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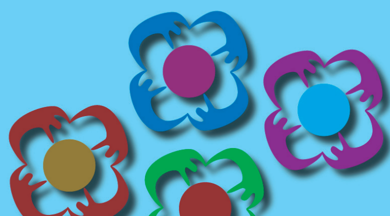
Noncommunicable diseases prevention and control in the South-eastern Europe Health Network

An analysis of intersectoral collaboration



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Abstract

The greatest burden of disease, at both the global and the European levels, is attributable to noncommunicable diseases. Health-promotion and disease-prevention activities aimed at reducing this burden need to involve non-health sectors and actors. This document provides an overview of the existing tools for implementing intersectoral action and highlights developments in this respect in the fields of tobacco and nutrition in south-eastern Europe. It also contains recommendations on key action to strengthen intersectoral collaboration in the prevention and control of noncommunicable diseases in the future, and guidance for the South-eastern Europe Health Network and Slovenia on designing and implementing joint action to this end.

Keywords

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Foreword

Increasingly, we are able to demonstrate that improvements in population health depend on the work of non-health sectors. It is, therefore, not surprising that the health in all policies (HiAP) approach has become a priority in many countries and that it is being adopted at various levels of policy-making: regional (European), national and local. For their 3rd Forum of Health Ministers in Banja Luka, Bosnia and Herzegovina, on 13–14 October 2011, the Member States of the South-eastern Europe Health Network (SEEHN)[1] and Slovenia chose to focus on HiAP, which is seen by these countries as essential to public health development and social progress. In addition, HiAP has been given a high profile in the new WHO European health policy – Health 2020 – which is currently being developed by the WHO Regional Office for Europe and its 53 Member States. The goal is to have a policy framework that facilitates – in an equitable and sustainable way – the protection and promotion of population health, the reduction of health inequity and the creation of conditions conducive to good health.

At the present time, economic difficulties are at the fore and governments are constantly under pressure to contain public-sector expenditure through the optimal use of existing resources and, at the same time, to deliver improved results. Thus, there is a strong need to "make the case" for HiAP and clearly illustrate that it makes good sense to promote equitable population health. It is recognized that mortality and prolonged disability from noncommunicable diseases (NCD) have a sizeable economic impact on the whole of society. It is projected that, for the period 2011–2025, there will be a cumulative loss of output of more than US$ 7 trillion in low- and middle-income countries, which can be attributed to the four NCD that are the focus of the Action Plan for the implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases, 2012–2016, and the Political Declaration of the high-level meeting of the United Nations General Assembly on NCD prevention and control, which took place in New York, United States of America, in September 2011 .

During the past year, the field of NCD prevention and control has attained a high position on the international agenda. In April 2011, the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Diseases Control was organized in Moscow, Russian Federation, followed five months later by the aforementioned meeting of the United Nations General Assembly. This was only the second time in the history of the United Nations that the General Assembly met on a health issue (the first time being on AIDS). Also within the WHO European Region, 2011 has been a year of immense progress. At the sixty-first session of the WHO Regional Committee for Europe in Baku, Azerbaijan, on 15 September 2011, the Member States agreed on the Action Plan for the implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases, 2012–2016.

The vision, commitment and plans embodied in the Banja Luka Pledge echo and reinforce the importance of working across sectors for the prevention and control of NCD. The Pledge provides a pioneering framework for strengthening public health capacities and services to this end. The SEEHN should be praised, encouraged and supported in its great work. I strongly believe in the saying, "If you want to go fast, go alone; if you want to go far, go together".

Zsuzsanna Jakab
WHO Regional Director for Europe

1 Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Israel, Montenegro, Republic of Moldova, Romania, Serbia and the former Yugoslav Republic of Macedonia.

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Introduction

The burden of noncommunicable diseases (NCD) is the predominant public health challenge in the WHO European Region. The new WHO estimates presented in the *Global status report on noncommunicable diseases 2010 (1)*, launched in Moscow, Russian Federation, in April 2011, illustrate its dimensions. Among the six regions of WHO, those for Europe and the Americas share the dubious honour of having the highest proportions of deaths from NCD and injuries. Furthermore, in relation to the risk factors for NCD, the European Region has the highest overall smoking rate, the highest per capita consumption of alcohol, the highest proportion of dietary-energy intake from fat, the highest rate of raised cholesterol, and the second-highest rate of overweight and obesity.

This burden is addressed in *The new European policy for health – Health 2020: vision, values, main directions and approaches (2)*, which responds to the changing context in Europe, including the glaring health inequities found in and among countries, and the alarming increase in rates of NCD. Health 2020 *(2)* also acknowledges that health and quality of life are influenced by a complex web of interrelated social, environmental and economic factors related to the broader determinants of health. This complexity leads to the necessity to take measures to promote and protect health and well-being that require the involvement of both the health and non-health sectors, making intersectoral collaboration a necessity for combating NCD.

Working across sectors is not a new concept. Already in 1978, WHO emphasized intersectoral action for health in the *Declaration of Alma-Ata (3)* as part of its primary health care (PHC) approach. The concept of strengthening healthy public policy was highlighted in the *Ottawa Charter for Health Promotion* in 1986 *(4)* and further developed in 1998 in the *Adelaide recommendations on healthy public policy (5)*. In 2006, the Finnish Presidency of the European Union identified health in all policies (HiAP) as one of their main themes, thus raising this approach on the European agenda *(6)*.

In 2010, the Government of South Australia, together with WHO, organized a meeting on the HiAP approach. Here, discussion between senior experts from a wide range of countries and sectors on the implementation of the approach resulted in the *Adelaide Statement on Health in All Policies (7)*.

Introducing the value and priority areas of the HiAP approach, and action to implement it, was one of the main goals of the 3rd Forum of Health Ministers of the South-eastern Europe Health Network (SEEHN) and Slovenia that took place in Banja Luka, Bosnia and Herzegovina, on 13–14 October 2011.

This publication was prepared as background information for the Forum with the aim of:

1. informing the Forum about state-of-the-art intersectoral action taken in the SEEHN countries and Slovenia in the area of NCD in accordance with strategies developed by WHO;
2. presenting an overview of existing tools for implementing intersectoral action in these countries;
3. highlighting development in intersectoral action for the prevention and control of NCD in SEEHN countries and Slovenia;
4. providing recommendations on key action for strengthening intersectoral collaboration in SEEHN countries and Slovenia with the goal of enhancing the prevention and control of NCD.

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Intersectoral action for the prevention and control of NCD and their key determinants

Recent NCD prevention and control strategies and intersectoral action

Recently, four important documents relating to NCD have been released by the United Nations and WHO, namely: the *Global status report on noncommunicable diseases 2010 (1)*; the *Moscow Declaration (8)*; the *Action plan for implementation of the European strategy for the prevention and control of noncommunicable diseases 2012–2016 (9)*; and the *Political Declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (10)*. These documents all acknowledge the fact that health-promotion and disease-prevention activities relating to NCD must involve non-health sectors and actors.

The *Global status report on noncommunicable diseases 2010 (1)* is the first report of its kind to contain information on ways to map the epidemic, reduce the major risk factors for NCD and strengthen health care for people already suffering from these diseases. The report was prepared by WHO in accordance with the 2008–2013 action plan for the global strategy for the prevention and control of NCD *(11)*. It includes a "best-buys" action package to accelerate results in terms of saving lives, preventing disease and avoiding heavy costs. To implement the interventions considered as "best buys", such as raising taxes on tobacco and alcohol, enforcing bans on advertising tobacco and alcohol, and reducing the content of salt in food, the integrated action of multiple sectors is required.

The *Moscow Declaration (8)* is one of the outcomes of the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Diseases Control, which took place in Moscow, Russian Federation, on 28–29 April 2011. It expresses the belief that "NCD should be considered in partnerships for health and that they should be integrated into health and other sectors' planning and programming in a coordinated manner". It also commits to developing "strengthened and reoriented policies and programmes that emphasize multisectoral action on the behavioural, environmental, social and economic factors ... Effective NCD prevention and control require leadership and concerted, whole-of-government action at all levels (national, sub-national and local) and across a number of sectors, such as health, education, energy, agriculture, sports, transport and urban planning, environment, labour, industry and trade, finance and economic development" *(8)*.

The *Action plan for implementation of the European strategy for the prevention and control of noncommunicable diseases 2012–2016 (9)*, which was agreed at the sixty-first session of the WHO Regional Committee in Baku, Azerbaijan, on 15 September 2011, identifies specific areas in which the Member States, WHO and partners have committed to taking action and achieving certain deliverables in the five-year period from 2012 to 2016. The plan takes a comprehensive and integrated approach to tackling NCD, in line with that of the *European strategy for the prevention and control of noncommunicables diseases (12)*. It is organized into four priority action areas, five priority interventions and two supporting interventions (Table 1).

Table 1. Action plan for implementation of the European strategy for the prevention and control of NCD 2012–2016: priority action areas, priority interventions and supporting interventions

Priority action areas	Priority interventions	Supporting interventions
Governance for NCD	Promotion of healthy consumption via fiscal and marketing policies	Promotion of active mobility
Surveillance, monitoring and evaluation, and research	Replacement of trans-fats in food with polyunsaturated fats	Promotion of health in settings
Health promotion and disease prevention	Salt reduction	
Health services	Cardiometabolic risk assessment and management	
	Early detection of cancer	

Source: Action plan for implementation of the European strategy for the prevention and control of noncommunicable diseases 2012–2016 (9).

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These action areas and interventions link the health sector with other sectors in multiple ways. For example, the action plan stresses that "governance for NCD prevention and control requires mechanisms that are participatory, cross-sectoral and multilevel, and which extend from local to global arenas". It also states that "such mechanisms include action to define shared goals and resources, identify the co-benefits of NCD prevention, assess the health impact of policies, and implement intersectoral action accountably and sustainably". *(9)*

The following priority intervention areas of the NCD action plan *(9)* have multisectoral elements: fiscal and marketing policies; replacement of trans-fat in processed food with polyunsaturated fat; and salt reduction. Both the supporting interventions imply collaboration with other sectors.

One week after the sixty-first session of the WHO Regional Committee for Europe in September 2011, global leaders met at the United Nations in New York for a high-level meeting of the General Assembly on the prevention and control of NCD. In the ensuing Political Declaration *(10)*, there are multiple references to intersectoral collaboration, for example, in connection with the commitment to strengthen national policies: "To promote, establish or support and strengthen ... multisectoral national policies and plans for the prevention and control of noncommunicable diseases...". Even one of the two follow-up activities requested of the Secretary-General relates to multisectoral action: "To submit by the end of 2012 to the General Assembly ... options for strengthening and facilitating multisectoral action for the prevention and control of non-communicable diseases through effective partnership".

Mental health

Mental health interacts strongly with NCD and is also a determinant of morbidity and mortality. Mental health and mental disorders will be addressed separately in the forthcoming European mental health strategy and action plan, which will also address co-morbidities.

Intersectoral action to tackle NCD risk factors

The burden of NCD is the result of a complex, but well-understood, sequence of causation in connection with which there is potential for intervention at multiple points. The main risk factors for NCD are the focus of fresh attention at both the global and European levels. The *Global status report on noncommunicable diseases 2010 (1)* identifies the following aims for immediate action:

1. to protect people from tobacco smoke, warn about the dangers of tobacco, enforce bans on tobacco advertising, and raise taxes on tobacco;
2. to restrict access to retailed alcohol, enforce bans on alcohol advertising and raise taxes on alcohol;
3. to reduce salt intake in the population, replace trans-fat with polyunsaturated fat and to promote public awareness about the dangers of unhealthy diet;
4. to promote physical activity through the mass media.

These interventions are identified in the report as "best buys" because they are cost-effective (US$ per DALY prevented < GDP per person) with low implementation costs (US$ per capita < US$0.50), and because it is considered feasible to implement them (vis-à-vis health-system constraints). It is clear that, although these interventions are the responsibility of the health sector, collaboration with other sectors in implementing them is necessary if they are to be effective. The following examples of possible interventions are provided to illustrate why collaboration with other sectors is important and how it can be achieved. They were extracted from recent European and global strategies and action plans developed to guide the current work of WHO in the area of NCD.

Tobacco use

WHO plays a leading role in coordinating global and regional action in the area of tobacco control. This has resulted in several World Health Assembly resolutions, the latest being on the Framework Convention on Tobacco Control (WHO FCTC) *(13)*. Being the first international treaty negotiated under the auspices of WHO, it includes provisions to reduce both supply and demand. As it was signed at the government rather than the ministry-of-health level, it requires interministerial collaboration, which makes it a true example of the whole-of-government approach.

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The MPOWER[2] package *(14)* contains six evidence-based and cost-effective key tobacco control measures, which can be used for implementing the WHO FCTC *(15)*, providing Member States with a road map for use in meeting their commitments and legal obligations under the Treaty.

Increasing tax on tobacco is the most effective way of reducing tobacco use and has the added benefit of increasing government revenue. The WHO FCTC *(15)* recommends increasing the excise tax on tobacco products to at least 70% of the price. It is clear that to implement this measure, collaboration between the health and the finance sectors is necessary. In addition, to control a possible increase in illicit trade as a result of the higher taxes, the customs and trade sectors should also be involved. Intersectoral collaboration is also essential for the successful implementation of other key measures, such as banning advertising, protecting people from second-hand smoke and warning the public about the dangers of tobacco use.

Harmful use of alcohol

The *European action plan to reduce the harmful use of alcohol 2012–2020 (16)* was adopted at the sixty-first session of the Regional Committee in Baku, Azerbaijan, in September 2011. It is closely linked to the *Action plan for the implementation of the European strategy for the prevention and control of noncommunicable diseases 2012–2016 (9)* and *The new European policy for health – Health 2020: vision, values, main directions and approaches (2)*, which prioritize NCD and their risk factors.

Although it is clear that effective alcohol policy would ensure collaboration among the different sectors, the *European status report on alcohol and health 2010 (17)* shows that alcohol policies in many countries still fail to be properly integrated with policies on overall health, social issues, agriculture, trade, industry and development. In addition, countries fail to provide adequate capacity to ensure intersectoral and interdepartmental action at government level. Therefore, the alcohol action plan *(16)* names concerted action as one of its five main objectives, in connection with which many of the action points have raised interest, such as that entitled "marketing of alcoholic beverages", which is identified as a "best buy". The alcohol action plan *(16)* states that whatever system is adopted to limit exposure to commercial advertising, "joint work between government, health systems, the media and all forms of telecommunications is essential". In addition, it underlines the fact that action related to leadership, community and the workplace, drink-driving policies, availability and pricing, all demand intersectoral collaboration.

Unhealthy diet

Several international agreements have been drawn up in the field of nutrition, such as the *Global Strategy on Diet, Physical Activity and Health (18)*, the *European Charter on Counteracting Obesity (19)*, and the *WHO European Action Plan for Food and Nutrition Policy 2007–2012 (20)*. The last mentioned encompasses six key action areas with goals and targets for the various health challenges. One of the specific actions mentioned in relation to supporting a healthy start is the development of policies on nutrition in schools, including, for example, the provision of healthy options in canteens and the establishment of fruit- and vegetable-distribution schemes. It is obvious that collaboration with the education sector is of the utmost importance in this connection. With respect to action to inform and educate consumers about healthy nutrition, it is stressed that collaboration with the consumer-protection sector is essential to "ensure that appropriate information is provided to consumers and that a suitable system is in place to assess, manage and communicate risks related to the nutritional characteristics of food and the presence of contaminants". This action to promote public awareness about diet is also referred to as a "best buy".

However, it is not only the action areas of the plan *(20)* that demonstrate the importance of collaboration with other sectors; the chapter that defines participation also makes this clear. It stresses that "whole-of-government commitment is necessary for implementation ..., in the spirit of health-in-all policies" and lists the sectors, which should be involved, i.e. those for agriculture, fisheries, food, consumer protection, education, sport, transport, urban planning and housing, environment, labour, social policy, and research *(20)*.

2 The WHO FCTC and its guidelines provide the foundation for countries to implement and manage tobacco control. To help make this a reality, WHO introduced the MPOWER package of six evidence-based measures contained in the WHO FCTC (i.e. monitoring tobacco use and prevention policies; protection from tobacco smoke; offering help to quit tobacco use; warning about the dangers of tobacco; enforcing bans on tobacco advertising; promotion and sponsorship; raising taxes on tobacco). These measures are intended to assist in the country-level implementation of effective interventions to reduce the demand for tobacco.

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Physical inactivity

The *Global Strategy on Diet, Physical Activity and Health (18)*, and the *European Charter on Counteracting Obesity (19)*, mentioned earlier, both stress the importance of physical activity for tackling obesity, among other things. The *Parma Declaration on Environment and Health (21)*, adopted by WHO European Member States at the Fifth Ministerial Conference on Environment and Health, Parma, Italy, on 10–12 March 2010, underscores the importance of providing safe environments conducive to physical activity, and commits countries to working towards the achievement of targets to that effect.

While the *Parma Declaration on Environment and Health (21)* is an example of intersectoral collaboration by definition, another document worth highlighting is *Steps to health. A European framework to promote physical activity for health (22)*, one of the working papers presented at the Ministerial Conference on Counteracting Obesity, held in Istanbul, Turkey, in 2006. One of the objectives of this document is to provide guidance on, and tools for use in, implementing multisectoral public health action related to physical activity at the national level. The recommendations contained in the document are organized according to sectors and settings and emphasize the importance of working across sectors, such as those for health, transport, urban planning and housing environment, schools and kindergartens, workplaces, and leisure-time activities. The chapter on building networks and alliances mentions that working across sectors in both the public and the commercial arenas will do much to facilitate progress towards healthier and more sustainable lifestyles, i.e. the synergies involved create a win-win situation for all actors.

Intersectoral action and inequities

The rapidly growing burden of NCD disproportionally affects people of lower socioeconomic status, e.g. people living in poverty and those with lower levels of education and/or income *(1)*. The successful implementation of intersectoral action to tackle NCD should, therefore, go hand in hand with an understanding of how its impact might potentially be distributed among the population, in that some groups would probably benefit more than others. As a minimum, it is important to ensure that interventions to prevent and control NCD do not exacerbate existing inequities by improving the health of those in the higher socioeconomic groups at a faster rate than in other groups of the population.

For example, as a result of work carried out in 2007–2008, the Global Task Force on Social Determinants and Cardiovascular Disease[3] recommended a combination of approaches to tackling the risk factors for cardiovascular disease (CVD), including proportionate universalism (i.e. focusing the scale and intensity of action proportionately to the level of disadvantage), as well as a whole-of-government approach to ensure the involvement of the sectors for finance, transport, education, agriculture, social security and youth affairs *(23)*.

As regards measures aimed at reducing the use of tobacco, it is important to bear in mind that it is just as likely for people of low socioeconomic status, or those experiencing multiple disadvantages, to attempt to quit smoking as it is for others but they may not be as successful. For example, in the United Kingdom, 60% of the most affluent smokers are now ex-smokers, compared with 15% of those living in the poorest circumstances *(24)*. An evaluation using longitudinal data from 2002 to 2009 revealed that having financial difficulties remains a key barrier to smokers' quit success. In fact, smokers reporting financial difficulties were 41% less likely to achieve quit success than their wealthier counterparts *(25)*.

What are the implications of this knowledge with respect to action and "best buys"? There is a clear relationship between the cost of cigarettes and the consumption rate. Increasing the tax on tobacco products is an effective upstream intervention for reducing their availability, notably to those in the most vulnerable groups, the young and the poor in particular. Studies have shown that a 10% increase in price reduces the smoking rate by as much as 8% in low- or middle-income countries, as opposed to 4% in high-income countries *(26)*. However, this intervention needs to be coupled with a mechanism to earmark a certain proportion of the revenue created by tobacco taxes for measures to tackle social inequity. An example of such measures could be to increase accessibility to PHC services and tobacco-cessation programmes, especially since smokers of low socioeconomic status who are unable to quit will be forced to spend even more and their families will often have to bear the cost. Other appropriate measures might include: eliminating fees for cessation programmes; subsidizing and deregulating nicotine-replacement

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3 Comprising representatives of the Priority Public Health Conditions Knowledge Network of the global Commission on Social Determinants of Health and its cardiovascular diseases group.

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therapy and other cessation aids; bringing cessation services to disadvantaged communities and settings where the poor, informal settlers and other disadvantaged groups congregate; and incorporating brief cessation activities in the basic-health-services package.

Looking through an equity lens at measures to reduce alcohol use, the relationship between alcohol, social determinants and equity is complex and has implications for universal interventions. For example, the above-mentioned Global Task Force on Social Determinants and CVD found that "… for a given consumption, poorer populations may experience disproportionately higher levels of alcohol-attributable harm" *(27)*. In the European Region, the findings of the Priority Public Health Conditions Task Group, established in connection with the strategic review of health inequalities in England post-2010 *(28)*, were similar, i.e., while people of a lower socioeconomic status are more likely to abstain, if they do consume alcohol, they tend to form problematic drinking patterns and dependence. In 2009, the same Task Group conducted a study on the use of screening and brief interventions to manage alcohol-related harm, mainly in primary-care settings, and found that this approach could inadvertently widen the gap. The rationale was that certain population groups, such as those of low socioeconomic status, may be less likely to be seen by a primary-care provider and, therefore, more likely to have limited access to brief interventions *(29)*. This underlines the importance of population-based preventive action, which reduces exposure to alcohol and harmful levels of drinking in the first place, such as enforcing bans on alcohol advertising and raising taxes on alcohol.

Evidence from interventions indicates that the rates of response to health-promotion programmes among the lower-income groups are likely to be lower and drop-out rates higher *(30)*. Being often of short duration, the interventions fail to take sufficient account of ethnic and social diversity. The evidence suggests that educational information alone is relatively ineffective among the lower-income groups and may increase inequities *(31)*. In relation to diet, for example, this underlines the importance of designing public-awareness strategies that make it possible to reach the lower-income groups and tackle social determinants, such as poverty, low-level family income and the relative cost of healthy food. For example, if the cost of a healthy food basket takes up a greater proportion of a family's disposable income than a less healthy basket, it could be a challenge for the family members to act on the educational information they receive. Changing this situation requires joint action and attention to equity issues, e.g. monitoring and evaluating different population groups (e.g. women in lower-socioeconomic groups) with a view to determining whether there are barriers to and/or differences in the adoption of healthier behaviour.

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Working across sectors: basic concepts

Strategies to promote intersectoral action for health

In 2010, Kickbusch and Buckett concluded that, since the late 1970s, three intellectual policy waves have contributed to the emergence of a 21st century model of horizontal health governance: intersectoral action for health, healthy public policy, and HiAP *(32)*. They define the three waves as follows.

- Intersectoral action comprises efforts by the health sector to work collaboratively with other sectors of society to achieve improved health outcomes *(3)*.
- Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy and by accountability for health impact *(5)*.
- HiAP is a horizontal, complementary, policy-related strategy with a high potential for contributing to population health. The core aim of HiAP is to examine determinants of health, which can be influenced to improve health but are mainly controlled by the policies of sectors other than health *(33)*.

Steps towards implementing intersectoral action for health

The *Global status report on noncommunicable diseases 2010 (1)* defines several steps that can be taken by the health sector to initiate and accomplish intersectoral action on health. These steps, which are relevant both to issue-centred approaches and to the general approach of the HiAP strategy, are: to carry out self-assessments and assessments of other sectors; to analyse the area(s) of concern; to develop plans on engaging other sectors in action to address these areas; to develop a framework for use in fostering common understanding among sectors; to strengthen governance structures, political will and accountability mechanisms; to enhance community participation; to choose other practices to foster intersectoral action; and to monitor and evaluate action taken.

A survey was conducted among health-promotion practitioners in Israel in 2003 *(34)* to identify the factors that either enhance or hinder intersectoral partnerships for health promotion and the partnership structures that are best suited to certain types of projects, participating organizations and teams. The three factors most important to intersectoral partnerships were related to project management, i.e. effective leadership, clear project goals and a shared vision. The greatest barriers to partnerships were related to malfunctioning of the steering committee and the lack of explicit procedures for collaboration. These results emphasize the importance of guidance and training to the success of intersectoral partnerships.

In analysing the steps of the *Global status report (1)* in light of the conclusions of the 2003 survey of health-promotion practitioners in Israel *(34)*, it is possible to make a distinction between the steps related to: expertise and competencies; project management; and governance.

Expertise and competencies

To ensure the necessary expertise and competencies for successful intersectoral action, the health sector needs to carry out self-assessments and assessments of the other sectors with a view to:

- clarifying the capability and readiness of the health sector for intersectoral collaboration;
- clarifying existing relationships;
- strengthening institutional capacity;
- gaining a better understanding the policies of other sectors;
- identifying the potential health impact of action (using health impact assessment as a tool);
- conducting stakeholder and sector analyses;
- improving interaction between, and strengthening the engagement of, the sectors involved;

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- collaborating with other sectors in establishing common policies, programmes and initiatives;
- becoming involved in the policies, programmes and initiatives of the other sectors;
- providing tools and techniques for including health in the policies of other sectors.

The health sector must learn to work in partnership with other sectors in exploring policy innovation, new mechanisms and tools, and advanced regulatory frameworks. In seeking the agreement of other sectors (or actors), it is important not only to be able to make the case to them but also to understand that they may feel threatened. For example, during discussions with manufacturers and entrepreneurs on issues relating to tobacco, alcohol and nutrition, it would be natural for them to have their own opinions on potential policy changes and do their best to ensure their interests were not in jeopardy. If there is any conflict of interest, it is important to acknowledge it. It is also important to identify at which point in the policy-making process stakeholders with highly vested interests may be included and to which extent they should take part.

According to the *Adelaide Statement on Health in All Policies (7)*, in connection with its new role in advancing HiAP, the health sector needs to be outward oriented, open to discussion, and equipped with the necessary knowledge, skills and mandate. It also needs to improve coordination within the health sector itself and to support its champions.

Project management

With a view to improving the management of intersectoral projects, the health sector should:

- define the areas of concern and potential interventions to deal with them;
- analyse sector-specific data to determine the feasibility of intervention;
- build the case using convincing data and evidence to highlight potential mutual benefits;
- develop a strategy to involve relevant sectors, with emphasis on win-win;
- use a single framework to facilitate a common understanding among sectors;
- monitor implementation closely to determine progress.

It is always useful to seek measures that are of mutual benefit to those involved. For example, it may be hard to convince the ministry of finance to commit to funding expensive activities, the benefits of which will be seen only years later. The ministry is more likely to be interested in cost-neutral measures, or measures that can increase revenue, such as raising taxes on products that are harmful to health.

The *Adelaide Statement on Health in All Policies (7)* highlights potential mutual benefits, as follows:

> Good health enhances quality of life, improves workforce productivity, increases the capacity for learning, strengthens families and communities, supports sustainable habitats and environments, and contributes to security, poverty reduction and social inclusion.

It describes them in more detail through specific examples of intersectoral relationships, such as that between the economy and employment sectors, which, according to the Adelaide Statement *(7)*, is stimulated by a healthy population.

> Healthier people can increase their household savings, are more productive at work, can adapt more easily to work changes, and can remain working for longer. Work and stable employment opportunities improve health for all people across different social groups.

Examples are also given on the mutual benefits of the following interrelationships: security and justice; education and early life; agriculture and food; infrastructure and transport; environments and sustainability; housing and community services; and land and culture.

The Adelaide Statement *(7)* also contains an overview of tools and mechanisms, which can be used for developing strategies and frameworks, and for monitoring and evaluation. These include: interministerial and interdepartmental committees; intersectoral action teams; integrated budget and accounting mechanisms; cross-cutting information and evaluation systems; joint workforce development teams;

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community consultations and citizens' juries[4]; partnership platforms; health-lens analysis[5]; impact assessment; and legislative frameworks. This topic is also covered in *Health in All Policies. Prospects and potentials (35)*.

Governance

To assure successful intersectoral action, good governance is crucial. To this end, it is necessary for the health sector to:

- establish new or strengthen existing governance structures;
- develop political will and mechanisms of accountability;
- utilize the relevant sections of human-rights treaties and international agreements;
- enhance community participation through consultations, the mass media, web sites and nongovernmental organizations (NGOs).

In 2008, St-Pierre *(36)* looked into the governance tools that allow the central government to promote collaborative work and policy coherence for the health and well-being of the population. He classified them into four categories: structures (e.g. committees and organizations dedicated to collaboration); processes (e.g. joint planning and evaluation); financial frameworks (e.g. mechanisms fostering intersectoral activities), and mandates (e.g. laws or regulations imposing accountability), illustrating in a chart those mentioned most frequently in the literature on governance, as well as the keys to success outlined therein.

Slovenia was one of the first European countries to introduce laws and regulations addressing intersectoral cooperation *(37)*. Joining the European Union (EU) triggered stronger intersectoral action in the areas of health, safety at work and food safety. As a result of cooperation between the health and agricultural sectors, it was decided to assess the health impact of proposed agricultural and food policies. This was the first time that any government had attempted to assess the health effects of agricultural policy at the national level.

Strong political will is one of the cornerstones for implementing the HiAP approach in Bosnia and Herzegovina and the former Yugoslav Republic of Macedonia *(38)*. In Bosnia and Herzegovina, HiAP is supported by the tradition and firm foundations of public health organization, and affords opportunities for the more active involvement of community members in decision-making on health care. In the former Yugoslav Republic of Macedonia, the creation of strong partnerships and alliances among sectors is emphasized in the Law on Public Health. This law supports the strengthening of multisectoral approaches and processes at the national, regional and local levels by establishing national and local public health councils.

It is crucial that the public has a sense of ownership of policies requiring behavioural change and is encouraged to participate in their implementation. This is especially true of measures directly affecting citizens' lives, e.g. limiting smoking areas, protecting children from the social and psychological effects of the harmful use of alcohol by adults, or changing the quality of food available to the public.

In order to implement some of the "best buys" included in the *Global status report on noncommunicable diseases 2010 (1)*, interaction with the private sector is needed. For example, to reduce salt intake and replace trans-fat with polyunsaturated fat (two of the "best buys"), dialogue with the food industry and the development of accountability mechanisms are important. Food manufacturers nowadays are able to reduce the levels of saturated fats, added sugars and salt in products and remove trans-fatty acids by using the relatively low-cost alternatives that are available to them. They could also consider introducing products with more balanced nutritional value that would be accessible to most groups of society.

There is a need to ensure that the parties that comply with the health requirements do not find themselves at a disadvantage compared to those that do not comply. For example, reducing salt in food products is a measure that should be taken step by step so that people do not become alienated to these products but gradually become used to the new levels of salt contained in them and begin to relate to their health qualities.

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4 Information available at: www.jefferson-center.org/, accessed 9 February 2012.

5 Information available at: http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/health+in+all+policies, accessed 13 February 2012.

Evidence and experience

There is growing evidence about the need for intersectoral action in the prevention and control of NCD and the potential effect of this action. This chapter discusses relevant experience gained in the SEEHN countries and Slovenia, starting with an overview of the burden of NCD.

As mentioned earlier in the publication, the underlying risk factors for NCD are tobacco use, harmful use of alcohol, unhealthy diet, and physical inactivity. Various intersectoral interventions exist for addressing them. This chapter looks at those relevant to taxation on tobacco and the reduction of salt in food, and highlights the results of national surveys conducted to reveal current mechanisms for intersectoral action in the area of NCD.

Methodology

Data were collected from the following sources:

- the European Health for All Database *(39)* (on the burden of disease);
- the *WHO report on the global tobacco epidemic, 2011* (for the highlight on mechanisms of intersectoral collaboration in the field of tobacco) *(26)*;
- the Global Health Observatory Data Repository (on the burden of overweight and obesity) *(40)*;
- the WHO Global Database on Child Growth and Malnutrition (on childhood overweight) *(41)*;
- the country information templates completed in 2010 by nutrition counterparts and focal points at the national level (for the highlight on mechanisms of intersectoral collaboration on the marketing of food and salt reduction);
- raw data gathered through the global survey of country capacity for the prevention and control of NCD conducted by WHO in 2009 and 2010 (for the highlight on intersectoral capacity to tackle NCD)[6].

In addition, a literature review was carried out to locate current evidence relating to use of the HiAP approach in the SEEHN countries and Slovenia. Of particular interest were the approaches proposed for tackling the priority areas of the *Action plan for implementation of the European strategy for the prevention and control of noncommmunicable diseases 2012–2016 (9)*.

Through individual country reports and examples of the use of the HiAP approach, the publication, *Opportunities for scaling up and strengthening health in all policies in south-eastern Europe (38)*, gives great insight into this situation in each of the SEEHN countries and Slovenia. This publication was prepared for the 3rd Forum of Health Ministers on Health in All Policies in South-eastern Europe in Banja Luka, Bosnia and Herzegovina, in October 2011.

In August and September 2011, semi-structured telephone interviews were conducted with key people working in the field of NCD in each of the SEEHN countries and Slovenia. Country examples included in this publication have been reviewed by the national counterparts.

Burden

Fig. 1 shows life expectancy at age 15 in the SEEHN countries and Slovenia. Fig. 2 illustrates the age-standardized death rates for diseases of the circulatory system in those aged 0–64 years. For reasons of comparison, graphs for Eur-A[7], Eur-B+C[8], and the WHO European Region have been included. These data are reported by the countries on an annual basis. The graphs are smoothed curves to soften fluctuation.

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6 As the selected survey data included in the report, *Noncommunicable diseases country profiles 2011 (42)* (which follows on from the *Global status report on noncommunicable diseases 2010 (1)*) were not relevant for this analysis, raw unpublished data from the survey were used for the highlight on intersectoral capacity to tackle NCD.

7 Andorra, Austria, Belgium, Croatia, Cyprus, Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland, United Kingdom.

8 Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Montenegro, Poland, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, Uzbekistan.

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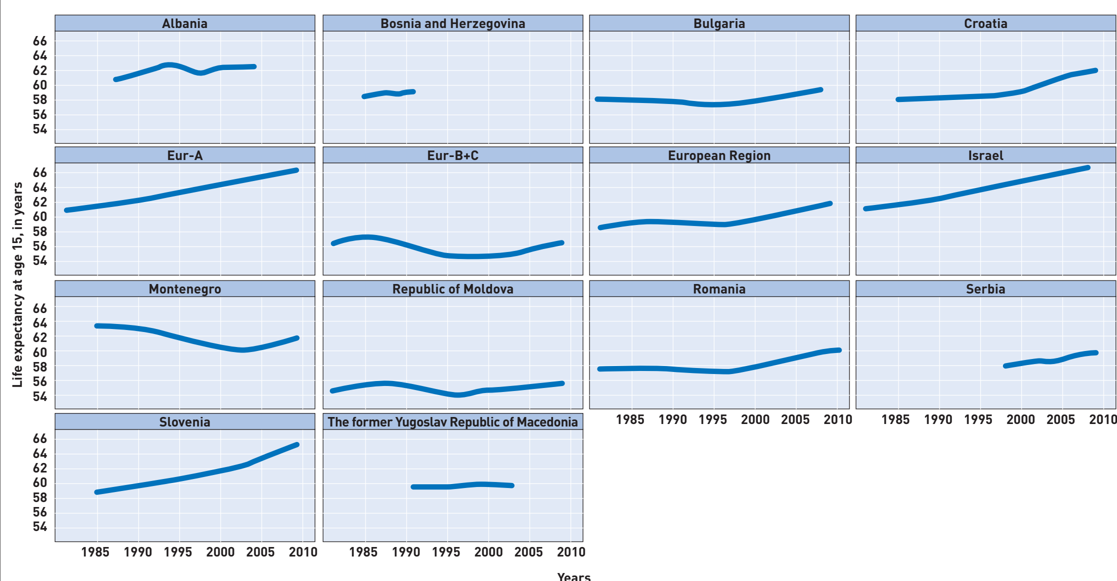
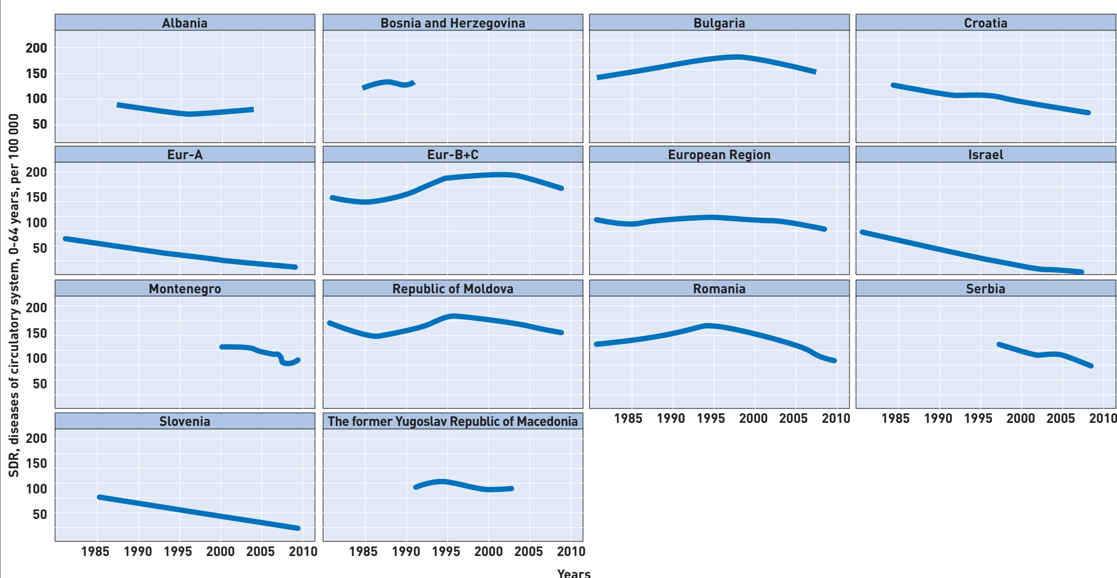
Fig. 1. Life expectancy at age 15 in SEEHN countries, Slovenia, Eur-A, Eur-B + C and the WHO European Region, 1985–2010



Source: European Health for All Database *(39)*.

Fig. 2. Age-standardized mortality (SDR) from diseases of the circulatory system in SEEHN countries, Slovenia, Eur-A, Eur-B + C and the WHO European Region, 0–64 years, per 100 000, 1985–2010



Source: European Health for All Database *(39)*.

The overall trend is promising. There was a clear increase in life expectancy and decrease in the rates of death from diseases of the circulatory system between 1995 and 2010. Although there is much variability, the graphs for each country (or group of countries) in Figs. 1 and 2 are almost horizontal mirror images of each other. This could be explained by the large contribution made by diseases of the circulatory system to loss of years of life.

The figures also show that the SEEHN countries and Slovenia represent the full range of those in the WHO European Region. Their trends in mortality from diseases of the circulatory system are uniformly better than the averages for Eur-B+C countries but worse than those for Eur-A countries. These observations suggest that the rates seen in the Eur-A region could serve as an attainable goal for CVD control in the SEEHN countries and Slovenia. In addition, the diversity of experiences in these countries is fertile ground for exchange and mutual learning.

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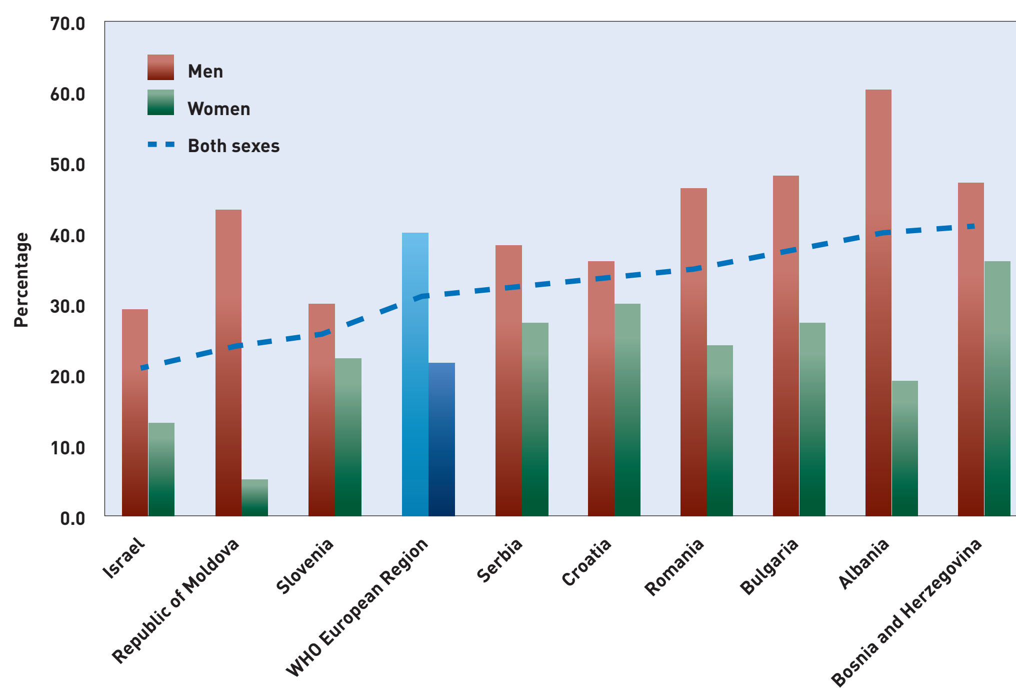
The graphs for Bulgaria, the Republic of Moldova and Romania show a reversal of the upward trend for mortality from diseases of the circulatory system. This could be associated with social and economic transition (e.g. the possible effects of changing patterns in death certification). Further study to determine the reasons for this change (e.g. policies adopted) is warranted.

The data for a number of countries are incomplete, a fact, which only reinforces the importance of data collection as a basis for policy-making.

Highlight: mechanisms of intersectoral collaboration on taxation in the field of tobacco

One of the underlying risk factors for NCD mentioned earlier in this paper is tobacco use. Fig. 3 shows the estimated prevalence of smoking in adults (current smokers and any product) in SEEHN countries and Slovenia. It should be noted that these data are all weight-adjusted estimates for the purpose of comparison across countries. The report does not contain prevalence estimates for Montenegro or the former Yugoslav Republic of Macedonia.

Fig. 3. Estimated prevalence of smoking in adults (currently smoking any tobacco product) in SEEHN countries[a] and Slovenia, 2009



[a] Excluding Montenegro and the former Yugoslav Republic of Macedonia.

Source: WHO report on the global tobacco epidemic, 2011: warning about the dangers of tobacco (26).

Fig. 3 illustrates that the prevalence estimates (for both sexes) in the majority of the countries (with the exception of Israel, the Republic of Moldova and Slovenia) are higher than the WHO European average. The male:female ratio varies among the countries; Bosnia and Herzegovina, Croatia, Serbia and Slovenia have narrower sex ratios than the other countries. The general (sometimes drastic) rise in the prevalence of female smoking across the WHO European Region is alarming. Therefore, efforts should continue not only to sustain the downward trend of smoking among males seen in some of the countries in the Region, but also to focus more attention on reversing the levels of smoking among females.

Several intersectoral measures exist for counteracting these trends, one of them being to increase the price of tobacco products by raising the taxes on tobacco. This is the single most effective way of decreasing consumption and encouraging tobacco users to quit. In addition, higher prices (through raised taxes) are

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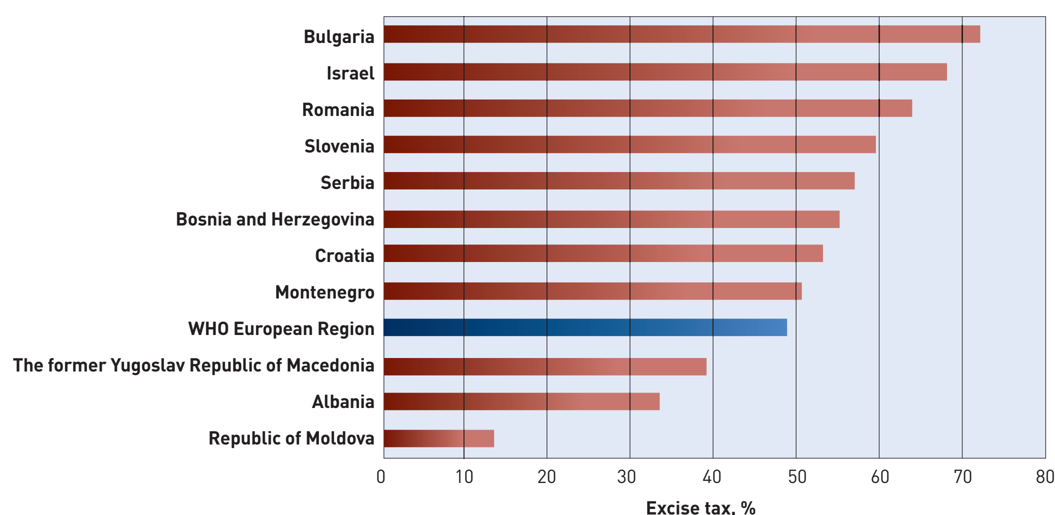
particularly effective in preventing young people from starting to smoke. There are many different types of taxes on tobacco products, but excise taxes (specific and ad valorem)[9] are the most important due to their specificity to tobacco products. The recommendation is that a combination of excise taxes constitutes at least 70% of the retail price of the product. Overviews of the taxes on and prices of cigarettes in the SEEHN countries and Slovenia are given in Figs. 4 and 5, respectively.

Fig. 4 shows that only one of the countries under review – Bulgaria – levies excise taxes at the recommended 70% level. Of the other countries, Bulgaria, Israel and Romania are among the top 10 countries in the WHO European Region with the highest percentage of excise tax on tobacco. In contrast, the Republic of Moldova is among the bottom 10, and Albania, Bosnia and Herzegovina and Montenegro among the bottom 20.

Fig. 4. Percentage of excise tax on a pack of the most-sold brands of cigarettes in SEEHN countries and Slovenia, 2010



Source: WHO report on the global tobacco epidemic, 2011: warning about the dangers of tobacco (26).

It is important not only that tobacco taxes are high but also that cigarette prices are high. Less affordable retail prices will contribute to reducing consumption. Fig. 5 illustrates the prices of one pack of the cheapest brand of cigarettes and one pack of the most sold brand of cigarettes in the SEEHN countries and Slovenia. In the WHO European Region, the 20 countries with the lowest prices include: Albania, Bosnia and Herzegovina, Montenegro, the Republic of Moldova, Serbia and the former Yugoslav Republic of Macedonia. Montenegro and the Republic of Moldova are among the bottom 10. The 20 countries in the Region with the highest prices include Bulgaria, Israel and Romania, Bulgaria and Israel being among the top 10. It is also worth mentioning that the price difference between the cheapest and most expensive cigarette brands (not shown) should be minimal to avoid brand-switching, especially in response to tax increases. In comparing the difference in price between the cheapest and most sold brands (Fig. 5) (as opposed to the most expensive brands), one can see that the phenomenon of a minimal price difference between brands has been accomplished in several countries, such as Bulgaria, Romania and Slovenia. In contrast, in the Republic of Moldova, there is a substantially large price difference between the two categories. There is no record of the price of the cheapest brand in Bosnia and Herzegovina.

9 Specific (or fixed) excise taxes are imposed as a set duty per unit of product. The same amount of tax is applied, whatever the base price, thereby not increasing the differences in price between cheaper and more expensive brands. Ad valorem excise taxes are a proportion of the retail price of tobacco products (i.e. a set percentage of the manufacturers' or retail prices). Unlike specific excise tax, ad valorem taxes increase with inflation, such as manufacturers' or other price increases.

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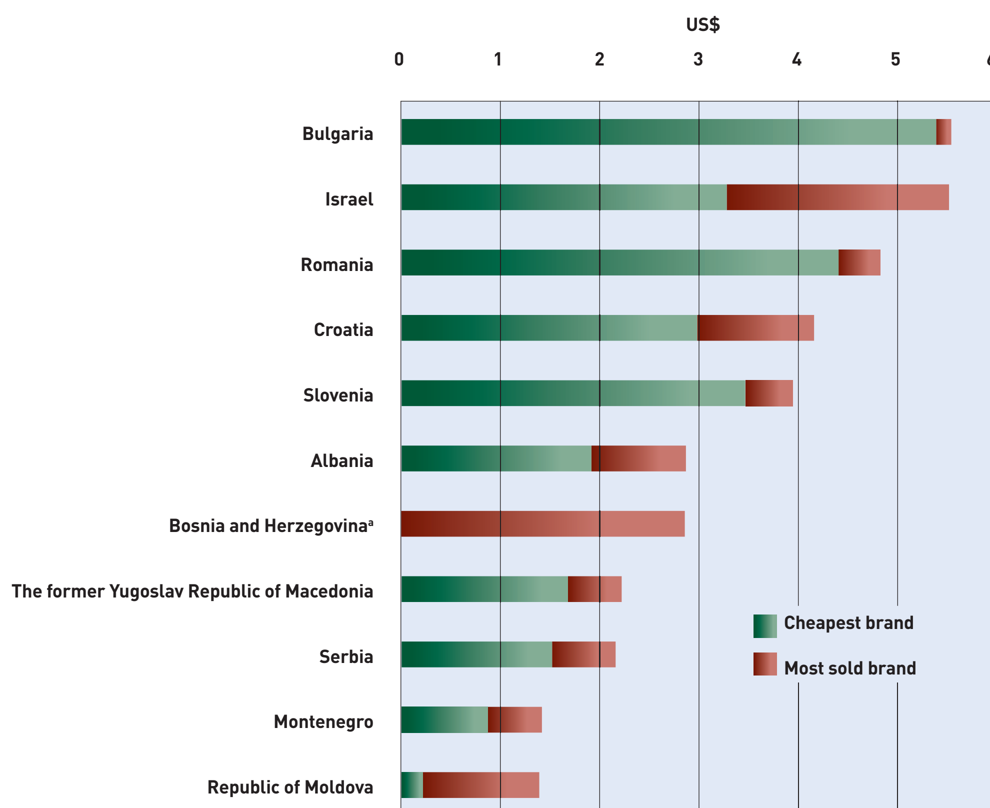
Fig. 5. Price of one pack (20 pieces) of the cheapest and most sold brands of cigarettes, international dollars, 2010



[a] No record available of the price of the cheapest brand in Bosnia and Herzegovina.
Source: WHO report on the global tobacco epidemic, 2011: warning about the dangers of tobacco (26).

For maximum policy impact, and to counteract smuggling, national efforts to raise the prices of and taxes on tobacco products should be coordinated with those of neighbouring countries. For example, there is a great variation in the prices of the most sold brands among the SEEHN countries and Slovenia. The highest price (US$ 5.58) is found in Bulgaria, followed by Romania (US$ 4.88); the prices in Serbia and the former Yugoslav Republic of Macedonia are almost half as much (US$ 2.19 and US$ 2.24, respectively).

To reduce tobacco consumption and improve public health, the taxation on tobacco should render tobacco products progressively less affordable by offsetting the combined effect of inflation (through ad valorem excise taxes, for example), increased consumer incomes and purchasing power. In many countries, tobacco products are becoming increasingly affordable because taxation does not keep pace with inflation and incomes. Fig. 6 indicates the affordability of cigarette prices by evaluating them as a percentage of the gross domestic product (GDP) per capita. Among the SEEHN countries and Slovenia, affordability compared to income is lowest in Albania, the Republic of Moldova and the former Yugoslav Republic of Macedonia. This is interesting since these three countries have the lowest percentages of excise taxes (Fig. 4) and one would expect that, in countries with the least affordability, there would be high excise taxes (more specifically, high ad valorem taxes). However, this requires a more in-depth look at the distribution of specific and ad valorem taxation within the excise systems in these countries.

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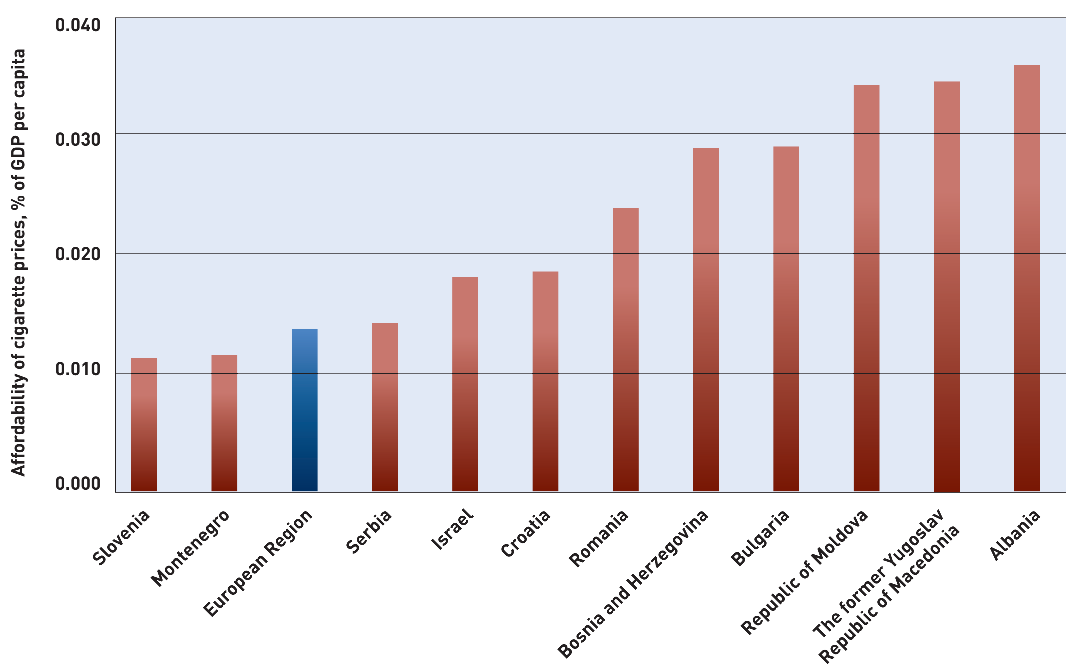
Fig. 6. Affordability of cigarette prices in SEEHN countries and Slovenia, % of GDP per capita, 2010

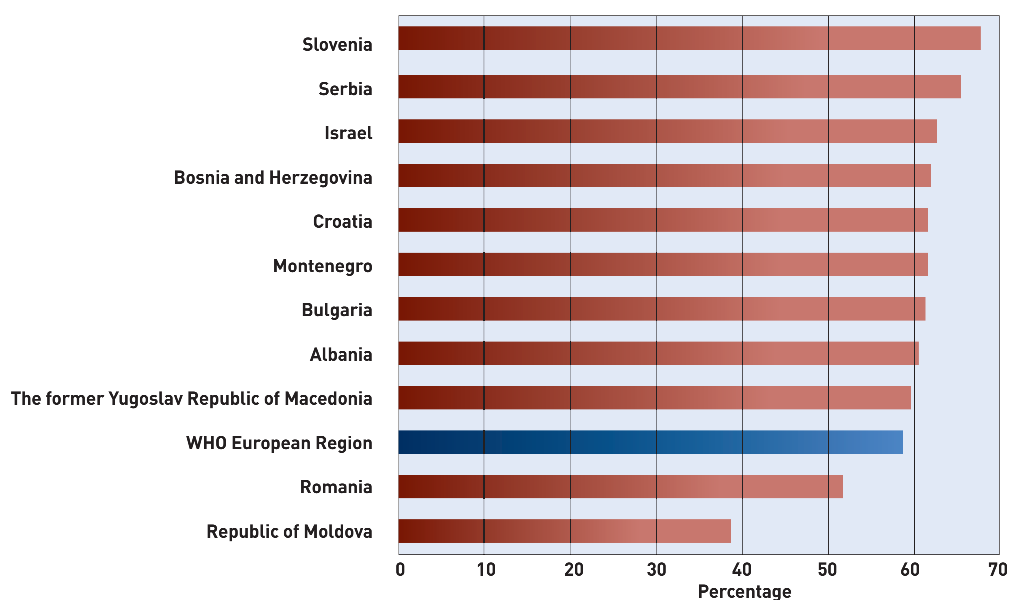


Source: WHO report on the global tobacco epidemic, 2011: warning about the dangers of tobacco (26).

Highlight: mechanisms of intersectoral collaboration on marketing of food and salt reduction

At the global level, overweight and obesity are the fifth leading cause of death. At least 2.8 million adults die each year as a result of these risk factors; in 2008, 1.5 billion people of 20 years and older were overweight *(1)*. Fig. 7 shows that in the SEEHN countries and Slovenia, the prevalence of overweight (defined by a body mass index (BMI) of 25 (kg/m^2) or higher) among adult males ranged from 39% in the Republic of Moldova to 68% in Slovenia.

Fig. 7. Age-standardized prevalence of overweight[a] (%) among males over 20 years in SEEHN countries, Slovenia and the WHO European Region, 2008



[a] Includes obesity: BMI >=25.0 (kg/m^2).
Source: Global Health Observatory Data Repository *(40)*.

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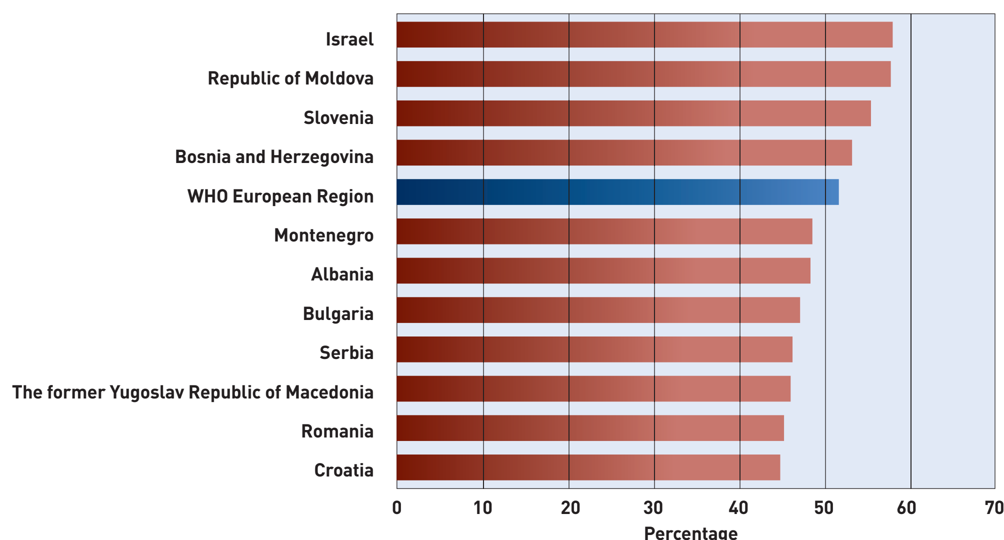
Among adult females (Fig. 8), the prevalence of overweight ranged from 45% in Croatia to 58% in Israel. While the prevalence of overweight among men was higher than the average estimate for the WHO European Region (58.3%) in most countries (except the Republic of Moldova and Romania), the prevalence of overweight among women was lower than the average estimate (51.3%) in most countries (except Bosnia and Herzegovina, Israel, the Republic of Moldova and Slovenia).

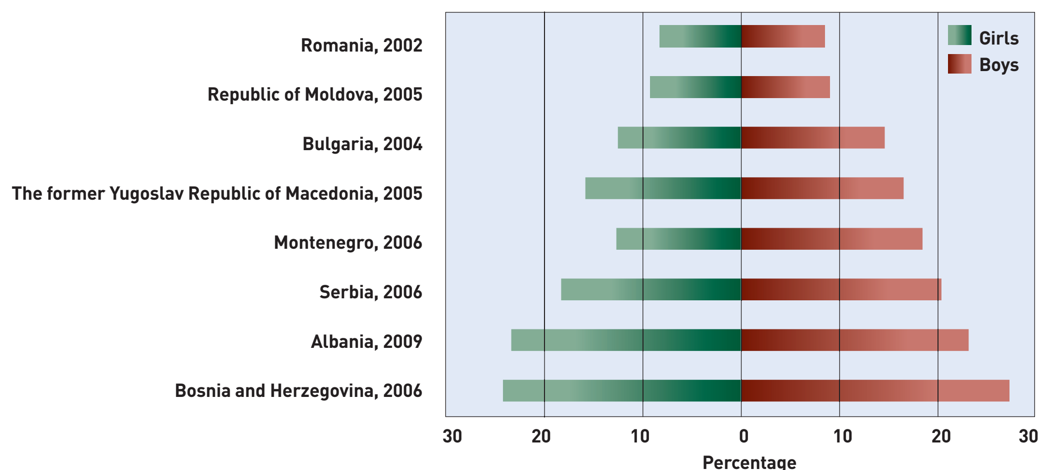
Fig. 8. Age-standardized prevalence of overweight[a] (%) among females over 20 years in SEEHN countries, Slovenia and the WHO European Region, 2008



[a] Includes obesity: BMI >=25.0 (kg/m²).
Source: Global Health Observatory Data Repository *(40)*.

Worldwide, nearly 43 million children under the age of five were overweight in 2010 *(43)* (defined as a BMI-for-age Z-score above the +2 standard deviations of the 2006 WHO child growth standards *(44)*. The prevalence of overweight among boys in this age group ranged from 9% in Romania to 27% in Bosnia and Herzegovina; the pattern for girls was similar (Fig. 9).

Fig. 9. Prevalence of overweight[a] (%) among preschool children aged 0-5 years in eight SEEHN countries[b]



[a] Includes obesity: BMI-for-age >+ 2 standard deviations of the 2006 WHO child growth standards *(44)*.
[b] Data unavailable for Croatia, Israel and Slovenia.
Source: Global Health Observatory Data Repository *(40)*.

In 2005, the WHO European Member States recognized the need for standardized and harmonized surveillance systems in connection with the development of policy on obesity in the Region. In response to this need, the Regional Office established a childhood-obesity surveillance system in 17 countries. The aim was to measure trends in overweight and obesity in primary-school children (6–9 years) on a routine basis to understand the progress of the epidemic in this population group and allow intercountry comparisons. The first data collection took place during the 2007–2008 school year with the participation of 13 countries: Belgium (Flemish region), Bulgaria, Cyprus, Czech Republic, Ireland, Italy, Latvia, Lithuania, Malta, Norway, Portugal, Slovenia and Sweden. The second round took place from spring to autumn 2010 with the participation of four additional countries: Greece, Hungary, Spain and the former Yugoslav Republic of Macedonia.

In the field of nutrition, intersectoral action is taking place in several countries of the European Region in connection, for example, with the marketing of food to children and the implementation of strategies on the reduction of salt intake. The Regional Office follows and supports the European Marketing Network (led by Norway) that coordinates the efforts of 19 countries of the Region to find ways of reducing the pressure put on children by the marketing of unhealthy food and beverages. Currently, the European Marketing Network includes four of the SEEHN countries (namely, Bulgaria, Israel, Montenegro and Serbia) and Slovenia. Taking part in the network does not imply any particular policy preference regarding regulatory approach. Some countries have introduced statutory regulations banning advertising and others have implemented non-statutory guidelines and self-regulation imposing some limitations, and various accountability models. Policy tools range from legislation to public-private partnerships, which attach particular importance to regulatory measures.

Tables 2 and 3 provide an overview of how the SEEHN countries and Slovenia have implemented the policy action recommended in the WHO policy framework for nutrition[10]. According to WHO, specific regulatory measures could be the adoption of regulations substantially reducing the extent and impact of the commercial promotion of energy-dense foods and beverages, particularly to children, and the development of international approaches to preventing this, e.g. a package of essential preventive action. Countries could prioritize interventions from this package, according to their national circumstances and level of policy development.

Table 2 gives an overview of policy action taken in the SEEHN countries and Slovenia on the marketing of food to children. The information was compiled from the country information templates completed by WHO nutrition counterparts at the national level. This also applies to Table 3.

10 Comprising the *European Charter on Counteracting Obesity (19)* and the *WHO European Action Plan for Food and Nutrition Policy 2007–2012 (20)*.

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Table 2. Overview of policy action taken in SEEHN countries and Slovenia on marketing of food to children, 2006–2010

Country	Description of action taken
Albania	No action.
Bosnia and Herzegovina	No action.
Bulgaria	A national food and nutrition plan was developed for the period 2005–2010 *(45)*. The plan had a multisectoral approach and included activities to address overweight, obesity, and the development of new standards for the marketing of foods. In 2010, implementation had reached the stage of preparation of a panel discussion with stakeholders (including institutions, producers, traders, NGOs and the media) on the initiation of national measures to reduce the advertising of 'unhealthy' foods and beverages to children
Croatia	The development of the *National action plan for overweight prevention and treatment (46)* facilitated the issuance of a government regulation (which came into effect in 2008) to prohibit vending machines in primary schools, the so-called "State pedagogy standard for elementary school education".
Israel	The Ministry of Education has published guidelines on nutrition in educational institutions *(47)* to prevent the marketing of energy-dense nutrient-poor foods and beverages in schools and other educational locations.
Montenegro	No action.
Republic of Moldova	The Ministry of Health issued Decision No. 13 (31 July 2007) of the Main State Sanitary Inspector *(48)* prohibiting the sale of energy-dense nutrient-poor foods in schools. The Decision came into force on 1 September 2007.
Romania	Ministerial Order No. 1563 on approval of the list of foods not recommended for preschool children and schoolchildren and of the principles underlying healthy diets for children and adolescents *(49)* was issued in 2008 establishing the criteria for recommending specific food items for sale in schools with the aim of creating healthy dietary habits in schoolchildren.
Serbia	No action.
Slovenia	The Ministry of Education adopted the Act on School Nutrition *(50)* in May 2010, introducing a ban on vending machines for foods and beverages in all Slovene primary and secondary schools. The Act came into force in June 2010.
The former Yugoslav Republic of Macedonia	*The second national action plan for food and nutrition policy (51)*, developed in 2009, covers marketing of food to children. It was based on the *WHO European Action Plan for Food and Nutrition Policy 2007–2012 (20).*

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Table 3. Overview of policy action taken in SEEHN countries and Slovenia to reduce salt intake, 2010

Country	Description of action taken
Albania	No action.
Bosnia and Herzegovina	No action.
Bulgaria	Bulgaria is a member of the EU Salt Action Network. Round-table discussions with food producers at the national level and forums on developing a salt-reduction strategy in line with the national food and nutrition action plan have taken place. A formal agreement on joint action to implement the plan has been signed by the national committee on implementation of the plan and dairy producers. Reduction of salt content in some foods has been realized in a number of enterprises thanks to activities at the regional and local levels.
Croatia	Action aimed at reducing salt intake in the population is being carried out (in cooperation with the WHO Regional Office for Europe), in accordance with the national food and nutrition action plan *(52)*.
Israel	The promotion of reduced salt intake in the population is included in the general guidelines on nutrition issued by the government *(53)*.
Montenegro	No action.
Republic of Moldova	No action.
Romania	The Ministry of Health and the Romanian Food Industry Federation have entered into negotiations on reformulating salt content in food *(54)*. Action to this end will include an evaluation of the current status of salt intake in the population and the provision of information to consumers on salt-related health risks.
Serbia	The national programme for prevention, medical treatment and control of cardiovascular diseases in Serbia until 2020 *(55)* covers all CVD risk factors and addresses the reduction of salt intake at population level.
Slovenia	Discussions with the food industry started in 2009 *(54)*. A national salt campaign was conducted from May 2010 to March 2011. The national action plan for salt was adopted in July 2010.
The former Yugoslav Republic of Macedonia	No action.

Highlight: intersectoral capacity to tackle NCD

In 2010, as part of implementing the action plan for the global strategy for the prevention and control of noncommunicable diseases *(11)*, WHO conducted a global survey of country capacity for the prevention and control of NCD, which was completed very successfully in the European Region. The results of this survey presented below provided valuable information on the capacity available for intersectoral action. Responses were in the form of "yes", "no" and "don't know".

Table 4 presents information on the partnerships for and collaborative agreements on the implementation of key activities for NCD prevention and control, which exist in the SEEHN countries and Slovenia. The telephone interviews confirmed that many of the countries have established intersectoral mechanisms, such as working groups, boards and committees, on the development of strategies and action plans.

Table 4. Existence of collaborative mechanisms in the implementation of NCD-related activities in SEEHN countries and Slovenia, 2010

Country	Main collaborative mechanisms for implementing NCD-related activities		
	Interdepartmental/ interministerial committees	Interdisciplinary committees	Joint task forces
Albania	No	No	No
Bosnia and Herzegovina	Yes	Yes	DK[a]
Bulgaria	Yes	Yes	Yes
Croatia	Yes	Yes	No
Israel	Yes	Yes	Yes
Montenegro	Yes	Yes	Yes
Republic of Moldova	Yes	Yes	Yes
Romania	Yes	Yes	No
Serbia	No	Yes	Yes
Slovenia	DK[a]	Yes	Yes
The former Yugoslav Republic of Macedonia	Yes	Yes	Yes

[a]DK = don't know.

The most common collaborative mechanism in operation is the interdisciplinary committee, which exists in all of the countries reporting the existence of partnerships. In the EU, the most common collaborative mechanism used is the interdepartmental or interministerial committee *(56)*.

Although Albania did not report collaborative mechanisms for NCD-related activities, a recent study on the opportunities for scaling up and strengthening the HiAP approach in south-eastern Europe *(38)* revealed the establishment (under the Albanian Public Health Law) of the National Public Health Council with effect from end 2011. The Council is responsible for coordinating the activities of the public health system and for facilitating policy development. In addition, it advises the Minister of Health on the development and implementation of coordinated public health policy on preserving and protecting the health of the population.

In Croatia, a national environmental health review conducted in 2009 found that, owing to a lack of horizontal collaboration among ministries, vertical laws and by-laws had been developed, which had resulted in a significant duplication and overlapping of responsibilities and a lack of the appropriate capacity for enforcing and implementing the laws. As a result, the National Chemical Safety Committee was established, comprising representatives of different ministries *(57)*. As a candidate for EU membership, Croatia has sought to review its processes of and capacity for monitoring and addressing environmental health, and developed a national chemical safety strategy, which clarifies the functions and responsibilities of the different sectors. Intersectoral cooperation is critical to enabling small countries with little capacity to develop specialist institutions that could facilitate fulfilment of the requirements for EU accession *(57)*. However, in spite of the success of the National Chemical Safety Committee, which is a good example of intersectoral collaboration, there has been no follow up in this area *(57)*.

Information collected through the WHO global survey of country capacity for the prevention and control of NCD also gave an insight into which stakeholders are the key in partnerships and collaboration (Table 5). Non-health ministries, academia and nongovernmental organizations (NGOs) and civil-society organizations were those most frequently reported.

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Table 5. Key stakeholders involved in partnerships and collaborative agreements on NCD-related activities in SEEHN countries and Slovenia, 2010

Country	Key stakeholders					
	Non-health ministries	United Nations agencies	International organizations	Academia (including research centres)	NGOs, community-based organizations, civil society	Private sector
Albania	–[a]	–[a]	–[a]	–[a]	–[a]	–[a]
Bosnia and Herzegovina	Yes	Yes	Yes	DK[b]	Yes	DK[b]
Bulgaria	Yes	Yes	Yes	Yes	Yes	No
Croatia	Yes	Yes	No	Yes	Yes	No
Israel	Yes	No	No	Yes	Yes	No
Montenegro	Yes	Yes	No	Yes	Yes	No
Republic of Moldova	Yes	Yes	Yes	Yes	Yes	Yes
Romania	Yes	Yes	Yes	Yes	Yes	Yes
Serbia	No	Yes	Yes	Yes	Yes	No
Slovenia	Yes	DK[b]	DK[b]	Yes	Yes	DK[b]
The former Yugoslav Republic of Macedonia	Yes	Yes	Yes	Yes	Yes	Yes

[a]No information received. [b]DK = don´t know.

The telephone interviews confirmed that most of the SEEHN countries and Slovenia have adopted strategies developed in cooperation with WHO, other international agencies and relevant government ministries. Although, in the main, NGOs only become involved in the development of strategies at the stage of public debate, they are perceived as important implementation partners and are often included in action plans.

At the local level, joint health campaigns and other health-related activities involving the community, the media and NGOs are organized in connection, for example, with World Health Day. Their aim is generally to raise awareness of the importance of healthy lifestyle.

In some countries, there is a long tradition of the involvement of public health institutes in NCD prevention and control. They often take the lead in initiating processes in this area (e.g. monitoring) at the national and local levels, as well as in assuring the implementation of national strategies and the coordination of related action at all levels. The public health institutes provide the media with evidence and information. Most of them regard the media as an important ally.

In Romania, an intersectoral approach involving the community and governmental and nongovernmental agencies, resulted in the success of a local copper-smelting plant in reducing the blood-lead levels of plant workers and young children living in the vicinity of the plant *(58)*.

In the Republic of Moldova, the national programme on the promotion of healthy lifestyle for 2007–2015, has brought together the following stakeholders: the Ministry of Health; the Ministry of Finance; the Ministry of Education; the Ministry of the Environment; the Ministry of Youth and Sport; the Ministry of Social Protection, Labour and Family; the Ministry of Regional Development and Construction; the Academy of Science; and the National Health Insurance Company. In addition, local public authorities are nominated as competent bodies *(38)*.

Montenegro has included an action plan with a multisectoral approach in its 2009 strategy for the prevention of chronic NCD *(38)*. Before the strategy was introduced, members of the public, journalists and representatives of NGOs were able to participate in a debate on its content. The action plan itself outlines many activities to be undertaken in non-health sectors, such as the construction of recreational

facilities (cycling and running tracks), the introduction of healthy meals for children in schools (education sector), and the mandatory inclusion in school curricula of "healthy lifestyle", which is currently optional. In connection with the implementation of the national tobacco strategy, the Ministry of Health cooperates with the Ministry of Economy on the pricing and taxation of cigarettes, with the Ministry of Tourism on the use of tobacco products in restaurants, and with the Ministry of Education on tobacco control in schools.

Partnerships or collaborative agreements related to tobacco use and unhealthy diet exist in all the countries that reported intersectoral collaboration on NCD prevention and control (Table 6).

Table 6. NCD-related areas in which partnerships or collaborative agreements exist in SEEHN countries and Slovenia, 2010

Country	NCD-related areas in which partnerships or collaborative agreements exist			
	Tobacco	Harmful use of alcohol	Unhealthy diet	Physical inactivity
Albania	[a]	– [a]	– [a]	– [a]
Bosnia and Herzegovina	Yes	Yes	Yes	Yes
Bulgaria	Yes	Yes	Yes	Yes
Croatia	Yes	Yes	Yes	Yes
Israel	Yes	Yes	Yes	Yes
Montenegro	Yes	Yes	Yes	Yes
Republic of Moldova	Yes	Yes	Yes	No
Romania	Yes	No	Yes	Yes
Serbia	Yes	Yes	Yes	Yes
Slovenia	Yes	Yes	Yes	Yes
The former Yugoslav Republic of Macedonia	Yes	Yes	Yes	Yes

[a] No information received.

An example of collaboration in the field of tobacco is the Council for Tobacco Control in Serbia. As a result of an initiative of the Ministry of Health, this multisectoral body was established by the Government in April 2006 and comprises representatives of ministries and professional organizations involved in tobacco control; observers from international organizations (WHO, UNICEF) are also included. The Council serves as a tool to ensure the involvement of all key stakeholders in tobacco-control activities, and to coordinate the implementation of the WHO FCTC, which was ratified by Serbia in 2005.

The law on the restricted use of tobacco products of the Federation of Bosnia and Herzegovina *(38)*, as well as the law on prohibition of the sale and use of tobacco products to persons under the age of 18, the law on prohibition of smoking tobacco products in public places, and the law on prohibition of advertising tobacco products of the Republic of Srpska are also good examples of intersectoral collaboration since their enforcement is supervised through sanitary inspections, labour inspections and market inspections.

In Bulgaria, an intersectoral approach to improving diet and reducing diet-related NCD involves the establishment of the National Coordination Council in connection with the implementation of the national food and nutrition action plan 2005–2010 *(38)*. Membership of the Council includes representatives of all ministries involved in the areas of food, nutrition and physical activity (such as those for agriculture, education and science, economics, and labour and social policy), the Agency for Youth and Sports, representatives of food producers' associations, professional organizations and NGOs, such as the National Association of Municipalities.

A range of health-promotion initiatives have been implemented based on the Health-promoting Schools (HPS) and Healthy Cities projects; these focus most frequently on NCD and least frequently on workplace wellness (Table 7). The telephone interviews confirmed that, in most of the countries, there is evidence of good and continuous cooperation between the health and school sectors. In most of the countries, to some

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extent at least, programmes have been implemented to improve the quality of nutrition in schools and to ensure that children from the lower-socioeconomic groups have access to meals at school. In some of the countries, health has been included in the school curricula.

Table 7. Implementation of health-promotion activities in SEEHN countries and Slovenia, 2010

Country	Health promotion activities aimed at:				
	fiscal interventions influencing behavioural change	regulating marketing of foods to children	community empowerment		
			HPS projects with NCD focus	projects on workplace wellness	Healthy Cities/ municipalities projects
Albania	Yes	No	Yes	-[a]	No
Bosnia and Herzegovina	No	Yes	Yes	DK[b]	Yes
Bulgaria	Yes	Yes	Yes	-[a]	Yes
Croatia	No	No	Yes	-[a]	Yes
Israel	Yes	No	Yes	Yes	Yes
Montenegro	No	Yes	Yes	-[a]	Yes
Republic of Moldova	No	Yes	Yes	Yes	Yes
Romania	Yes	Yes	Yes	-[a]	Yes
Serbia	Yes	Yes	Yes	No	Yes
Slovenia	Yes	No	Yes	-[a]	Yes
The former Yugoslav Republic of Macedonia	Yes	Yes	No	DK[b]	Yes

[a] No information received. [b]DK = don't know.

The intersectoral approach used in Sarajevo in the prevention of drug use in schoolchildren and adolescents could be applied more broadly as a model for initiating and progressing intersectoral collaboration for health promotion *(59)*.

The Healthy Cities approach, which seeks to put health high on cities' political and social agenda and build a strong movement for public health at the local level, is a true example of intersectoral collaboration. It strongly emphasizes the importance of working across sectors in addressing the determinants of health.

The 2000 Sarajevo Healthy City Project is a successful local experience, which illustrate the importance of municipalities in the process of implementing HiAP *(38)*. Between 2000 and 2002, representatives of the project actively participated in the work of the Sarajevo Environmental Council to ensure that environmental conservation policy and spatial planning were based on experience gained in intersectoral cooperation and responsibility for health. In 2004, the Sarajevo City Council approved the health plan for the citizens of Sarajevo. This plan and the studies behind it represent a significant contribution to a holistic understanding of health and to improving multisectoral responsibility for it.

The Israeli network of Healthy Cities has been operating since 1990. When the Israeli Healthy Cities approach was evaluated in 2005, intersectoral partnership achieved the highest score of the six dimensions of the approach assessed in most of the participating cities *(60)*. These partnerships also pursued community participation, on which "Project Renewal", an earlier initiative targeting distressed residential areas, was based, and which may have paved the way for the further development of intersectoral and participatory approaches in Israel *(61)*. A significant predictor of Healthy Cities' success in Israel was the political support and commitment enjoyed by the project *(60)*.

Reflection and proposals for action

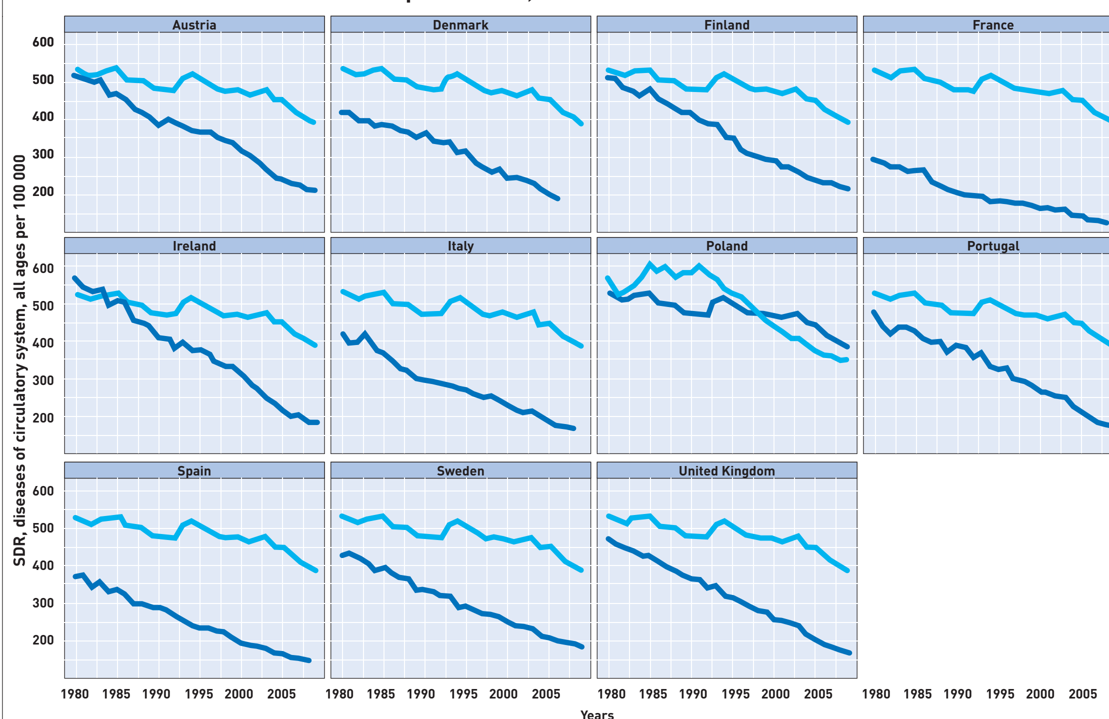
Reflection

This publication describes the burden of NCD and their major risk factors and outlines recently developed global and European strategies in this field. It also discusses "best buys", i.e. cost-effective action to accelerate results in terms of saving lives, preventing disease and avoiding heavy costs *(1)*.

The health sector needs to ensure the quality, universality and accessibility of its services. This means implementing cost-effective, evidence-based interventions aimed at assuring quality care for all, according to their health needs. It also means placing appropriate emphasis on health promotion and disease prevention.

Public policies can have a rapid effect on the burden of NCD. For example, as illustrated in Fig. 10, mortality from circulatory diseases has been declining fast in many European countries over the last three decades. While at individual level, heart disease is a chronic condition, at population level, the risk of dying from it can be reduced remarkably quickly if the right policies are in place.

Fig. 10. Age-standardized mortality from diseases of the circulatory system, all ages, per 100 000, in selected Member States of the European Union, 1980-2005



Note: The light blue line in each graph represents the weighted average for the WHO European Region.
Source: European Health for All Database *(39)*.

Several theoretical frameworks are available to help analyse problems in managing policy change. Kingdon's theory *(62)* simplifies the policy-making process into three main issues: problems, policies and politics.

- The *problem* needs to be acknowledged and included in the policy-making agenda.
- *Policies* to address the problem need to be in place.
- *Political agreement* is needed to address the problem.

To adapt the tasks involved in HiAP decision-making, this framework is used in the following reflections on some of the challenges relating to the three main issues of policy-making in the light of Ollila's observations on creating windows of opportunity for HiAP *(63)*.

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Problem

The description of a health problem is usually based on evidence, such as epidemiological data and medical literature related to the problem, its risk factors and their determinants and distribution (aggregated by sex, age and socioeconomic factors). It is, therefore, important that countries invest in reliable systems of surveillance, monitoring and data analysis. In the absence of data, literary examples of the health effects of measures taken to tackle NCD risk factors and their determinants are helpful in making the case. This is also an obvious way of providing evidence on the predicted trends and consequences of NCD when evidence is not available.

Surveillance data and research results should be easily accessible to the public, politicians and policy-makers alike. The format in which they are presented should be clear, making it possible for the audience to understand how the diseases, their risk factors and determinants are linked, and how important it is to consider this scenario in formulating related policy and, later, in implementing it.

It can be difficult – if not impossible – to implement measures that are seen to restrict people's lives or affect them negatively. It is, therefore, important to enhance public knowledge about measures that are conducive to good health. Ensuring the transparency of planned policies is also important.

Policies

WHO has defined policies to improve the NCD situation, such as those outlined in the *Global status report on noncommunicable diseases (1)*, and in the newly adopted *Action plan for the implementation of the European strategy for the prevention and control of noncommunicable diseases 2012–2016 (9)*. Decision-making on, or even the implementation of, many of the identified priority actions appears very simple. In practice, this is not the case, since action is often required by non-health sectors and stakeholders that may be seen to impinge on their interests. It may well be necessary to adjust policy to accommodate the goals, objectives and interests of various actors. This is especially true in connection with the technical feasibility and cost of proposed policies, as well as with their political and public acceptance.

Politics

Politics is about creating agreement on what is to be done and how it is to be done. The role of the health sector in the process of finding appropriate solutions to health problems is to make the case for health. This requires a good surveillance and monitoring system, the capacity to identify the right policy solutions and the capability to adjust them, in collaboration with other sectors. It is important that health-sector professionals have the mandate to work across sectors, as well as the appropriate resources, including well-qualified staff who have an understanding of public health and health policy and good negotiating skills.

Various structures and processes exist for building intersectoral collaboration, ranging from permanent committees and partnerships to public consultations to plain communication with other sectors. To ensure optimal consideration of equity issues, provision should be made for involving the community, especially the groups known to be more adversely affected by and/or vulnerable to NCD and their risk factors than the rest of the population; the potential distribution of the impact of policies should also be taken into account. Intersectoral committees on public health, including, when appropriate, various levels of government and bodies comprising representatives of different political parties and civil-society organizations, can be very useful, not only in long-term processes of consensus-building and policy planning, but also in dealing with more focused problems or ad hoc matters. For the work of such bodies to be fruitful, they should be fed with concrete, well-prepared issues for discussion and all parties involved should have the opportunity to present their ideas and problems.

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Proposals for action

The Banja Luka Pledge, adopted during the 3rd Forum of Health Ministers of South-eastern Europe in Banja Luka, Bosnia and Herzegovina, in October 2011, commits to resolving to work towards "...strengthening public health capacities and services for the control and prevention of NCD by accepting, adhering to and implementing ... the European action plan for preventing noncommunicable diseases ..."and "...developing and implementing national action plans..." *(64)*. The following proposals for action are based on discussion in Banja Luka and aim to reflect the message conveyed in this publication. They are organized according to Kingdon's policy streams to create the windows of opportunity for HiAP described by Ollila *(62, 63)*.

Proposed problem-related action	Points for consideration
Set up appropriate surveillance systems for gathering data on NCD (aggregated by age, sex and socioeconomic status) and their main risk factors and determinants.	The lack of monitoring, reporting on, and evaluation of the effectiveness of action taken to prevent and control NCD constitutes a main weakness in almost all of the countries assessed. External evaluations of strategic action for use in preparing a new strategy or action plan had been carried out in only a few of the countries.
Build capacity for analysing data from a public health and health determinants' perspective, and other evidence on health situations, policies, policy proposals and policy trends.	The existing information systems do not respond well to the current demands of monitoring NCD trends and the impact of action taken in this area. There has been little monitoring of the social determinants of NCD and related inequities, partly due to the fact that data are not always available. Even where data are available (mainly sex- and age-disaggregated data), the extent to which they have been analysed or linked to socioeconomic determinants, such as level of education, place of residence and family income, is limited. In discussions with other sectors, the health sector should ensure that appropriate evidence and information is made available to them. At the 3rd Forum of Health Ministers of the SEEHN, it was suggested that the Member and partner States of the SEEHN join forces to contribute, as a network, to the input of the European Region to the Global Monitoring Framework developed in response to paragraphs 61 and 62 of the Political Declaration of the General Assembly on the prevention and control of NCD *(10)*, and to the development of an information system for the WHO European Region within the Framework. The SEEHN is well equipped to emphasize the importance of inequity, migration and vulnerable populations.

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Proposed policy-related action	Points for consideration
Develop sustainable funding sources	In most of the countries, the main reason for the failure to implement strategies and action plans as planned is the lack of resources (both human and financial) and assurance of continued funding, particularly for health promotion and NCD prevention. To successfully prevent and control NCD, substantial investment is needed in order, for example, to develop the public health workforce, upgrade information systems (including those related to equity), assure the continuous funding of NGOs, and develop the infrastructure necessary for building supportive environments. The additional financial resources required are difficult to assure in times of crisis. Many initiatives in south-eastern Europe are supported by and dependent on international funding. Assuring the continuation and systematization of projects when such funding runs out could present an additional challenge. The existing collaboration among the SEEHN countries and Slovenia also represents an opportunity for developing common projects and combining resources. The joint training of health and public health professionals in different areas of NCD, organized within this framework in cooperation with WHO, could serve as a model of good practice and could be further developed in the form of a summer school.
Set up collaborative projects	At the 3rd Forum of Health Ministers of the SEEHN, a proposal to establish a regional health development centre on NCD was accepted. This centre, which will be set up in Montenegro, will coordinate cross-border projects on, for example, the strengthening of national NCD plans to develop, evaluate and advocate cost-effective methods of reducing the risks for chronic disease and assist national and international health agencies in the development, implementation and monitoring of NCD programmes. Albania suggested setting up a flagship project on cervical cancer. Croatia was in support of collaboration on NCD-related action, for example, to strengthen or develop national public health strategies (taking the social determinants of health into account), and on activities related to mental health and to the implementation of the WHO FCTC. Israel highlighted the added value of collaborative action. The Republic of Moldova stressed the importance of regional collaboration in the area of physical activity. Romania requested that the development of a regional approach to cancer be considered.

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Proposed action related to politics	Points for consideration
Strengthen the ability to identify policy contexts conducive to dialogue on health perspectives.	To implement international and national NCD action plans, it is important that the mandate and responsibility of the health sector with respect to health promotion and disease prevention reaches beyond service provision.
Make the case in a way in which non-health professionals, politicians and the public alike will understand it. To this end, strengthen negotiating and networking skills.	It is clear that the action required to implement "best buys" will inevitably vary, as do the country contexts. For example, to be successful in raising taxes on alcohol and tobacco, negotiations would need primarily to be with the ministry of finance, and when preparing a budget proposal for submission to the ministry of finance, it would be wise to include information about revenues. It is likely that the alcohol and tobacco industry and enterprises involved in the delivery of "best buys" will be opposed to them. To influence the content of processed food, it is necessary for the health sector to negotiate with the producers at an early stage. At the same time, regulation of this area must remain with the public sector. Planning a comprehensive tobacco or alcohol policy, requires comprehensive discussion between the various public sectors and, most likely, the establishment of an intersectoral working group to prepare it. At the 3rd Forum of Health Ministers in South-eastern Europe, cross-border issues were discussed, including fiscal policies, nutrition, and the Common Agriculture Policy (CAP) reform. The SEEHN underlined the importance of working on these issues as a region in order to make a strong case. The former Yugoslav Republic of Macedonia stressed the importance of collaborating on climate change.
Enhance community participation throughout the processes of policy development, implementation and evaluation through public consultations, the dissemination of information (using the mass media and web-based tools) and facilitation of the equal and meaningful involvement of constituency and NGO representatives at all levels.	The assessment revealed that only few countries have developed special mechanisms at the governmental level for involving representatives of civil society in developing strategies, or in decision-making in general. NGOs are struggling with cuts in funding; in addition, they are seldom involved in coalitions or international networks. Improving strategies and processes to ensure greater inclusion, particularly of the marginalized and disadvantaged, is a key recommendation of the Global Commission on the Social Determinants of Health. Increasing the participation and active engagement of those most affected by NCD in the development of strategies would be taking an important step towards a more equitable distribution of the health improvements achieved by interventions to tackle these diseases. At the 3rd Forum of Health Ministers of South-eastern Europe, Bulgaria stressed the importance of using the media to ensure behavioural change.

Proposed action related to politics	Points for consideration
Utilize experts, networks and examples of good practice to foster intersectoral action	One of the main capacities of the SEEHN countries and Slovenia comprises the expertise of a number of health professionals (national counterparts) who, for many years have been collaborating with WHO on different aspects related to NCD prevention and control and with various relevant networks in Europe. These experts have access to evidence-based information and, through international networks, to information on the different practices followed and measures used in the countries for the prevention and control of NCD. The countries of the SEEHN and Slovenia possess an enormous wealth of information on good practice in the area of NCD in south-eastern Europe, such as initiatives to: involve ethnic minorities (e.g. the Roma population) in NCD prevention and control; tackle health determinants by linking health and development at the local level with the aim of reducing inequity in health; introduce taxes on earmarked tobacco products; and to promote taxation on unhealthy food products.

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References

1. *Global status report on noncommunicable diseases 2010*. Geneva, World Health Organization, 2011 (http://www.who.int/nmh/publications/ncd_report2010/en/, accessed 7 February 2012).

2. *The new European policy for health – Health 2020: vision, values, main directions and approaches. Provisional agenda item 6(a). Sixty-first session of the Regional Committee for Europe, Baku, Azerbaijan, 12–15 September 2011*. Copenhagen, WHO Regional Office for Europe, 2011 (http://www.euro.who.int/__data/assets/pdf_file/0007/147724/wd09E_Health2020_111332.pdf, accessed 7 February 2012).

3. *Declaration of Alma-Ata*. Copenhagen, WHO Regional Office for Europe, 1978 (http://www.euro.who.int/__data/assets/pdf_file/0009/113877/E93944.pdf, accessed 29 February 2012).

4. *Ottawa Charter for Health Promotion*. Copenhagen, WHO Regional Office for Europe, 1986 (http://www.euro.who.int/en/who-we-are/policy-documents/ottawa-charter-for-health-promotion,-1986, accessed 29 February 2012).

5. *Adelaide recommendations on healthy public policy*. Geneva, World Health Organization, 1998 (http://www.who.int/hpr/NPH/docs/Adelaide_recommendations.pdf, accessed 7 February 2012).

6. *Intersectoral action on health: impact on noncommunicable diseases through diet and physical activity. Report of an expert consultation, Helsinki, Finland, 6–7 September 2010*. Geneva, World Health Organization, 2010 (http://www.who.or.jp/publications/2008-2010/ISA_Report_Helsinki-2010_FINAL.pdf, accessed 7 February 2012).

7. *Adelaide Statement on Health in All Policies*. Geneva, World Health Organization, 2010 (www.who.int/social_determinants/en/, accessed 7 February 2012).

8. *Moscow Declaration*. Geneva, World Health Organization, 2011 (http://www.euro.who.int/moscow-declaration-on-healthy-lifestyles-and-ncds, accessed 7 February 2012).

9. *Action plan for implementation of the European strategy for the prevention and control of noncommunicable diseases 2012–2016*. Copenhagen, WHO Regional Office for Europe, 2011 (http://www.euro.who.int/ncd-actionplan, accessed 7 February 2012).

10. *Political Declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases*. New York, United Nations, 2011 (http://www.un.org/ga/search/view_doc.asp?symbol=A%2F66%2FL.1&Lang=E, accessed 7 February 2012).

11. Action plan for the global strategy for the prevention and control of noncommunicable diseases. In: *Sixty-first World Health Assembly, Geneva, 19–24 May 2008. Resolutions and decisions, Annexes*. Geneva, World Health Organization, 2008 (WHA61/2008/REC 1) Annex 3:82–99 (http://apps.who.int/gb/ebwha/pdf_files/WHA61-REC1/A61_Rec1-part4-en.pdf, accessed 7 February 2012).

12. *Gaining health. The European strategy for the prevention and control of noncommunicable diseases*. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/european-strategy-for-prevention-and-control-of-ncds, accessed 7 February 2012).

13. Resolution WHA56.1. WHO Framework Convention on Tobacco Control. In: *Fifty-sixth World Health Assembly, Geneva, 19–28 May 2003. Resolutions and decisions*. Geneva, World Health Organization, 2003 (http://apps.who.int/gb/archive/pdf_files/WHA56/ea56r1.pdf, accessed 1 March 2012).

14. *WHO report on the global tobacco epidemic, 2008: the MPOWER package*. Geneva, World Health Organization, 2008 (http://www.who.int/tobacco/mpower/mpower_report_full_2008.pdf, accessed 7 February 2012).

15. *WHO Framework Convention on Tobacco Control*. Geneva, World Health Organization, 2003 (http://ww.who.int/tobacco/framework/WHO_FCTC_english.pdf, accessed 7 February 2012).

16. *European action plan to reduce the harmful use of alcohol 2012–2020*. Copenhagen, WHO Regional Office for Europe, 2011 (http://www.euro.who.int/__data/assets/pdf_file/0006/147732/wd13E_Alcohol_111372.pdf, accessed 7 February 2012).

NCD_publication_2012.indd 30 09-05-2012 15:21:02

17. *European status report on alcohol and health 2010*. Copenhagen, WHO Regional Office for Europe, 2010 (http://www.euro.who.int/__data/assets/pdf_file/0004/128065/e94533.pdf, accessed 7 February 2012).

18. *Global strategy on diet, physical activity and health*. Geneva, World Health Organization, 2004 (http://www.who.int/entity/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf, accessed 7 February 2012).

19. *European Charter on Counteracting Obesity*. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/en/what-we-do/health-topics/noncommunicable-diseases/obesity/publications/pre-2009/european-charter-on-counteracting-obesity, accessed 7 February 2012).

20. *WHO European Action Plan for Food and Nutrition Policy 2007–2012*. Copenhagen, WHO Regional Office for Europe, 2008 (http://www.euro.who.int/__data/assets/pdf_file/0017/74402/E91153.pdf, accessed 7 February 2012).

21. *Parma Declaration on Environment and Health*. Copenhagen, WHO Regional Office for Europe, 2010 (http://www.euro.who.int/en/who-we-are/policy-documents/parma-declaration-on-environment-and-health, accessed 7 February 2012).

22. *Steps to health. A European framework to promote physical activity for health*. Copenhagen, WHO Regional Office for Europe, 2007 (http://www.euro.who.int/_data/assets/pdf_file/0020/101684/E90191.pdf, accessed 7 February 2012).

23. Mendis S, Banerjee A. Cardiovascular disease: equity and social determinants. In: Blas E, Kurup AS, eds. *Equity, social determinants and public health programmes*. Geneva, World Health Organization, 2010 (http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf, accessed 7 February 2012).

24. Blas E, Kurup AS, eds. *Equity, social determinants and public health programmes*. Geneva, World Health Organization, 2010 (http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf, accessed 7 February 2012).

25. Caleyachetty A et al. Struggling to make ends meet: exploring pathways to understand why smokers in financial difficulties are less likely to quit successfully. *European Journal of Public Health*, 2012, 22(1):41-48.

26. *WHO report on the global tobacco epidemic, 2011: warning about the dangers of tobacco*. Geneva, World Health Organization, 2011 (http://www.who.int/tobacco/global_report/2011/en/index.html, accessed 7 February 2012).

27. Schmidt LA et al. Alcohol: equity and social determinants. In: Blas E, Kurup A, eds. *Equity, social determinants and public health programmes*. Geneva, World Health Organization, 2010 (http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf, accessed 7 February 2012).

28. Bambra C, Joyce KE, Maryon-Davis A. *Strategic review of health inequalities in England post-2010 (Marmot Review). Task Group 8: Priority public health conditions. Final report*. London, University College London, Department of Epidemiology and Public Health, the Global Health Equity Group, 2009.

29. Mulia N et al. Preventing disparities in alcohol screening and brief intervention: the need to move beyond primary care. *Alcoholism: clinical and experimental research*, 2011, 35(9):1557–1560 (http://onlinelibrary.wiley.com/doi/10.1111/j.1530-0277.2011.01501.x/abstract, accessed 1 March 2012).

30. Dahlgren G, Whitehead M. *European strategies for tackling social inequities in health: levelling up part 2*. Copenhagen, WHO Regional Office for Europe, 2007 (http://www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf, accessed 28 February 2012).

31. Robertson A, Lobstein T, Knai C. *Obesity and socio-economic groups in Europe: Evidence review and implications for action*. Brussels, European Commission, 2007 (http://ec.europa.eu/health/ph_determinants/life_style/nutrition/documents/ev20081028_rep_en.pdf, accessed 7 February 2012).

32. Kickbusch I, Buckett K, eds. *Implementing Health in All Policies*. Adelaide, Government of South Australia, 2010 (http://www.sahealth.sa.gov.au/wps/wcm/connect/0ab5f18043aee450b600feed1a914d95/implementinghiapadel-sahealth-100622.pdf?MOD=AJPERES&CACHEID=0ab5f18043aee450b600feed1a914d95, accessed 7 February 2012).

NCD_publication_2012.indd 31 09-05-2012 15:21:02

33. Sihto M, Ollila E, Koivusalo M. Principles and challenges of Health in All Policies. In: Ståhl T et al, eds. *Health in All Policies. Prospects and potentials*. Helsinki, Ministry of Social Affairs and Health, 2006:3–20 (http://ec.europa.eu/health/archive/ph_information/documents/health_in_all_policies.pdf, accessed 1 March 2012).

34. Baron-Epel O, Drach-Zahavy A, Peleg H. Health promotion partnerships in Israel: motives, enhancing and inhibiting factors, and modes of structure. *Health Promotion International*, 2003, 18(1):15–23 (http://www.ncbi.nlm.nih.gov/pubmed/12571088, accessed 1 March 2012).

35. Ståhl T et al, eds. *Health in All Policies. Prospects and potentials*. Helsinki, Ministry of Social Affairs and Health, 2006 (http://ec.europa.eu/health/archive/ph_information/documents/health_in_all_policies.pdf, accessed 8 February 2012).

36. St-Pierre, L. *Governance tools and framework for Health in All Policies*. Quebec, National Collaborating Centre for Healthy Public Policy, 2008 (http://rvz.net/uploads/docs/Achtergrondstudie_-_Governance_tools_and_framework.pdf, accessed 8 February 2012).

37. Cesen M, Mocnik Drnovsek VM. The process of health legislation reform in the Republic of Slovenia. *European Journal of Health Law*, 2000, 7(1), 73–84 (http://booksandjournals.brillonline.com/content/10.1163/15718090020523061, accessed 1 March 2012).

38. *Opportunities for scaling up and strengthening health in all policies in south-eastern Europe*. Copenhagen, WHO Regional Office for Europe (in press).

39. European Health for All Database [online database]. Copenhagen, WHO Regional Office for Europe, 2012 (http://data.euro.who.int/hfadb/, accessed 23 February 2012).

40. Global Health Observatory Data Repository [online database]. Geneva, World Health Organization, 2011 (http://apps.who.int/ghodata/, accessed 23 February 2012).

41. WHO Global Database on Child Growth and Malnutrition [online database]. Geneva, World Health Organization, 2012 (http://www.who.int/nutgrowthdb/en/, accessed 23 February 2012).

42. *Noncommunicable diseases country profiles 2011*. Geneva, World Health Organization, 2011 (http://www.who.int/nmh/publications/ncd_profiles2011/en/index.html, accessed 7 February 2012).

43. de Onis M, Blössner M, Borghi E. Global prevalence and trends of overweight and obesity among preschool children. *American Journal of Clinical Nutrition*, 2010, 92:1257–1264 (http://www.ajcn.org/content/early/2010/09/22/ajcn.2010.29786, accessed 1 March 2012).

44. WHO Multicentre Growth Reference Study Group. WHO child growth standards based on length/height, weight and age. *Acta Paediatrica Supplement*, 2006, 450:76–85 (http://www.ncbi.nlm.nih.gov/pubmed/16817681, accessed 8 February 2012).

45. *National food and nutrition action plan 2005–2010*. Sofia, Council of Ministers, 2005 (http://www.seefsnp.org.rs/documents/bulgaria/Bul_FNAP.pdf, accessed 8 February 2012).

46. *National action plan for overweight prevention and treatment*. Zagreb, Ministry of Health and Social Welfare of the Republic of Croatia, 2008.

47. *Guidelines on nutrition in educational institutions*. Jerusalem, Ministry of Education, 2010.

48. *Decision No. 13 of the Main State Sanitary Inspector of 31 July 2007*. Chisinau, Ministry of Health of the Republic of Moldova, 2007.

49. Ordin Nr. 1563 din 12 septembrie 2008 pentru aprobarea Listei alimentelor nerecomandate preșcolarilor și școlarilor și a principiilor care stau la baza unei alimentații sănătoase pentru copii și adolescenți [Ministerial Order Nr. 1563 of 12 September 2008 recommending approved list of preschool and school food and underlying principles of healthy eating for children and adolescents], *Official Journal for Romania*, 2008, 651 (http://str.calificativ.ro/news/preview/alimente_nerecomandate-1528.pdf, accessed 1 March 2012).

NCD_publication_2012.indd 32 09-05-2012 15:21:02

50. O Razglasitvi Zakona O Solski Prehrani (ZSolPre) [Act on School Nutrition]. *Official Gazette of the Republic of Slovenia*, 2010, 43 (http://www.uradni-list.si/1/content?id=98032, accessed 8 February 2012).

51. *Second national action plan for food and nutrition policy*. Skopje, Ministry of Health of the former Yugoslav Republic of Macedonia, 2009.

52. *Food and nutrition action plan 2008–2012*. Zagreb, Ministry of Health and Welfare of Croatia, 2008.

53. *From safe food chain to healthy nutrition*. Jerusalem, Ministry of Health, 2002.

54. *Current Implementation status of the Strategy for Europe on Nutrition, Overweight and Obesity related health issues*. Luxembourg, Directorate-General for Health and Consumers, 2010 (http://ec.europa.eu/health/nutrition_physical_activity/docs/implementation_report_a6_en.pdf, accessed 1 March 2012).

55. National programme for prevention, medical treatment and control of cardiovascular diseases in Serbia until 2020. *Official Gazette of the Republic of Serbia*, 2010, 5(110):1266.

56. *Country capacity for noncommunicable disease prevention and control in the WHO European Region. Preliminary report*. Copenhagen, WHO Regional Office for Europe, 2010 (http://www.euro.who.int/european-country-capacity-for-ncd-prevention-and-control, accessed 8 February 2012).

57. Capak K, Petrovic G. Environmental health in Croatia – current status and perspectives. *Periodicum Biologorum*, 2009, 111(1):13–19 (http://hrcak.srce.hr/35953, accessed 1 March 2012).

58. Billig P et al. Innovative intersectoral approach reduces blood lead levels of children and workers in Romania. *International Journal of Occupational and Environmental Health*, 1999, 5(1):50–56 (http://www.mendeley.com/research/innovative-intersectoral-approach-reduces-blood-leads-levels-children-workers-romania/, accessed 1 March 2012).

59. Dracic S et al. A model of intersectoral contributions in preventing drug addiction in schoolchildren and adolescents in the Canton of Sarajevo. *Medicinski Arhiv*, 2004, 58(Suppl. 1):15–17 (http://www.mendeley.com/research/model-intersectoral-contributions-preventing-drug-addiction-schoolchildren-adolescents-canton-sarajevo/, accessed 1 March 2012).

60. Donchin M et al. Implementation of the Healthy Cities' principles and strategies: An evaluation of the Israeli Healthy Cities network. *Health Promotion International*, 2006, 21(4):266–273 (http://www.healthycities.co.il/upload/infocenter/info_images/25082010230018@evaluation2004.pdf, accessed 1 March 2012).

61. Carmon N, Baron M. Reducing inequality by means of neighbourhood rehabilitation: an Israeli experiment and its lessons. *Urban Studies*, 1994, 31(9):1465–1479 (http://iew3.technion.ac.il/Home/Users/mbaron/A_10_Carmon_Baron_.pdf, accessed 1 March 2012).

62. Kingdon JW. *Agendas, alternatives and public policies*. Glenview, Il, Scott Foresman, 1984.

63. Olilla A. Health in all policies: from rhetoric to action. *Scandinavian Journal of Public Health*, 2011, 39(Suppl. 6):11–18 (http://sjp.sagepub.com/content/39/6_suppl/11, accessed 8 February 2012).

64. *The Banja Luka Pledge*. Copenhagen, WHO Regional Office for Europe, 2011 (http://www.euro.who.int/en/what-we-do/health-topics/Health-systems/public-health-services/activities/south-eastern-europe-health-network-seehn/third-health-ministers-forum-health-in-all-policies-in-south-eastern-europe-a-shared-goal-and-responsibility/documentation/banja-luka-pledge, accessed 8 February 2012).

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Noncommunicable diseases prevention and control in the South-eastern Europe Health Network

An analysis of intersectoral collaboration

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