in the professional associations related to surgery and collaborating with the National Nuclear Council to prevent adverse events linked to radiation.

The Ministry of Health leads the Strategy on Patient Safety. There have been some attempts to involve the Ministry of Education but no formal agreement has been signed. Some relationships have been created with universities through members of scientific societies who also have a teaching function.

Facilitating factors include strong leadership and political commitment, investments in education tools and implementation projects, evaluation of the activities and feedback. The main obstacles to achieving better patient safety are an overall lack of safety culture, gaps in professional training and communication skills, and resistance to change within the system.

Patient organizations helped to develop the Strategy and are involved in all working groups. Since 2006, there has been special training for patients to raise their awareness about patient safety issues and empower them to train others.

The Strategy was initially funded by the Ministry of Health and financial support was limited to a communication campaign on hand hygiene; there have been no funds allocated since 2011. However, an EU funded project on patient safety from 2012 to 2016 has allowed regional authorities to access ongoing training and good practices.

Specific projects on reducing infections (Bacteraemia Zero and Pneumonia Zero) have delivered good results in terms of lives saved and reductions in hospitalization costs.

Leadership is needed at all levels; failure at one level is very visible in some projects. For example, the Bacteraemia Zero project saw smaller reductions in infection in regions without strong leadership.

The decentralized nature of health care in Spain means that it is not easy to achieve coordinated movement in the same direction. There is agreement on the importance of patient safety and the regions share the task of developing the strategic objectives.

34. Sweden: Promoting social sustainability through intersectoral action at the local and regional level



In Sweden, social sustainability has been promoted through intersectoral action at the local and regional level. In 2011, the Swedish Association of Local Authorities and Regions, at the request of some municipalities and regions, initiated an intersectoral project, Joint Action for Social Sustainability, to reduce inequalities in health in 2011–2013. The work was initiated as a response to health inequality problems, which were evident at both local and regional levels. The project was started as a joint local and regional effort, acknowledging the fact that facing these problems would require the efforts of multiple sectors. As a result of this initiative, the Swedish Association, in collaboration with the Public Health Agency of Sweden, established an intersectoral Social Sustainability Forum (2014); this includes 16 representatives from the local and regional authorities, state authorities, the private sector and the civil society.

The Forum aims to promote welfare in a socially sustainable way by providing for the basic needs of all people, by guaranteeing human rights in practice and by contributing to the inclusion of all people. More specifically, it aims to strengthen knowledge about how to implement social sustainability issues in regular governance and management systems, and to pursue successful strategic cooperation within and between the public sector and NGOs, the business sector and the research community.

The Joint Action for Social Sustainability and the Social Sustainability Forum are good examples of local and regional level intersectoral action, and there are many key lessons to

be learnt from this experience that may benefit local, municipal and national decision-makers and other actors in other countries. First, use of term social sustainability instead of public health has been innovative. Terms and goals such as “reducing the health gap” are not always understood or appealing to other sectors, and “social sustainability” language was seen to work better with other sectors in Sweden than typical public health language. Another lesson is that clear short-term and long-term goals should be set. At the local level, the focus of action should be on what can be changed – in other words, issues that are the responsibility of the local governments. The fact that some sectors have national policy goals whereas others may set their goals at the local level can complicate intersectoral working. Actions should also be prioritized and, importantly, economic impact needs to be demonstrated to policy-makers. Costs of the actual intersectoral actions should be carefully planned, and this should be taken into consideration in prioritization of actions. Sustainability and ownership of intersectoral action was deemed good in this case, because it was initiated from the bottom to the top: some municipalities and regions asked the Swedish Association of Local Authorities and Regions to take a national lead in coordinating support for local intersectoral action for health. The local stakeholders benefit from the support they receive from the Swedish Association and the Public Health Agency of Sweden.

35. Switzerland: Swiss Health Foreign Policy



The process of globalization in general and of the public health sector has generated a great demand for coordination between health, foreign and development policies. Thematic areas such as transport, environment, energy, security and global health are increasingly important topics in international relations. They play a substantial role in the sustainable development of societies and can, therefore, no longer be addressed in isolation – nor be restricted to a state’s territory. In order to ensure Switzerland’s capability to be a convincing partner with a coherent position and to represent its interests in the best way possible, the Swiss Health Foreign Policy was approved in 2012 to serve as an instrument for this coordination. This has equipped Switzerland well to formulate and implement a coordinated and coherent health policy approach at both national and international levels.

Switzerland was the first country to adopt an interministerial agreement on health foreign objectives, which it did in 2006. Since the agreement was signed, it has been regarded as a model at the international level. Swiss Health Foreign Policy is the revised version of the 2006 Agreement of the Health Foreign Policy Objectives. The consultation process involved relevant federal authorities, interested parties from civil society, the private sector, research, Swiss health system actors, and the Swiss Conference of the Cantonal Ministers of Public Health.

Swiss Health Foreign Policy covers all international concerns related to health with neighbouring countries, with European policy, on the subject of global public goods and development policy. It relates to 20 objectives in the area of governance, interactions with other policy areas and specific health issues that are of interest to the Swiss population, either as part of a global responsibility for health or of general interest. The national objectives that influence international cooperation are defined in the Health 2020 Strategy, which was approved by the Swiss Government in January 2013.

A focused and intersectoral approach was used to ensure that Swiss values such as human rights, the rule of law and democracy are guaranteed and that the interest of a wide variety of Swiss actors can be taken into account.

Coherence within the Federal Administration is a key success factor for Swiss Health Foreign Policy. The mutual gains were identified as new forms of cooperation, improved integration of wide variety of activities in the health field, and taking a more systematic approach to the development of synergies in all sectors involved.

Interdepartmental structures include the Interdepartmental Conference on Health Foreign Policy, which defines current priorities and joint projects. It meets annually and is jointly chaired by the Director of the Federal Office of Public Health, the Director of the Swiss Agency for Development and Cooperation and the State Secretary of the Federal Department of Foreign Affairs. The Interdepartmental Conference is supported by interdepartmental working groups, which hold regular meetings at least twice a year. An executive- level support group meets at least twice a year to promote policy coherence and to reach consensus if necessary.

Trust and partnership building needs time. While the diversity of the issues involved keeps increasing and their complexity grows, the resources to implement the Health Foreign Policy remain limited. Therefore, the constant challenge is to focus on the concerns and the partners who are expected to generate the greatest added value for public and global health interests.

36. The former Yugoslav Republic of Macedonia: Government Committee on Environment and Health



The former Yugoslav Republic of Macedonia has made an effort to improve the health and well-being of the population to reduce health inequalities, to advance public health and to ensure a health system where the people will have a central position. WHO's Health 2020 framework has been used as guidance and a source of best practices in developing the first overarching national health policy since the independence of the country.

The Environment and Health Action Plan has been developed as part of the implementing strategy for the National Health Plan. This development has directly evolved from the active role of the country in the WHO European Region process for health and environment. As a result, national environment and health processes have been strong, with a central role for the expert community in moving the Environment and Health Action Plan forward, lobbying for changes, bridging sectors and informing the public of the evidence and related action to remedy the situation.

Using this opportunity to keep health in the focus of the Government, the Minister of Health requested technical assistance from the WHO Country Office to engage in making a case for an overarching environment and health action plan (and public health) and policy development. WHO 2014 and 2015 biennium work was focused on filling the evidence gaps, where the WHO Regional Office for Europe and WHO European Centre for Environment and Health in Bonn have been deeply involved. The Ministry of Finance was brought into the initiative and became interested because the actions detected during the process would require significant funds to be employed (e.g. for action in the areas of transportation, energy or industry).

The WHO missions supported intersectoral work on evidence gathering while a policy dialogue was opened by the Ministry of Health, fully supported by WHO. This has broken the “silo thinking” of all the sectors involved, particularly health, environment and transport. Central and local levels were included.

Drafting of the Action Plan on Environment and Health was completed in August 2015 and the draft was posted for public debate alongside other public debate areas on the Ministry of Health site designated for the overarching Health Policy 2020 (http://zdravstvo.gov.mk/health_2020/).

The Action Plan on Environment and Health presents one of the main pillars of, and venues to implement, the Health Policy 2020 in the former Yugoslav Republic of Macedonia and is expected to be endorsed by the Government in the first half of 2016.

Conclusions

The analysis of the 36 collected case stories emphasizes the notion that fostering effective and sustainable multisectoral and intersectoral action is key to ensuring improved health and well-being for all throughout the European Region. Furthermore, multisectoral and intersectoral action and collaboration are necessary for the new transformative model of governance needed to achieve the 2030 Agenda. Multisectoral and intersectoral action needs not just to occur across sectors but also to be coherent across levels of governance – from international, to national to local. WHO has mechanisms to achieve this coherence, such as the WHO European Healthy Cities Network and the Regions for Health Network, which work at the local level for the improvement of health and well-being for all.

Promoting transformative change in line with the 2030 Agenda

The 2030 Agenda calls for a transformative response to our global challenges, in order to meet the 17 SDGs. The analysis of these case stories shows that multisectoral and intersectoral action for health and well-being can do more than simply address immediate health and well-being problems; it can improve health and well-being outcomes for all.

By addressing the determinants of health and well-being, multisectoral and intersectoral action can encourage more fundamental, health-promoting changes in sectors beyond the health sector. The ability to inspire this kind of transformative change is particularly critical for the achievement of the 2030 Agenda and the strategic objectives of Health 2020, which requires transformative governance. The involvement of diverse actors across all levels of government, and beyond, is necessary to achieve global, regional and national goals and targets and to effectively address today's complex global challenges. The transformative approach to improved governance is facilitated through whole-systems approaches (whole of government, whole of society, whole of city, whole of school) that engage all levels of governance, from the international through the national and the regional to the local.

Transformative change means going beyond business as usual. In 27 of the 36 case stories, there was a reported change in another sector in addition to the health sector, with only nine being restricted to the health sector. Most often, this kind of transformative change manifested by ensuring that health and well-being concerns were given a higher priority within other sectors, and by changing institutional structures and practises both within and beyond the health sector.

Long-term vision and political commitment, from the highest levels down, are needed to implement multisectoral and intersectoral actions for health. Ideally, this commitment should be operationalized in long- and short-term goals, measurable indicators and targets with a monitoring and accountability framework. Special attention should be paid to horizontal and

vertical coordination within and between sectors. However, it was also noted that bureaucratic procedures were often a barrier rather than a facilitating factor. Engaged policy-makers and technical experts should be given reasonable levels of autonomy and independence to take decisions without the impediment of heavy bureaucracy when multisectoral and intersectoral mechanisms are implemented.

Furthermore, it is critical that the health sector develops its capacity to bring other sectors into a given process, which requires strong partnership and collaboration. Good collaboration is based on trust, which takes time to build, and concrete results can only be expected after this initial time is invested. Creating ownership across sectors is crucial; this is best fostered by involving all key actors from the start, communicating clearly using accessible language, providing reliable information and ensuring that the factors to ensure the sustainability and continuity of the collaboration are in place.

Identifying win–win situations and co-benefits for all involved is vital in order to strengthen the commitment of stakeholders across different sectors. It is also important to identify partners with influence on the policy question at hand (e.g. certain politicians, NGOs, professional bodies, media representatives and other groups with shared interests). Equally, it is beneficial to identify the opposition and their arguments (e.g. private actors with vested interests or strong interest groups with conflicting ideas or values). This is particularly important given the essential role of intersectoral and multisectoral approaches to addressing key public health priority areas. Where there are conflicts of interest or strong commercial determinants of health, a strengthened governance approach is critical for effective action. This includes strengthened governance for health and well-being not only within health governance but also across all governance architecture up to the highest levels of both government and public institutions.

Actions should be prioritized, and their social and economic impact should be demonstrated through evidence whenever possible. The focus of the multisectoral and intersectoral action undertaken should be both realistic and achievable, making continuity and sustainability more likely. Various tools (e.g. health impact assessments) and other methods for public consultation and community participation should also be used throughout the process in order to increase its legitimacy and efficiency. There is a clear role for WHO in supporting methods for implementation through the development of tools to strengthen existing implementation, and innovation through sharing good practice on the effectiveness of new instruments and mechanisms.

A legislative base can give a strong mandate for multisectoral and intersectoral work and can facilitate cross-sectoral collaboration. Mandates may include more traditional constitutions, laws and decrees but may also include institutional guidelines, strategies, and action plans at the national or local level that can steer actors toward multisectoral and intersectoral action. To ensure continuity, it is important that multisectoral and intersectoral mechanisms exist

beyond election periods and particular electoral mandates, as political changes can quickly abolish initiatives and mechanisms established by a previous government. Therefore, varying types of permanent multisectoral and intersectoral structure are needed to guarantee stability and sustainability. This suggests the importance of an integrated approach to governance for health and well-being, through both existing governance architecture, and central policies and processes such as national development plans and national strategic economic documents.

These case stories have also contributed to an improved understanding of the role of the WHO Regional Office for Europe in promoting new approaches and models for governance to support multisectoral and intersectoral for health and well-being throughout its 53 Member States. The 2030 Agenda demands a framework to better understand and support governance for health and well-being, as well as tools to apply it across different contexts.

This mapping exercise aimed to collate and share examples of best practice of multisectoral and intersectoral action to improve health and well-being for all throughout the WHO European Region. The case stories collected cover a wide range of topics and policy areas and have been implemented in varying contexts. Both multisectoral and intersectoral actions are necessary to achieve the 2030 Agenda, and the case stories collected here aim to contribute to the achievement of this transformative, global and common agenda.

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Annex 1. Template for case stories on multisectoral and intersectoral action for health and well-being (interview guide)

The questions in this template are partially adapted from a case study template developed by the WHO Centre for Health Development (in Kobe) and the WHO Regional Office for the Americas (AMRO/PAHO) (1) and from case study guidelines developed by the Public Health Agency of Canada in collaboration with WHO (2). In addition, the work builds on the WHO Regional Office for Europe's internal working paper Mapping exercise to support multisectoral and intersectoral action: results of the in-house consultation with programme managers, unit leaders and technical officers at the WHO Regional Office for Europe. This mapping exercise uses an umbrella term multisectoral and intersectoral action for health and well-being to refer to a number of approaches (e.g. whole-of-government or whole-of-society approach, HiAP, healthy public policy and social determinants of health approach) that highlight the importance of working collaboratively across sectors to promote health.

| SECTION 1: Background Information | |
|--|---|
| Name of the case story | |
| Member State | |
| Contact person (consultant/rapporteur) | Name: Title: Telephone (incl. Member State code): Email: Address: |

| | |
|--|--|
| <p>Contact person (in-Member State)</p> | <p>Name: Title: Telephone (incl. Member State code): Email: Address:</p> |
| <p>Brief description of the case story and its focus including the time span (3–5 sentences: what was the issue/ challenge)</p> | |
| <p>Describe the key strategic goals (*GER)²</p> | |
| <p>At what level is the case implemented?</p> | <p><input type="checkbox"/> International <input type="checkbox"/> National <input type="checkbox"/> Regional <input type="checkbox"/> Local <input type="checkbox"/> Other, please specify:</p> |
| <p>How the nature of the case can be best described? (E.g. a project, strategy, action plan, permanent/temporary structure, law, tool, other)</p> | |
| <p>What is the level of intersectoral action in the case example? Please mark all that apply (Descriptions adapted from WHO Kobe, 2013 (1) and Shankardass et. al. 2011 (3))</p> | <p><input type="checkbox"/> Information sharing: A one-way relationship where information from one sector is shared with other sectors. This may be the first step towards an intersectoral process.</p> |

² Please consider this question also from a GER (gender, equity, and human rights) perspective.

| | |
|--|---|
| | <p><input type="checkbox"/> Cooperation: Interaction between sectors to achieve greater efficiency in their actions. This involves optimizing resources while establishing formalities in the work relationships. It results in a loss of autonomy for each sector and may be one of the first stages of an intersectoral process.</p> <p><input type="checkbox"/> Coordination: Adjusting the policies and programmes of each sector. This leads to increased horizontal networking among sectors. Shared financing sources may be used. This is an intersectoral relationship that leads to greater dependence between sectors and loss of autonomy.</p> <p><input type="checkbox"/> Integration: A political process where a new policy or a programme (representing multiple sectors) is defined. This may entail systematic integration of objectives and administrative processes and the sharing of resources, responsibilities and actions.</p> <p><input type="checkbox"/> Other, please describe:</p> |
|--|---|

SECTION 2: Setting, Background, and Implementation

| | |
|--|--|
| <p>What or who stimulated/<u>triggered</u> the initiative (a brief description of the process)?</p> | |
| <p>Why intersectoral action was chosen as a better way to achieve the goal as compared to involvement of one-sector alone?</p> | |

| | |
|--|--|
| Describe the role of political will and how higher levels of government have been involved | |
| Describe the roles of the main sectors involved. Did a cross-sector team exist? List all sectors involved (*GER) | |
| Describe the win–win situations/co-benefits/mutual gains that can be identified to different sectors | |
| Describe the role of the health sector and that of the leader/initiator/coordinator of the process | |
| What other mechanisms were used to facilitate the work between the sectors? (A list of mechanism here?) | |
| Describe the financial mechanisms of the case; does it possess its own budget or is joint funding available? | |
| Have any non-governmental actors been involved (e.g. NGOs, the private sector)? Describe their role and specific contribution | |

| | |
|--|--|
| <p>Describe the role of public participation; were there any participatory mechanisms utilized? (*GER)</p> | |
| <p>Describe the role of media in initiation and implementation of the case (if applicable)</p> | |
| <p>Were any tools utilized to facilitate the work (e.g. health impact assessments, policy reviews, parliamentary hearings etc.) (*GER)</p> | |
| <p>Other considerations</p> | |

SECTION 3: Policy Considerations

| | |
|--|--|
| <p>Is the work with other sectors supported by a mandate (e.g. law, decree, act, government policy)?</p> | <p><input type="checkbox"/> No <input type="checkbox"/> Yes, please describe Description:</p> |
| <p>Was there an inter-ministerial or inter-departmental committee?</p> | <p><input type="checkbox"/> No <input type="checkbox"/> Yes, please describe Description (if possible, please include an organigramme depicting the different actors/sectors):</p> |

| | |
|--|---|
| <p>Has the case led to (policy) changes in other sectors?</p> | <p><input type="checkbox"/> No <input type="checkbox"/> Yes, please describe Description:</p> |
| <p>Has the case involved or led to collaboration between the public and private sectors? (Considerations: accountability, transparency, conflict of interests, risk assessment, good governance?)</p> | <p><input type="checkbox"/> No <input type="checkbox"/> Yes, please describe Description:</p> |
| <p>Other considerations</p> | |

| <h3>SECTION 4: Impact and Lessons Learned</h3> | |
|---|--|
| <p>What were the key lessons learned? Was each of these a generalizable lesson or context-specific?</p> | |
| <p>Describe to what extent have the objectives been met in relation to 1) work with other sectors 2) other expected outcomes (e.g. improvements in health and/or its determinants)</p> | |
| <p>How and by whom were the objectives assessed/monitored/evaluated? (*GER) Are any measurable outcomes or indicators set to measure the impact?</p> | |

| | |
|--|--|
| <p>Describe the perception/acceptance of the action by different actors (E.g. politicians, civil servants, the media, and the general public)</p> | |
| <p>Describe the key challenges/barriers encountered in the initiation and implementation of the case (E.g. political, institutional, bureaucratic, skill-related, knowledge, other?)</p> | |
| <p>Describe the main facilitating factors in the initiation and implementation of the case (E.g. political, institutional, bureaucratic, skill-related, knowledge, other?)</p> | |
| <p>Based on these experiences, what kinds of capacities/tools/resources might be needed to support a successful implementation of intersectoral action for health and well-being in the future? (*GER)</p> | |
| <p>Is it likely that the practice can be applied to other Member States/regions?</p> | |

SECTION 5: Evaluation and Dissemination of the Results

| | |
|---|--|
| <p>Has any literature been published about this case (e.g. formal evaluations by research institutes etc.)?</p> | <p><input type="checkbox"/> No <input type="checkbox"/> Yes, please specify Description:</p> |
|---|--|

| | |
|--|--|
| Has the media been included in evaluation or dissemination of the results of the case? | <input type="checkbox"/> No <input type="checkbox"/> Yes, please describe Description: |
| Please attach any material or evidence of the experience | |
| Does this case example have a website and can it be found online on social networks? | |
| Any additional comments (e.g. how was the case perceived/presented; what is the perceived legacy?) | |

SECTION 6: Overall Summary

Title:

Abstract (300–500 words):

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

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World Health Organization Regional Office for Europe
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
E-mail: contact@euro.who.int