World Health Organization

REGIONAL OFFICE FOR Europe

# Intersectoral action for health – Experiences from small countries in the WHO European Region

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Abstract

Health and well-being are affected by social, economic and environmental determinants. Intersectoral action can play a crucial role in addressing today's biggest public health challenges. This report shows how eight small countries, with a population of less than one million, used intersectoral action to address a diverse set of health needs, thus sharing their knowledge on implementing Health 2020. Many sectors were involved in the country case stories with the health sector taking the lead in most cases, coordinating action and engaging other players. The other main sectors involved were agriculture, education, family affairs, interior, labour, justice, sports and tourism. The case stories reveal a number of mechanisms that facilitated intersectoral action with lessons learnt focusing on the importance of establishing common goals, engaging sectors and implementing mechanisms for intersectoral work.

**Keywords:** HEALTH PROMOTION, HEALTH POLICY, SMALL COUNTRIES, INTERSECTORAL ACTION, GOVERNANCE FOR HEALTH, CONSUMER PARTICIPATION.

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## *Foreword*

*I am pleased to present this report that showcases intersectoral actions taken for the health and well-being of the citizens of the eight small countries in the WHO European Region with a population of under one million. It is very timely in light of the recently adopted 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs) and targets. Whole-of-government and health-in-all-policies approaches, as guiding principles of the European Health 2020 framework, translate into a health-in-all-SDGs approach; the implementation of the SDGs in the national context will therefore provide an additional positive dynamic for intersectoral, equity-focused health interventions that leave no one behind.*

*This report is a key part of a systematic mapping exercise of intersectoral health interventions on country level, carried out by the WHO Regional Office for Europe in 2015, and a first of its kind globally. It clearly illustrates the unique quality of intersectoral actions in the settings of small countries. The case stories featured show that elements for successful intersectoral action are diverse, but that they also provide an increasing evidence-base for establishing general success factors and common approaches to overcome challenges. Further, countries with small populations have a social and cultural cohesion that can facilitate the design and testing of innovative policies and implementation processes that will also contribute to further advancements in other countries and in the WHO European Region as a whole.*

*Today, health ministries are already committed to intersectoral collaboration to achieve health goals. The critical importance of social, economic and environmental determinants of health and health equity are well acknowledged. The small country case stories serve as a re-confirmation of policies and strategies, and move our focus to the implementation side.*

*What does the new intersectoral governance for health look like? Above all, high-level political commitment and advocacy are needed from presidents, prime ministers, mayors, civil society, nongovernmental entities and all key opinion leaders. Supportive institutional structures and dedicated resources are also important. Joint planning can be supported by legislative tools relating to health promotion and health impact assessments. Clear accountability and strong transparency, supported by monitoring and reporting, are essential.*

*Let me repeat what I said in 2015 in Andorra at the second high-level meeting of small countries: big ideas can come from small places. With this report, we can add that lessons learnt from implementing big ideas can also come from small places. It is not the size that matters but the commitment to and quality of our actions.*

Zsuzsanna Jakab
WHO Regional Director for Europe

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# Executive summary

Effective intersectoral action is crucial to address today's biggest public health challenges. Health and well-being are affected by social, economic and environmental determinants. A successful policy response to address these determinants therefore necessitates an approach that is intersectoral. Increased involvement and coherent cooperation between actors in different sectors are necessary to achieve strategic goals. Intersectoral action is also a precondition for and an outcome of all dimensions of sustainable development.

This report shows how eight small countries, with a population of less than one million, used intersectoral action to address a diverse set of health needs. These included overweight and obesity in children and adolescents; salt reduction in bakery products; promotion of sustainably grown foods and balanced diets; prevention of child sexual abuse and pornography; and control of potential outbreaks of highly infectious diseases.

Many sectors were involved in the country case stories with the health sector taking the lead in most cases, coordinating action and engaging other players. The other main sectors involved in intersectoral action were agriculture, education, family affairs, interior, labour, justice, sports and tourism. Nongovernmental organizations played active roles in intersectoral actions in addition to private entities such as the media.

The case stories revealed a number of mechanisms that facilitated intersectoral action for health such as passing new legislation or enforcing already existing legislation, using intersectoral working groups and promoting working relations with minimal bureaucracy. A variety of financial mechanisms and funding sources were used ranging from the health ministry's budget to the prime minister's budget to each involved sector contributing a part of the overall cost. A biannual collaborative agreement or nongovernmental organizations or other entities sometimes provided partial funding.

Lessons learnt centred on establishing common goals, engaging sectors and implementing mechanisms for intersectoral work. Engaging stakeholders early on in the process, building up personal relations, identifying sectoral champions, using a common language, and establishing clear roles and responsibilities were noted as key to successful relationships.

Small size (in terms of geography and population) was an advantage since it was easier to reach everyone equitably. Having high-level support and firm government commitment was mentioned as a facilitator. Existing mechanisms such as international commitments and global/regional policy frameworks also facilitated intersectoral collaboration.

General challenges reported were lack of funding, resources and time. Lack of a common language and difficulty in showing the financial benefits of investing in disease prevention were also mentioned.

Gender, equity and human rights were also discussed when compiling the case stories. One third of the country case stories considered gender; the remaining focused on issues affecting the entire population. Most countries considered equity with strategic goals that ranged from protecting all children from exploitation to reducing overweight and obesity in all children to ensuring equal access to programmes. The human right to health was considered an integral part of most case stories' strategic goals.

# 1. Introduction

## 1.1 Background

Effective intersectoral action is crucial to address today's biggest public health challenges. Health and well-being are affected by social, economic and environmental determinants. A successful policy response to address these determinants therefore necessitates an approach that is intersectoral and multidisciplinary.

One of WHO's strategic objectives is advancing intersectoral action for health starting with the 1978 Declaration of Alma-Ata, which called for the involvement of "all related sectors and aspects of national and community development" in efforts to promote health *(1)*, through to the prominent role of both equity and intersectoral action in the Health for All movement *(2,3)* and *HEALTH 21: the health-for-all policy framework for the WHO European Region (4)*. The 1986 Ottawa Charter for Health Promotion *(5)* also recognized the principles of healthy public policy and the importance of involving other sectors in health promotion. This has been reinforced more recently in WHO recommendations on implementing sustainable policies in order to promote health *(6)* and the 2011 Rio Political Declaration on Social Determinants of Health *(7)*, which called for action to be taken on the social determinants of health through the involvement of all sectors of society.

In 2012, Member States of the WHO European Region adopted the Health 2020 policy framework with its two strategic objectives of improving health for all and reducing health inequalities, and improving leadership and participatory governance for health *(8)*. This marked a pivotal moment in the Region's strategic approach to further strengthen intersectoral action.

In 2014, Member States repeated the call to strengthen intersectoral action for health by endorsing World Health Assembly resolution WHA67.12 on contributing to social and economic development: sustainable action across sectors to improve health and health equity *(9)*.

In 2015, the WHO Regional Committee for Europe reaffirmed the central role of intersectoral action in the implementation of Health 2020 in decision EUR/RC65(1) on promoting intersectoral action for health and well-being in the WHO European Region: health is a political choice *(10)*. Accompanying the decision is a publication *(11)*

that emphasizes the need to further encourage the development of sustainable mechanisms that enable increased cooperation between sectors.

As the operationalization and implementation of the 2030 Agenda for Sustainable Development and the Sustainable Development Goals intensifies throughout the European Region, new models of partnership and the scaling up of intersectoral work are being further explored. Increasing the involvement and coherent cooperation between actors in different sectors are both necessary to achieve the Sustainable Development Goals at global, regional, national and subnational levels, and to address the central role of health. Intersectoral action is also a precondition for and an outcome of all dimensions of sustainable development *(12)*. The 2030 Agenda for Sustainable Development, alongside the ongoing implementation of Health 2020, has therefore served to invigorate the WHO European regional discussion surrounding intersectoral action, providing a timely platform for countries to engage further in intersectoral responses to improve health and well-being.

Various Region-wide meetings have taken place to further enrich this discussion at the country level. Two high-level technical meetings – Promoting intersectoral and interagency action for health and well-being in the WHO European Region: synergy among the health, education and social sectors, held in Paris, France, on 24 April 2015 *(13)*, and Strengthening health in foreign policy and development cooperation, held in Berlin, Germany, on 28–29 April 2015 *(14)* – and discussions on intersectoral action during high-level and ministerial WHO fora in 2015 contributed to informing this report. These discussions will be taken forward to the WHO high-level conference on working together for better health and well-being to be held in Paris, France, on 7–8 December 2016, focussing on intersectoral action between the health, education and social sectors to improve health and well-being throughout the Region.

In addition in 2015, the WHO Regional Office for Europe began to identify (through a mapping exercise) intersectoral initiatives that carry credibility and can strengthen the regional implementation of Health 2020 and the 2030 Agenda for Sustainable Development. This exercise aimed to provide an overview of the instruments and mechanisms used to inform and inspire intersectoral action for health and well-being with a focus on the key entry points for intersectoral action.

The Regional Office will continue to support Member States and to facilitate intersectoral action using the data and experiences collected by this exercise.

## 1.2 The small countries initiative

In 2013, WHO established the small countries initiative so that countries in the Region with a population of less than one million people – Andorra, Cyprus, Iceland, Luxembourg, Malta, Monaco, Montenegro and San Marino – can share their knowledge on implementing Health 2020.

The topic of intersectoral action for health was an important agenda item at the second high-level meeting of the small countries held in Soldeu, Andorra, on 2–3 July 2015. The panellists who discussed this topic:

- identified how other sectors are getting involved to make a positive impact on health;
- reviewed current developments in the field of intersectoral action for health;
- distilled lessons learnt;
- examined the diverse processes related to governance and intersectoral collaboration.

Discussions revealed that small countries are advantaged when building intersectoral collaboration and setting up new initiatives due to existing mechanisms of collaboration and proximity of working relations. Intersectoral collaboration should be seen as a natural process and be institutionalized and strengthened. The meeting highlighted that a common agenda was needed for joint action across sectors. National responses should be multidisciplinary and unified involving other sectors to address the underlying factors related to health inequities. Documenting how intersectoral action is facilitated by institutional, legislative, financial and accountability mechanisms to promote health and reduce inequities is key to implementing measures in small countries. Small countries expressed interest in learning more about these mechanisms and models to engage other sectors and establish a similar way of thinking, which makes cross-sector collaboration and coordination easier.

## 2. Methodology

WHO performed a mapping exercise by collecting and analysing case stories – narratives of good practice – of successful intersectoral action for health from 36 of the 53 countries of the European Region. While similar mapping studies have been undertaken previously, this is the first time that WHO has examined aspects of intersectoral action across an entire region at one particular time, and resulted in the largest amount of data collected in any WHO mapping exercise undertaken in the Region. This mapping exercise is part of a larger Region-wide mapping exercise on intersectoral action for health.[1]

In order to facilitate data collection, the 53 countries were split into categories, based on geographic criteria. Each category was assigned to a designated expert with specific experience on intersectoral action for health within the context of the countries in the category.

To help collect data, WHO identified priority areas on intersectoral action based on a literature review, expert consultations, ongoing policy discussions and the results of internal WHO consultations. Some of the key priority areas included: triggers for intersectoral action; mechanisms of action; the number of sectors and stakeholders involved; the level of political commitment; the sustainability of the intersectoral action; and the consideration of equity dimensions including gender and human rights in the intersectoral action.

WHO then created an interview guide, based on expert consultations, to gather country information on each of the priority areas. Some questions in the interview guide were partially adapted from elements of two previous projects that carried out similar mapping exercises. The first was a set of case study guidelines, produced by a 2007 WHO and Public Health Agency of Canada collaboration on intersectoral action *(15)*. The second was a case study template, developed by the WHO Centre for Health Development (Kobe, Japan) and the Pan American Health Organization and used in a similar mapping exercise *(16)*.

[1] The regional data collection was preceded by 28 in-house consultations with programme managers, unit leaders and technical officers at the WHO Regional Office for Europe in 2015. The outcomes of this initial phase were raw data and notes, a set of case studies illustrating underlying concepts for intersectoral action for health, and an understanding of challenges and opportunities encountered.

The Regional Office sent a letter to the 53 Member States, requesting them to nominate a country representative who would participate in interviews and assist WHO experts in finding information on intersectoral initiatives within the country. The official nature of the nominations through WHO and the Member States' governments aimed to ensure the validity of the data, and that the country representative would be knowledgeable about intersectoral action and the specific case story example.

WHO sent country representatives a one-page summary explaining the essence of the interview to be conducted and set up an interview time with each one. Prior to initiating the interviews, country representatives were asked for permission to be recorded to facilitate the process of transcribing the interviews and writing them up as case stories. Everyone interviewed agreed to be recorded. Recorded interviews were conducted either face-to-face or via Skype. The interviewer took notes in the interview guide, asking additional questions as needed. After the interview, the interviewer filled out a case story template using the written notes from the interview guide, and cross-checked information against the recordings to capture additional data. If gaps were noted, follow-up interviews via email were carried out to request additional information or background documents needed to complete the case story.

## 3. The small countries case stories

This report focuses solely on the case stories of the eight small countries of the 36 country-level consultations carried out. It presents a summary of the case stories; the full versions are published elsewhere *(17)*. The case stories demonstrate the breadth of experience in implementing intersectoral actions, as well as the diversity of topics selected. Table 1 shows the full list of case stories collected as part of this exercise.

**Table 1. Small country case stories, collected December 2015–March 2016**

| Country | Interviewee | Case story topic |
|---|---|---|
| Andorra | Jesús Galindo Ortego<br>Head of the Department of Food Safety and Environment, Ministry of Health, Social Affairs and Employment, Andorra<br>Gemma Marsal<br>Health Technician, Department of Food Safety and Environment, Ministry of Health, Social Affairs and Employment, Andorra | Nereu programme on using an intersectoral approach to tackle child obesity and sedentary lifestyles |
| Cyprus | Myrto Azina-Chronides<br>Medical Officer, Ministry of Health, Cyprus | A national strategy and action plan to fight sexual abuse, exploitation of children and child pornography |
| Iceland | Dora G. Gudmundsdottir<br>Director, Determinants of Health and Well-being, Ministry of Welfare, Iceland<br>Una Maria Oskarsdottir<br>Project Manager, Ministerial Council on Public Health, Iceland | Establishment of the Ministerial Council on Public Health: a public health milestone for Iceland |
| Luxembourg | Robert Goerens<br>Senior Policy Officer Ministry of Health, Luxembourg | Get moving and eat healthier. A decade of intersectoral action to reduce obesity in Luxembourg |
| Malta | Charmaine Gauci<br>Director, Health Promotion and Disease Prevention Directorate Ministry of Health, Malta | A whole school approach to healthy lifestyles: healthy eating and physical activity – a policy and strategy |

Table 1 contd

| Country | Interviewee | Case story topic |
|---|---|---|
| Monaco | Jean Lorenzi<br>Public Health Physician, Department of Health Affairs, Ministry of Health and Social Affairs | Intersectoral collaboration to test an alert system for arrival of highly infectious diseases by sea |
| Montenegro | Natasa Terzic<br>Director, Centre for Health System Development, Institute of Public Health, Montenegro<br>Mina Brajovic<br>Head of WHO Country Office, Montenegro | Intersectoral action to reduce salt intake in Montenegro |
| San Marino | Andrea Gualtieri<br>Director, Health Authority, San Marino<br>Arianna Serra<br>Project and Sales Manager for San Marino EXPO 2015, San Marino | EXPO 2015: an opportunity to highlight the importance of nutrition and sustainable agriculture in school settings |

## 3.1 Andorra

In Andorra, among 11–12-year-olds, 8% of children are overweight and 5.5% are obese *(18)*. Action is needed to stop this trend since overweight and obese children are likely to stay obese into their adulthood and more likely to develop noncommunicable diseases (NCDs).

Data from the country's first national nutritional survey in 2004 showing increasing levels of overweight and obesity, combined with WHO recommendations to reduce overweight and obesity, and the 2007 national strategy for nutrition, sport and health triggered the **Nereu programme to tackle childhood overweight and obesity**.

The programme's goal is to reduce the prevalence of obesity in line with the Andorran Health 2020 goals, by reaching 60% of overweight or obese children in the country. It aims to promote a change towards or maintenance of healthy eating habits in primary school-age children who are overweight or obese and have sedentary lifestyles by engaging them in regular physical activity and healthy eating. The programme also extends to their families. It provides equal opportunities for participation, regardless of gender, income, education or fitness level. Participation fees are waived for financial reasons.

The programme began with a pilot project for overweight and obese children with sedentary lifestyles in seven schools in Andorra in 2015. Children attended three weekly extracurricular physical activity lessons where they practiced new skills involving different sports, and received information on healthy eating and lifestyles. Families received two monthly behavioural counselling sessions from dieticians on healthy eating and physically active lifestyles.

The Ministry of Health led the Nereu programme and promoted it in partnership with the Ministry of Education and the Ministry of Culture, Youth and Sports. These ministries have a history of working together on an education for health programme and in implementing activities in the national strategy for nutrition, sport and health. The Ministry of Health was also responsible for managing user data, and monitoring and evaluating the pilot phase. The Nereu Association, a nongovernmental organization (NGO), coordinated, monitored and supervised implementation. The Ministry of Education managed the extracurricular sports activities and reported progress to all involved sectors. The State Sport Secretariat engaged sports clubs and informed sports facilities about the Nereu programme. The Andorran School for Training Sport and Mountain Professions provided sports counsellors for extracurricular activities. The media presented the programme in a press conference and in an interview aired on Andorran television.

Mechanisms to facilitate intersectoral work included setting up a committee between the Ministry of Health, the Ministry of Education and the Nereu Association, which met regularly. The Ministry of Education used its intranet to keep internal stakeholders informed, and a web-based platform was also set up for coordination.

The Ministry of Health's budget provided the primary funds for the programme, and the Ministry of Education funded physical activity sessions.

One main challenge encountered by the programme is the work schedules of families, many of which are employed in the tourism sector and have shift work schedules not permitting them to attend family counselling sessions.

The involvement of primary care professionals is essential for the programme's success. Their role in the community as the first point of contact with the health care system is key to identifying families with children who might benefit from the Nereu programme. They also

provide a common thread that can link families with other sectors and initiatives. The existence of extracurricular sports programmes, good working relationships with the Ministry of Education and its willingness to take an active role in the programme have been facilitating factors.

When the one-year pilot programme ended in 2015, indicators including anthropometric measurements were collected on a small sample of children. The programme was very well perceived and accepted by the population at first. After the initial stage though, participation rates dropped, which may be due to a fear that participating children will be stigmatized or to the parents' work schedule conflicts.

Full implementation of the Nereu programme will begin in September or October 2016 and last five years. At the end of this period, a final evaluation will be carried out to see if children have acquired and incorporated healthy habits into their everyday lifestyles.

## 3.2 Cyprus

**Cyprus has a national strategy and action plan to fight sexual abuse and exploitation of children and child pornography.** Child sexual abuse, a worldwide problem, persists in the WHO European Region. Analyses of community surveys from Europe and around the world have estimated a prevalence rate for sexual abuse of 9.6% (13.4% in girls and 5.7% in boys) *(19)*.

In 2015, the Council of Ministers of Cyprus established an ad hoc ministerial committee with the ministers of education, health, justice and labour to coordinate preparation of a national strategy and action plan to protect children from all forms of sexual abuse and exploitation and pornography. The health of all children including present and future psychological well-being, a human right, is the foundation for this plan and its strategic goals. Gender was explicitly considered, ensuring that education initiatives would address boys and girls.

This initiative received high-level political commitment, triggered by the need to enforce existing legislation (2014) based on the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse. Intersectoral action was chosen to ensure coordination with regard to addressing cases, as well as application of a coherent, systematic approach to dealing with the issue. Another important trigger was the media, which raised public

awareness by addressing this topic in news stories. This, coupled with the introduction of a new law to fight sexual violence against children and the ongoing Council of Europe ONE in FIVE campaign *(20)*, provided momentum for action.

Since social issues fall under its mandate, the Ministry of Labour, Welfare and Social Insurance took the lead. The Ministry of Health provided technical expertise and assumed an advisory role providing scientific evidence. The availability of WHO literature and guidelines on violence and injury prevention *(21)* played a prominent role in developing both the strategy and action plan. Within the context of national strategy development, the Ministry of Justice and Public Order ensured that a specialized police group receive education on conducting video recorded statements to investigate sexual violence offenses against children according to location (rural or urban). Within the same context, the Ministry of Education and Culture offered seminars in schools for teachers on sex education, prevention of sexual abuse, sexual and reproductive health of adolescents, anti-racist policies and actions, diversity in school and other topics. Nongovernmental Organizations put pressure on the Government to act on this issue, prepared the action plan (for the national strategy) and provided funding. The private sector – psychologists and social workers contracted to fill a resource gap in the public sector – offered their specialized services. The media ensured wide coverage of the issue.

Information sharing came naturally through enforcement of existing legislation. Parliament encouraged sectors to work towards a single strategic plan; an intersectoral working group was set up with accountability for the action plan. Parliamentary hearings facilitated the process. The ministers agreed to eliminate bureaucracy and promote open communication, which facilitated the intersectoral working group's job.

The Government of Cyprus was the main financial leader of the initiative. Budget was initially an issue until the Hope for Children NGO provided €300 000 and a house for victims.

Initial resistance to intersectoral working was overcome once work began. The intersectoral working group met frequently and avoided duplication of efforts; open communication was key to the initiative's success. Small country size and proximity made for easy dissemination. Existing legislation meant that a legal framework was available to

build upon with international commitments supporting this. Involved Government parties have committed to guarantee the sustainability of actions despite political changes. Support from NGOs and private practitioners by means of funding and person time were also key enablers.

Wide sector involvement, including a strong NGO presence and media pressure, helped them to develop a comprehensive plan that benefits all children. This initiative has led to better links and collaboration being established with other sectors.

Internal and external monitoring mechanisms are in place but since the strategy and action plan were approved in March 2016, no assessment has yet taken place. Outcomes are expected to be measured over the next 5–10 years.

### 3.3 Iceland

Iceland faces demographic changes and other major challenges calling for effective solutions to preserve and improve health and well-being in all stages of life. One of the priorities of the current coalition Government's (2013–2017) platform is to ensure equality for all citizens by means of public health and disease prevention measures.

In 2014, with the approval of the Government, the Prime Minister of **Iceland established the Ministerial Council on Public Health**. The main role of the Council is to promote dialogue and cooperation between ministers and ministries, harmonize overlapping thematic areas and prepare a comprehensive public health policy and action plan for submission to the Government.

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

The core members of the Ministerial Council are the Prime Minister (chair); the Minister of Health; the Minister of Education, Science and Culture;

and the Minister of Social Affairs and Housing; and their respective ministries; other ministries, such as the Ministry for the Environment, participate as needed. The Public Health Committee, also established in 2014 under the authority of the Minister of Health, involves stakeholders from a wide range of sectors. The Public Health Committee's main role is to advise and support the work of the Ministerial Council by drafting the public health policy and action plan, and consulting regularly with it. Aside from the sectors represented in the Ministerial Council, the Public Health Committee engages representatives of unions, public health centres, universities and associations.

Participatory mechanisms have brought together stakeholders from different sectors including nongovernmental actors through the work of the Ministerial Council and the Public Health Committee thereby facilitating communication, joint understanding and a sense of ownership among those involved; all stakeholders in the Public Health Committee were invited to contribute to the draft strategy. The Prime Minister's office hired a staff member to support the Ministerial Council's work.

The Ministerial Council on Public Health earmarked funding from the State budget to implement the health promoting community project in 2016. An evaluation plan will be included in the public health strategy, and some suggested activities in the draft action plan are under assessment.

Challenges relate to limited resources such as time, staff and funding, as well as a lack of clearly identified roles. Maintaining its continuity despite possible changes in government at national and/or local levels is essential to ensure sustainability of this work.

Lessons learnt emphasize the importance of using language and concepts to which everyone can relate. Work should be founded on a common ground and understanding so everyone can see the benefits of participating and contributing. Showing other sectors how promoting public health and well-being and reducing health inequalities helped them reach their goals and facilitated the work of the Ministerial Council.

The Ministerial Council is currently in place and has discussed, among other things, determinants of health, health in all policies, health tourism, a comprehensive public health policy, public health indicators and an action plan to improve public health in all age groups.

## 3.4 Luxembourg

**Luxembourg started a decade-long intersectoral action to reduce obesity with its "Get moving and eat healthier" campaign.** According to 2013/2014 Health Behaviour in School-aged Children survey data from Luxembourg, 26% of boys and 14% of girls aged 11 years are overweight or obese *(22)*. Data from the national medical school surveillance system (2014/2015 school year) showed that 14.1% of boys and 14.3% of girls in primary schools are overweight or obese *(23)*. The rise in obesity among children is worrying as childhood obesity often leads to adult obesity.

Growing levels of overweight and obesity in Luxembourg triggered action to:

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

In 2006, Luxembourg created a project and a national strategy to increase physical activity and promote balanced diets for all its residents called *Gesond iessen, méi bewgen* (Get moving and eat healthier). While its initial focus was primary schoolchildren and adolescents, today the project targets the entire population. Ten years after its start, the project has gone nationwide and been adopted by approximately 1000 communities now offering sports opportunities for all ages, genders and interests.

Intersectoral action was chosen since the Ministry of Health realized it could not act alone on this issue. This triggered a national debate in Parliament on obesity, and four ministries – Health; Sport; Family Affairs, Integration and the Greater Region; and Education, Children and Youth – decided to work together.

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

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

Factors that facilitated work were the easy engagement of sectors once the decision was taken by the Prime Minister to support the project. As a result, contacting the Ministry of Sport and getting support when initiating sports activities in communities is now easier. Small country size was also a great advantage, facilitating the ability to reach everyone in an equitable manner.

An initial challenge was engaging sports federations or fitness clubs, which were not keen on promoting low-priced fitness options, but have come to understand that promoting sport for all benefits the whole population. The project has led to an increase in demand for trained professionals who can teach sports, which cannot always be met.

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

### 3.5 Malta

**Malta implemented a whole school approach to a healthy lifestyle, a policy and a strategy to promote healthy eating and physical activity.** The major health challenge affecting schoolchildren in Malta is overweight and obesity; almost 47% of 11-year-olds in 2012 were either overweight or obese with boys showing increasing trends *(24)*.

This motivated the health and education sectors to join efforts to implement a national school-wide policy and strategy to:

- achieve better physical activity and nutrition for all schoolchildren in Malta; and
- create a level playing field in all schools by offering equal

opportunities for all children to engage in physical activity and benefit from improved nutrition in school settings.

*A whole school approach to a healthy lifestyle: healthy eating and physical activity (24)* includes initiatives that target adolescents in secondary schools. Examples of initiatives include dance sessions offered to students during class breaks that considered adolescent girls' preferences, mandated changes to the types of foods sold in school-based snack shops to promote healthier eating, cooking classes on healthy meals for children and parents, and a campaign to encourage healthier lunchboxes promoted by television, radio and social media.

Intersectoral action was built on existing relations with the education sector; this was an opportunity to identify common goals and work towards them. The highest levels of government were involved in policy and strategy development; education and health sectors shared the lead and established an intersectoral working group. Many levels of society were involved. Parent associations were consulted during the development of the policy. The media played an active role in promotion and information dissemination. School-based snack shops (the private sector) changed their purchasing choices. Cereal companies were informed of mandatory nutrient levels and sought to promote healthy cereals (according to the WHO nutrient model *(25)*). Sports clubs (private sector), previously promoting elite sports, now promotes health-enhancing physical activity at schools. During the summer, children can enrol in non-competitive swimming classes.

No additional funding was required for policy and strategy. Each sector used its own budgets and staff time.

Challenges are related to factors outside the school that impact implementation of the policy and strategy in schools and eventual health outcomes. The policy has no power over neighbourhood shops that sell unhealthy food. Finding a balance with the private sector is also a challenge. Initially fruit juice vendors were trying to promote juices saying that they were a fruit equivalent. Policy-makers were supportive in blocking this.

Evaluations include regular audits of school-based snack shops and checks on the types of food sold in schools.

One lesson learnt is that successful intersectoral collaboration requires the goals of each sector to be complementary; conflicting goals impede

smooth working. Building up personal relations and identifying a champion from each sector are essential. Commitment of people working in the field and at policy level facilitates this process. Having schools involved in developing policies supports their ownership of the initiative.

The whole school policy was launched in January 2015 and is currently being implemented.

### 3.6 Monaco

In Monaco, the authorities conscious that any infectious disease can spread very quickly due to the small size of the country, the high density of population and the large number of visitors by sea each year, have developed a structured alert system that can save lives. Work to **develop an alert system for dealing with the arrival of highly infectious diseases to Monaco by sea** started in 2013, with a first test carried out using the hypothetical case of pneumonic plague. The alert system aims to ensure a coordinated approach so that affected persons receive appropriate care, health workers are protected and the spread of the infectious disease is halted.

The core of the alert system is the crisis unit, which relies on a set of intersectoral stakeholders and procedures. The alert system includes protocol for health workers, care of affected persons and needed infrastructure.

The alert system relies on International Health Regulations *(26)*, requiring every ship entering a foreign country to submit a Maritime Declaration of Health to the Port Authority within 24 hours of arrival. If highly infectious diseases are identified on board, the police are notified and then the Ministry of Health and Social Affairs. The crisis unit is convened with relevant sector officials who divide up tasks according to expertise.

This initiative received high-level (minister) support from many government sectors. The Ministry of Interior (police) receives the Maritime Declaration of Health; the Ministry of Health and Social Affairs (staff) informs hospitals upon receipt of the alert and hospitals provide care to the affected. Firefighters (part of the armed forces) provide rescue services, logistics for citizen protection and organization of transport to the hospital by protected ambulance. The Department of Maritime Affairs, with the Port Authority, facilitates the docking of

the ship to evacuate sick people while limiting ship crossings at that moment. A cruise ship (private sector) was engaged to improve its preparedness in terms of training. The media disseminated general information about the test to the local press. The crisis unit also proposes public information messages.

The test did not require any additional funding; each ministry provided financing and person time from its own budgets.

The owner of the cruise ship, wishing to protect the reputations of the ship and shipping company, asked that these names be kept anonymous during the test. The media needed to emphasize that this was an exercise so as not to alarm the population. Lack of time and human resources were a constraint, as people needed to perform the testing activities in addition to their regular duties.

Bringing together sector-specific expertise facilitated work. The intersectoral crisis unit and interministerial committee, set up for this initiative, aided coordination.

The test of the alert system on the cruise ship provided an opportunity for evaluation. It confirmed the need to train all sectors to coordinate and follow established procedure. Firefighters need to have appropriate clothing and materials. The Ministry of Health and Social Affairs needs health information and techniques for dealing with highly infectious diseases. Regular training of health workers on workplace practices to minimize the risk of occupational exposures to infectious diseases when caring or transporting patients, and ensuring the availability of appropriate materials on ships to protect passengers are essential. Intersectoral collaboration worked smoothly for Monaco, and the experience has been positive for all sectors involved.

The test of the alert system has concluded, and a repeat of this exercise with a staged chemical threat situation is planned.

## 3.7 Montenegro

The reduction of dietary salt intake is considered one of the most cost-effective public-health measures. Excessive dietary salt intake is directly linked to the development of certain NCDs, which are the leading cause of death worldwide. One of the most important elements for implementing a strategy for reducing dietary salt intake is intersectoral

cooperation, especially with the food and catering industries, because a large part of salt intake is hidden in foods.

Circulatory system disease estimates of approximately 50% (2010–2012) in Montenegro warranted population-wide action to reduce salt intake *(27)*. At national level, policy-makers – aware that NCD risk factors threaten not only public health but also economic development – realized that action was needed. As a consequence, **Montenegro embarked on a programme (2014–2025) to reduce salt intake in its population** to below 5 g/day per capita in line with WHO recommendations, by raising awareness, reducing salt content in processed foods and using a harmonized national response *(28)*. The programme recommends a reduction in salt intake by 16% over the 2014–2020 period and by 30% by the year 2025.

Montenegro began to address salt intake in 2008, when the Ministry of Health developed a strategy for the prevention and control of NCDs with a framework for action for 2008–2013. A mid-term NCD action plan (2014–2015) with intersectoral activities was developed with priority given to prevention of NCDs and education of food industry staff on reducing salt content in foods. In addition, in 2012, the health sector launched an initiative to reduce salt consumption, and included the baking industry in an effort to reduce the amount of salt in bread and baking products. The initiative was closely linked to activities from the NCD strategy and WHO support from a 2012–2013 biennial collaborative agreement on implementing the NCD framework for action for 2008–2013.

The 2012 initiative demonstrated the importance of intersectoral work. The health sector shared epidemiological data with the agriculture sector to communicate that excessive salt intake is a health risk factor. An analysis of bakery products revealed high salt content, and reducing salt in bread was the primary mechanism for salt reduction as it was consumed at every meal. An agreement was reached on the maximum content of salt that would be allowed in bread to be implemented at local level, and a link was made between health and tourism in the capital, Podgorica, where local authorities and the hospitality sector will begin to offer low-salt options in restaurants in the near future.

The development and implementation of the draft programme for reducing dietary salt intake in Montenegro for 2014–2025 is a continuation of activities, resulting from the 2012 initiative, and aims

to reach a broader population and achieve even greater reductions in salt intake. As a consequence, intersectoral action involving health, agriculture and the private sector is promoted from the outset; the health sector recognizes that sustainable reductions in salt intake requires both broad intersectoral involvement and broad awareness among the population.

A multidisciplinary core group was established to develop the draft programme for reducing dietary salt intake. Just as in the 2012 initiative, continuous dialogue by means of consultations took place during the programme's infancy such as with the bakery industry to assure them that business would not suffer. Technical consultations between health, agriculture and the bakery industry helped achieve expert consensus, policy-maker commitment and agreement on maximum salt thresholds. Once legislation for the programme is expected to pass in 2016, the Ministry of Agriculture will regulate food item labelling to conform to agreed salt levels.

High-level political support and diverse stakeholders including community, civil society and local municipalities are involved in the programme. Besides the health and agriculture sectors, other supporting sectors include the chamber of commerce and the private sector (bakery industry). The media are also involved to promote the programme and raise awareness among the population on the importance of reducing salt intake.

A national council to support the implementation of the NCD strategy will also be established with the Prime Minister acting as council chair.

The Government currently co-finances the programme with WHO, which initially provided a small amount of funding as part of the 2012–2013 biennial collaborative agreement. The country also mobilized financial resources to support national consultations on the subject.

No evaluation has taken place yet, but an estimate of 24-hour urinary sodium excretion is planned to establish a baseline and measure progress. The United Nations development framework for Montenegro (2017–2021) includes salt intake as an indicator to measure progress in addressing health risk factors.

Lessons learnt from the 2012 initiative reaffirm the importance of engaging different sectors from the start and regular information sharing. Governance arrangements need a sustainable lifespan

covering the implementation period and should be integrated into existing policies or programmes. Capacity-building for health advocacy is needed so benefits beyond the health sector can be reaped. Despite ample evidence supporting salt reduction programmes, health advocates do not use it to engage other sectors.

Challenges were lack of budget allocation, and an inability to use financial terms and health evidence to show the financial benefits of investing in disease prevention.

International commitments and global or regional policy frameworks helped promote intersectoral collaboration. The existence of subregional technical networks facilitated the exchange of knowledge, lessons and experiences.

Other sectors such as agriculture now consider the health risks of high salt content when drafting regulations on food labelling. Overall, the intersectoral collaborative process ran smoothly and transparently with information shared freely among stakeholders.

The programme on salt reduction will be officially adopted in 2016.

### 3.8 San Marino

According to data from the WHO European Childhood Obesity Surveillance Initiative study (2014), 31% of primary schoolchildren in San Marino are overweight or obese *(29)*.

The strategic goal was to ensure that **all children in San Marino had access to sustainably grown nutritious foods in school** and educational opportunities to learn about these foods. Gender, equity and human rights were implicitly considered; all children in San Marino have the right to have a healthy diet, and support is offered to those who cannot afford to pay for school meals.

The country incorporated nutrition and agricultural components into an existing project on nutrition in schools. Intersectoral action and an international event (EXPO 2015)[2] were used to promote balanced diets and food quality standards that prevent overweight and obesity among children.

[2] EXPO 2015 was a world exposition hosted by Milan, Italy, in May 2015 with the theme "Feeding the Planet, Energy for Life".

Two congressional resolutions backed up this process. The first, in 2013, established a multidisciplinary and intersectoral working group for planning and coordination of the health promotion and education interventions in schools. The second, passed specifically for EXPO 2015, focused on the promotion of balanced diets and food quality standards.

Sectors took turns leading. The health ministry,[3] with the support and coordination of the Health Authority, provided guidelines on health education in school settings, and guidance to dietitians and paediatricians on menu development and special diets. The education ministry ensured a link was made between school science lessons and off-campus workshops. The tourism ministry, responsible for EXPO 2015, highlighted agricultural production in San Marino to the outside world. The agriculture sector and a private sector agricultural consortium organized workshops for schoolchildren on their different products. The sector agreed to follow a number of integrated agriculture standards that would help ensure sustainable production of the six main food products. The media highlighted and promoted best practices broadcasting programmes highlighting food quality and healthy diets.

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

While the health effects or decreases in obesity cannot yet be seen, indirect evaluations carried out every two years such as *OKkio alla SALUTE (30)* will provide indications of change in overweight and obesity. Intersectoral work was successful with an indicator of interest being high attendance at nutrition workshops organized by the agricultural consortium (1500 children). Other elements to evaluate are the effect of direct training of cooks by the Social Security Institute dietitians, knowledge passed on to children by teachers in science lessons and results of a dietary assessment of third grade children.

[3] The health ministry in San Marino is the State Secretariat for Health and Social Security. It is comprised of two branches, the Health Authority, the technical arm of the Secretariat that coordinates and develops health policy; and the Social Security Institute, charged with management and delivery of health and social services and implementation.

With strong government support, a mechanism such as the education for health working group can be activated. EXPO 2015 provided an opportunity for the country to bring together all its skills to work on a common project. An understanding by all stakeholders of the benefits of integrated work helped streamline activities and led to better coordination. Challenges that were overcome during the project included finding a common language between schools and the health sector, and identifying goals of mutual benefit.

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

# 4. Observations

## 4.1 Triggers for intersectoral action

Intersectoral action can be used to address a broad range of health issues that impact a population such as obesity; nationwide salt reduction in bakery products; child sexual abuse and pornography; the arrival of highly infectious diseases to a country; and the establishment of a Ministerial Council on Public Health to promote intersectoral dialogue and cooperation. Despite this diversity of public health needs, 50% of the case stories addressed overweight and obesity in children and adolescents. The main triggers for these were national-level data revealing growing prevalence of overweight and obesity in the country; WHO reports or guidelines; the development of a national strategy and political attention being drawn to this health issue; and the need to curb the future risk of NCDs in the country.

The triggers to take action on child sexual abuse included high-level political support, the media, which played an awareness raising role, and the need to enforce existing legislation. Other countries also reported high-level political support, the growing understanding that good health is essential for economic development, and preparedness in case of an infectious disease outbreak.

## 4.2 Initiating intersectoral work

Most countries agreed that work should be founded on common goals and the benefits of participating should be clear. Furthermore, the goals of each sector need to be complementary, and the action to be undertaken needs to be logistically feasible. Countries reported that identifying win-win situations made intersectoral collaboration flow smoothly with little need to convince partners to participate.

An example of an effective comprehensive approach to intersectoral working with a common goal is the whole school approach reported by one country. The approach built upon existing policy to effectively build up a new national school-wide policy and strategy to increase physical activity and improve nutrition in schools. This approach takes into account key school settings such as classrooms, playgrounds and snack shops, which can influence overweight and obesity and physical activity.

## 4.3 Engaging sectors

Countries reported that the involvement of non-health sectors was key to any intersectoral undertaking, since many influential health determinants are outside the health sector. They stressed that communication among sectors should use a common language that is understandable by all stakeholders. Relevant sectors, including their representatives, should be involved from the start. Dedicating time to building up personal relations and identifying sectoral champions were also reported as important. Having an intersectoral working group throughout the initiative's planning and implementation phases was reported as a way to engage and maintain sector involvement.

Some countries emphasized the importance of ensuring sustainability of the intersectoral working group for the duration of the project's lifetime. Establishing and maintaining clear sector roles and responsibilities from the outset with adequate resources allocated for preparation, implementation and evaluation were also highlighted.

Table 2 shows the sectors involved in the country case stories.

**Table 2. Sectors involved in country case stories**

| Country | Agriculture | Armed forces | Commerce | Education | Environment | Family affairs | Health | Interior | Justice | Labour | Media | Nongovernmental actors[a] | Private | Social affairs and housing | Sport | Tourism |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Andorra | | | | ■ | | | ■ | | | | ■ | ■ | | | ■ | |
| Cyprus | | | | ■ | | | ■ | | ■ | ■ | ■ | ■ | ■ | | | |
| Iceland | | | | ■ | ■ | | ■ | | | | | ■ | | ■ | | |
| Luxembourg | | | | ■ | | ■ | ■ | | | | ■ | | | | ■ | |
| Malta | | | | ■ | | | ■ | | | | ■ | ■ | ■ | | | |
| Monaco | | ■ | | | | | ■ | ■ | | | ■ | | ■ | | | |
| Montenegro | ■ | | ■ | | | | ■ | | | | | | ■ | | | ■ |
| San Marino | ■ | | | ■ | | | ■ | | | | ■ | | ■ | | | ■ |

[a] Nongovernment actors include NGOs but exclude the media and the private sector.

### 4.3.1 Agriculture sector

In countries where food-related issues formed the core of intersectoral action, the agriculture sector was a key player. Its role ranged from involvement in national technical consultations where expert consensus and policy-maker commitments were obtained on food thresholds to responsibility for developing new legislation regulating foods. In other settings, the agriculture sector played a prominent role in promoting balanced diets and food quality standards through educational workshops to prevent overweight and obesity among children, and contributing to an education for health working group.

### 4.3.2 Education sector

The education sector was a core player in six of the eight case stories. It was reported as the key entry point into the educational system and schools. It often took the lead and organized sports activities; oversaw school-based activities; provided school facilities, technical staff and funding for physical activity sessions; and offered resources such as its intranet to keep other sectoral partners informed of programme progress in school settings. This sector also played a key role in promoting disease prevention by offering educational opportunities to students, teachers and parents. In some cases, it jointly launched policies with health ministries. It also formed part of intersectoral working groups promoting health in schools, which also benefits the child's educational performance.

### 4.3.3 Health sector

The health sector (ministry) took the leading role in coordinating most initiatives and worked internally to engage health professionals and hospitals. The health sector often assumed an advisory role providing scientific evidence when planning actions. It took an active role in sharing epidemiological data with other sectors, delivering training on and promoting disease prevention activities by working through school health services and other relevant actors.

### 4.3.4 Sport sector

The sport sector was instrumental to achieving intersectoral collaboration in two of the case stories. In both countries, the health and sport sectors

have a history of working together, and the sport ministry was key to engaging sports clubs and informing sports facilities about the need to promote physical activity to people of all ages or to overweight and obese children. In one country, the sport ministry – one of four ministries in an intersectoral working group – helped to develop a project and national strategy on increasing physical activity and promoting balanced diets.

### 4.3.5 Other sectors

One country involved the **armed forces** (fire-fighters) who played a key role due to their training, and ability to provide rescue services and logistical information to protect the health of the citizen population. It also involved the **interior ministry** (police) as part of its multisectoral response to infectious disease control.

In another country, the **family affairs ministry** – one of four ministries in an intersectoral working group – helped to develop a national strategy on increasing physical activity and promoting balanced diets. This ministry became interested in offering opportunities for sports inside its various institutes throughout the country.

In another country, the **labour ministry**, with the mandate to take care of social issues, collaborated with ministers of education, health and justice in intersectoral working groups to carry out actions to protect children from sexual abuse and exploitation. In this same setting, the **justice ministry** ensured that a specialized police group received training needed to detect and investigate child sexual abuse.

Two countries made a link between the health and **tourism** sectors. One agreed to offer low-salt food options in restaurants. In the other, the tourism sector, responsible for EXPO 2015, partnered with the health and education sectors to promote the production of sustainable foods and healthy diets.

### 4.3.6 Media

In most case stories, the media were reported to play an important role in raising awareness on health issues. They were one of the main triggers for action and disseminated information to the public. They also brought attention to and promoted a number of initiatives in social

networks, and were proactive partners in several media campaigns. The media were also provided with training to better understand new policies so that they could transmit accurate messages to the public by radio and television.

### 4.3.7 Nongovernmental actors (NGOs/associations)

Nongovernmental actors were reported to play a key yet diverse role in each case story. In some cases, they coordinated and monitored the programme and supervised implementation. They often put pressure on a government to act on certain issues of concern, and ensured the involvement of a wide range of associations for health, youth, sports and other special interest groups. One NGO provided key funding for a country initiative.

### 4.3.8 Private sector

The private sector collaborated with the other actors in a variety of ways. In one country, school-based snack shops opted to offer healthy snacks to children, and cereal companies began to promote healthier and lower-sugar options for children. In another, the bakery industry was a key partner and through the chamber of commerce, participated in a national consultation to help reduce salt intake. In another country, private psychologists and social workers offered their specialized services since ministries lacked time, resources and expertise. In two other countries, private sports clubs and federations were very involved in community promotion of physical activity; some sports clubs and federations now contribute to non-organized sports not normally in their domain.

## 4.4 Mechanisms to facilitate intersectoral work

The small country case stories show that several mechanisms facilitated intersectoral action for health. In some countries, passing new relevant legislation helped ensure that the given action would be implemented. The use of existing legislation helped stakeholders identify how they could contribute to the initiative. Most case stories reported on the existence or establishment of a working group to encourage frequent interaction and coordination among stakeholders. These working groups also helped prevent duplication of efforts and brought together

sector-specific expertise. A few countries hired a staff member whose role was to liaise with the other sector stakeholders. In another country, ministers agreed to eliminate bureaucracy and promote open communication among different sectors, which resulted in people working smoothly across sectors.

Countries stressed the importance of having governance arrangements institutionalized with a lifespan covering the programme at hand. Some countries reported that having high-level government support should not be underestimated. They also spoke to the importance of integrating the intersectoral initiative into an existing policy or programme. Using the opportunity provided by international events could encourage countries to bring together their skills to work on a common project.

**Communication** played an important role in facilitating intersectoral work. Many countries used the intranet to keep internal stakeholders informed while others reported setting up a web-based platform to coordinate work. Promotion of person-to-person communication and continuous dialogue by means of consultations between sectors on technical issues, or to reach expert consensus and policy-maker commitment were also noted. In some countries parliamentary hearings were found to be key to getting high-level support and encouraging collaboration.

The use of participatory mechanisms facilitated communication, joint understanding and a sense of ownership among those involved. The use of WHO guidelines during the programme's development stage was noted in several cases.

### 4.5 Financial mechanisms

Funding sources ranged from the health ministry to the prime minister's office to other stakeholder budgets. At times, specific components of projects were directly financed by nongovernmental actors such as staff needed to implement the intervention. Many countries noted that their initiatives received no additional funding and that each ministry provided financing and person time from its own budgets. No countries reported having a budget that all sectors could tap into for intersectoral action.

Some countries mobilized financial resources to support national consultations on the topic and if a time-limited event took place, funding

was earmarked under the state budget for that specific initiative. One case story reported that intersectoral collaboration was initiated using funds from a biennial collaborative agreement. One country reported that as the initiative matured, funding was shared between cities and ministries.

## 4.6 Evaluation

Most countries reported that evaluations had not taken place yet but were planned for the near future. One country reported that specific parts of the initiative were currently under evaluation whereas other reported needing a period of 5–10 years to be able to assess expected outcomes. One country had indicators from its United Nations development framework. Others had internal and external monitoring mechanisms in place.

Most countries reported having qualitative evaluation measures such as positive impact on non-health sector behaviours, raised awareness and private sector changes in ways of working. National health surveys provided indirect evaluations (for overweight and obesity), and relevant biomonitoring (on sodium excretion) could be used to establish baselines and measure progress in implementing one programme.

## 4.7 Facilitating factors

Countries mentioned that their small size (both geographical and population) was a great advantage since it was easier to reach everyone in an equitable manner. The ability to obtain high-level support and government commitment was also mentioned as key facilitators in most country case stories; countries reported the ease of working once a decision was taken from the top by a prime minister or a group of key ministers. The commitment of people at local and policy levels facilitated the intersectoral collaboration process and made for ownership of the initiative. Many case stories reported that support from nongovernmental actors, the private sector and the media in promoting initiatives was of considerable value.

The existence of international commitments and adopted global/regional policy frameworks facilitated intersectoral collaboration. Subregional technical networks facilitated the exchange and communication of knowledge, lessons and experiences which helped in working intersectorally.

## 4.8 Challenges

Countries reported general challenges as lack of funding, shortage of staff and insufficient time. Most countries reported no budget allocation for intersectoral action. Capacity-building for health advocacy is needed. One country lacked available evidence to show the positive financial benefits of investing in disease prevention. Linked to this was the challenge of how to show non-health sectors that their contribution to health could help them achieve their particular development goals, agenda and policy priorities. Some countries initially faced resistance to intersectoral working; thinking beyond each sector's own silo was often overcome once the benefits of intersectoral work were apparent. Countries reported that maintaining the continuity of work despite possible changes in government at national and/or local levels, as well as keeping work streamlined were challenges.

One country, focusing on overweight and obesity, found that its initiative seemed to conflict with parent work schedules. Family fear of child stigmatization was also a challenge to overcome. Initial resistance from the private sector, such as a company's concern about its reputation or another's concern about a decrease in the sale of bakery products, were overcome. Some challenges were outside the control of the initiative, such as shops located near schools that sell unhealthy food.

## 4.9 Gender, equity and human rights

In a few case stories, health issues, such as overweight and obesity, were examined by gender to see if one gender was more affected than another. In another, gender was taken into consideration by considering the physical activity preferences of adolescent girls. The other case stories did not mention gender as they focused on issues affecting the entire population.

Most country case stories considered equity in their strategic goals that ranged from protecting all children (e.g. from sexual exploitation or unhealthy food) to ensuring equal access to the initiatives (regardless of cost or geographical location). Examples include equitable uptake of physical activity by making it affordable and attractive. Ensuring equity is also considered in a case where the salt content was reduced in food (bread) consumed by most of the population. While case stories reported aiming to make interventions feasible and obtainable for all, this was not always the case since many factors, such as parent work schedules, were not under the control of the intersectoral initiative.

Human rights and the right to health were considered as part of most case stories' strategic goals. Children's health, including ensuring present and future psychological well-being as a human right, is a foundation for many case stories.

## 5. Recommendations

On the basis of the lessons learnt, a number of recommendations can be made.

A health issue should be chosen that can be linked to:

- international political commitments
- related national strategy, survey or other convincing data
- existing legislation or legislation in the making.

High-level political support for intersectoral action should be obtained early on.

Non-health sectors should be engaged early on and aim for diversity to ensure that sufficient topic-specific expertise is available to address all determinants of health.

Intersectoral action should be initiated by:

- identifying common goals and interests;
- establishing a working group, committee and agreements on ways of working early on;
- ensuring the flow of continuous dialogue and feedback (e.g. by using a web-based or other platform); and
- utilizing participatory approaches to involve all stakeholders including civil society, NGOs, the media and other associations.

Existing collaborations should be built on, such as already functioning working groups and related projects.

Capacity for health advocacy and financial arguments for investing in health promotion should be strengthened.

Financial mechanisms should be identified that are linked to European Commission projects, WHO biennial collaborative agreements and bilateral projects with other countries or regions (e.g. WHO Regions for Health Network or WHO Healthy Cities).

Governance mechanisms should be institutionalized to cover the initiative's lifespan.

Evaluation activities should be planned early on so they take place periodically.

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Health and well-being are affected by social, economic and environmental determinants. Intersectoral action can play a crucial role in addressing today's biggest public health challenges. This report shows how eight small countries, with a population of less than one million, used intersectoral action to address a diverse set of health needs, thus sharing their knowledge on implementing Health 2020. Many sectors were involved in the country case stories with the health sector taking the lead in most cases, coordinating action and engaging other players. The other main sectors involved were agriculture, education, family affairs, interior, labour, justice, sports and tourism. The case stories reveal a number of mechanisms that facilitated intersectoral action with lessons learnt focusing on the importance of establishing common goals, engaging sectors and implementing mechanisms for intersectoral work.

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