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CHRODIS+
IMPLEMENTING GOOD PRACTICES FOR CHRONIC DISEASES

D5.4 Recommendations for intra- and inter-sectoral collaboration for health promotion and chronic disease prevention

WP5 Health Promotion and Disease Prevention

Task 5.3 To support health promotion across the broader health system

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The CHRODIS PLUS Joint Action

CHRODIS PLUS is a three-year initiative (2017-2020) funded by the European Commission and participating organisations. Altogether, 42 beneficiaries representing 20 European countries collaborate on implementing pilot projects and generating practical lessons in the field of chronic diseases.

The very core of the Action includes 21 pilot implementations and 17 policy dialogues:

- The pilot projects focus on the following areas: health promotion & primary prevention, an Integrated Multimorbidity Care Model, fostering the quality of care for people with chronic diseases, ICT-based patient empowerment and employment & chronic diseases.
- The policy dialogues (15 at the national level, and 2 at the EU level) raise awareness and recognition in decision-makers with respect to improved actions for combatting chronic diseases.

A heavy price for chronic diseases: Estimates are that chronic diseases cost EU economies €115 billion or 0.8% of GDP annually. Approximately 70% to 80% of healthcare budgets across the EU are spent on treating chronic diseases.

The EU and chronic diseases: Reducing the burden of chronic diseases such as diabetes, cardiovascular disease, cancer and mental disorders is a priority for EU Member States and at the EU Policy level, since they affect 8 out of 10 people aged over 65 in Europe.

A wealth of knowledge exists within EU Member States on effective and efficient ways to prevent and manage cardiovascular disease, strokes and type-2 diabetes. There is also great potential for reducing the burden of chronic disease by using this knowledge in a more effective manner.

The role of CHRODIS PLUS: CHRODIS PLUS, during its 36 months of operation, will contribute to the reduction of this burden by promoting the implementation of policies and practices that have been demonstrated to be successful. The development and sharing of these tested policies and projects across EU countries is the core idea driving this action.

The cornerstones of CHRODIS PLUS: This Joint Action raises awareness of the notion that in a health-promoting Europe - free of preventable chronic diseases, premature death and avoidable disability - initiatives on chronic diseases should build on the following four cornerstones:

- health promotion and primary prevention as a way to reduce the burden of chronic diseases
- patient empowerment
- tackling functional decline and a reduction in the quality of life as the main consequences of chronic diseases
- making health systems sustainable and responsive to the ageing of our populations associated with the epidemiological transition

Abbreviations

BG1	Bulgaria: National Programme for Prevention of NCDs
CR1	Croatia: Living Healthy
DK1	Denmark: The Hygiene Week
ES1	Spain: The Andalusian Strategy of Local Action in Health
FL1	Finland: Tobacco Cessation Services for Patients with Mental Health Disorders and Substance Abuse
FL2	Finland: VESOTE life counselling project
FL3	Finland: The Strength in Old Age Programme
GP	Good Practice
HiAP	Health in All Policies
HPDP	Health Promotion and Disease Prevention
HU1	Hungary: The process towards a smoke-free Hungary – Tobacco control in practice
IS1	Iceland: Coordinated strategy and action in health promotion for school health care
IT1	Italia: Walking on the path of wellbeing
IT2	Italia: Gaining Health - making healthy choices
IT3	Italia: The Lombardy Workplace Health Promotion Network
JOGG	Jongeren op Gezond Gewicht (Young People at Healthy Weight)
LT1	Lithuania: Health promotion program for people with risk of cardiovascular disease and diabetes
MT1	Malta: Living with Diabetes: Education and Weight Management
NCDs	Non Communicable Diseases
NL1	The Netherlands: Jongeren op Gezond Gewicht (JOGG; Young People at Healthy Weight)
NL2	The Netherlands: Healthy Overvecht
PL1	Poland: Prevention of cardiovascular system and respiratory system diseases

PT1	Portugal: National Health Plan (Plano Nacional de Saúde)
PT2	Portugal: Healthy Aveiro Programme
RIVM	National Institute of Public Health and Environment, the Netherlands
RS1	Serbia: Roma health mediators
WP	Work Package

Glossary

Term	Definition
Best practice	A best practice is a relevant policy or intervention implemented in a real life setting and which has been favourable assessed in terms of adequacy (ethics and evidence) and equity as well as effectiveness and efficiency related to process and outcomes. Other criteria are important for a successful transferability of the practice such as a clear definition of the context, sustainability, intersectorality and participation of stakeholders[1].
Chronic diseases	Diseases that are not passed from person to person. They are of long duration and generally slow progression. The four main typesare cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes [2].
Disease prevention	Disease prevention, understood as specific, population-based and individual-based interventions for primary and secondary (early detection) prevention, aiming to minimize the burden of diseases and associated risk factors[3].
Discipline	A branch or domain of knowledge, instruction, or learning. Nursing, medicine, physical therapy, and social work are examples of health-related or professional disciplines[4].
Good practice	A good practice is not only a practice that is good, but a practice that has been proven to work well and produce good results, and is therefore recommended as a model. It is a successful experience, which has been tested and validated, in the broad sense, which has been repeated and deserves to be shared so that a greater number of people can adopt it[5] .
Health promotion	Health promotion enables people to increase control over their own health. It covers a wide range of social and environmental interventions that are designed to benefit and protect individual people's health and quality of life by addressing and preventing the root causes of ill health, not just focusing on treatment and cure[6].
Intersectoral collaboration	Recognized relationship between a part or parts of the health sector with a part or parts of another sector that has been formed to take action on an issue to achieve health outcomes or (intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone[7]

[1] Definition of Steeringgroup on Health Promotion and Disease Prevention
[2] Source http://www.who.int/topics/noncommunicable_diseases/en/
[3] http://www.emro.who.int/about-who/public-health-functions/health-promotion-disease-prevention.html
[4] https://medical-dictionary.thefreedictionary.com/disciplines
[5] Definition used in JA CHRODIS 2014-2017
[6] https://www.who.int/news-room/q-a-detail/what-is-health-promotion
[7] Dubois *et al.* [1]

Term	Definition
Ottawa Charter	The first International Conference on Health Promotion was held in Ottawa in 1986, and was primarily a response to growing expectations for a new public health movement around the world. It launched a series of actions among international organizations, national governments and local communities to achieve the goal of "Health For All" by the year 2000 and beyond. The basic strategies for health promotion identified in the Ottawa Charter were: advocate (to boost the factors which encourage health), enable (allowing all people to achieve health equity) and mediate (through collaboration across all sectors)[8]
Sector	A complex of organisations that share basic characteristics[9]
4D model	This is a model to methodically map the patient's problems. While filling out the 4D model, the professional looks together with the patient at what is going well in the domains of body, mind, social and relations/network, and what problems there are. This model is used in the Netherlands in the primary health care but also in social care[10]

[8] https://www.who.int/healthpromotion/conferences/previous/ottawa/en/

[9] Derived from Salamon (1992) In search of the non-profit sector. I: The question of definitions. International Journal of Voluntary and Nonprofit Organizations, Jaargang:3, Uitgave:2, Pagina(s):125

[10] See table 1, nr 2 for description of practice and page 29 of this report

Executive summary

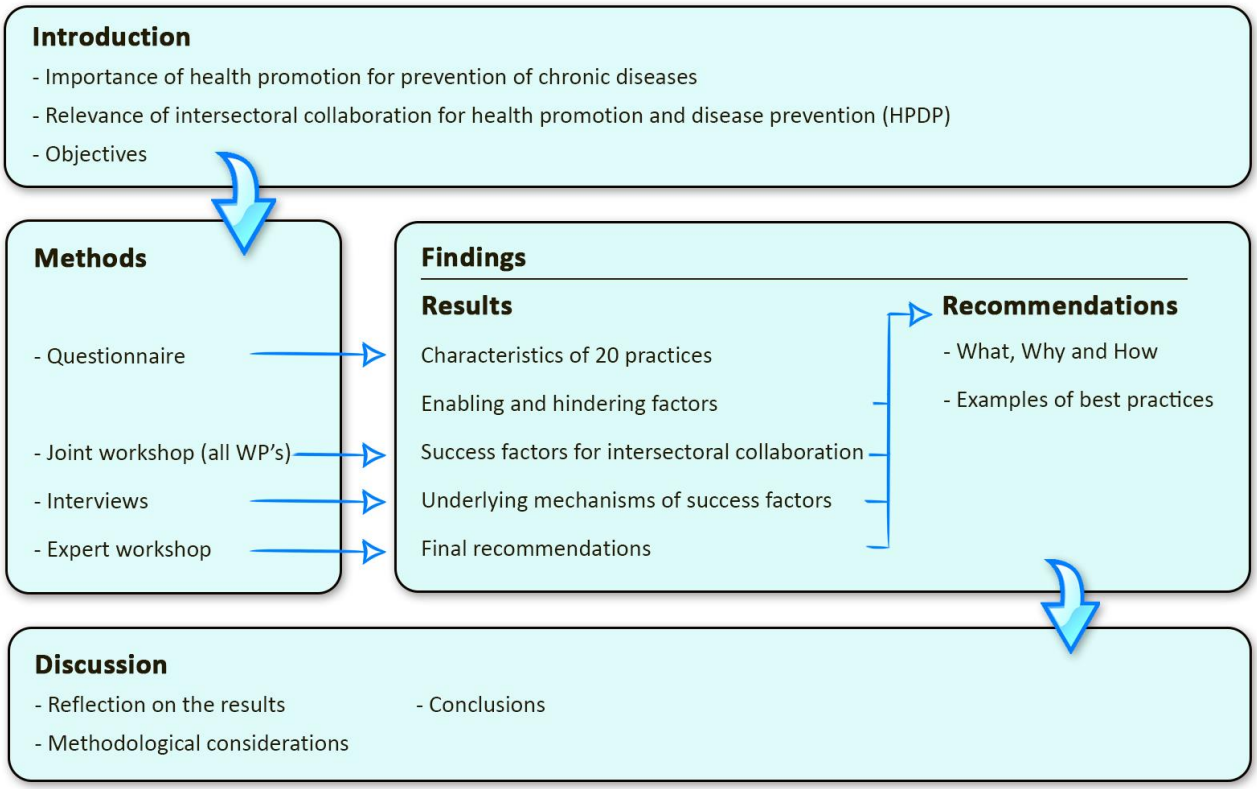
The burden of chronic disease in Europe continues to grow. A major challenge facing National governments is how to tackle the risk factors of sedentary lifestyle, alcohol abuse, smoking, and unhealthy diet. These factors are complex and necessitate intersectoral collaboration to strengthen health promotion activities, counter-act the social determinants of health, and reduce the prevalence of chronic disease. European countries have diverse intersectoral collaboration to encourage health promotion activities. In Joint Action CHRODIS PLUS work package (WP) 5 task 3 we sought to identify success factors for intersectoral collaboration within and outside health care which strengthen health promotion activities.

An online questionnaire was developed to explore the role of intersectoral collaboration in health promotion good practices. Representatives of twenty good practices in fourteen European countries responded to the survey and data on enablers and barriers for intersectoral collaboration was extracted. , a workshop was held with partners from all CHRODIS PLUS work packages aimed at formulating success factors and recommendations on intersectoral collaboration. Then, from the original twenty practices six health promotion interventions were identified for in-depth interviews. The aim of the interviews was to identify the underlying mechanisms of the success factors for intersectoral collaboration, and to probe further into how they were achieved, as well as the barriers that arose and how they were overcome. Based on all results recommendations for successful intersectoral collaboration were drafted. These draft recommendations were then presented to two experts and to all partners within the work package in a second online workshop. The aim was to reach consensus on a final set of recommendations that are considered to be essential for fostering intersectoral collaboration and improving health promoting activities.

In the framework of the Joint Action CHRODIS PLUS, WP5 task 3 examined twenty identified good practices of intersectoral collaboration in health promotion from all over Europe. These were predominantly national programs with regional components and consisted of a mix of interventions, and examples included community interventions, policy actions, integrated approaches, capacity building or training activities. Most practices worked together with more than six sectors outside the health care sector. Experiences associated with successful intersectoral collaboration were synthesized to determine cross-cutting barriers and enablers and generate a set of seven recommendations. Each recommendation includes concrete steps to implement the recommendation and was found, in general, to be in line with the literature. The recommendations include: connecting with existing policies and advocating for political support, defining a shared vision, creating an effective mix of different partners, encouraging effective leadership, keeping collaboration partners engaged, using a planned systematic approach, and ensuring sufficient resources to sustain the collaboration (see textbox below). These recommendations and their implementation strategies will be used by CHRODIS PLUS partners to enhance intersectoral collaboration and consequently strengthens health promotion activities in intervention programs across Europe.

1. Connect collaboration goals with existing key policies, while actively advocating for political support: *Political support is a prerequisite to get resources allocated for the implementation and for the sustainability of health promotion programs. In order to gain political support, the collaboration goals should be aligned with key policies*
2. Define a shared vision of the problem to be solved aligned with organisational goals: *Commitment of all partners is crucial for successful collaboration. Agreeing on the problem to be solved and defining a shared vision of how to solve the problem helps to create this commitment.*
3. Create an effective mix of different partners with diverse background and skills: *To be able to reach the target group effectively, all relevant parties that could influence the health behaviour of the target group should be involved in the collaboration.*
4. Build bridges between sectors and disciplines through effective leadership: *Leadership is essential and closely tied to strong working relationships and a transparent process for collaboration. Effective leadership fosters trust and good working relationships between collaboration partners.*
5. Keep collaboration partners in all sectors engaged: *Crucial for the success of the collaboration is keeping the partners engaged by informing, motivating and entrusting them, thus sustaining commitment of all partners.*
6. Use a planned/ systematic approach suitable for all partners: *Using a systematic approach based on scientific evidence and on experiences from the past will improve the implementation of the collaboration in each sector. Moreover, this systematic approach should allow all partners to combine their health promotion efforts and enhance the effectiveness of the programme.*
7. Ensure sufficient resources to sustain the collaboration: *To establish a sustainable collaboration it is important that resources, such as dedicated time, qualified personnel and funding, are and remain available. The distribution of these resources should be transparent and fair to all partners.*

Content overview of the report ***Recommendations for intersectoral collaboration for health promotion and disease prevention***



Introduction

Introduction

- Importance of health promotion for prevention of chronic diseases
- Relevance of intersectoral collaboration for health promotion and disease prevention (HPDP)
- Objectives

Supporting health promotion across the broader health system

Chronic diseases are the leading cause of mortality and morbidity in Europe [2-4]. One of the strategies to decrease the burden of chronic disease in Europe is tackling the major risk factors such as sedentary lifestyle, alcohol abuse, smoking and unhealthy diet [5-8]. There is much evidence of the value of health promotion to health systems performance, outcomes, and sustainability [9-11]. Disadvantaged groups, however, are often out of reach of health promotion activities [5]. Reasons for infrequent uptake include the fragmentation of services and lack of integration within regular care [12].

Another cause of the difficulty to tackle the problem is the complex nature of chronic diseases [13]. Wider social determinants are underlying causes of unhealthy behaviour and the onset of chronic diseases [14]. These social determinants of health are complex, dynamic, and interdependent [15, 16]. Given this interdependent nature of the determinants, inter- and intra-sectoral collaboration is necessary. The health sector alone, even with intra sectoral collaboration, cannot solve such a complex problem [7, 10, 17-19]. Therefore, collaboration between different sectors is urgently required to improve health across society [20-22].

For example, concerning impact on areas of life such as the employment sector, recent data from 27 EU member states showed that about one quarter of the working age population (23.5%) had a chronic disease, while 19% reported having long-standing health issues. Work and health are interrelated in many ways. The ageing of the working population combined with the dramatic low employment rates of persons with chronic diseases is an indicative depiction of this particular relation [23, 24]. All mechanisms should champion the importance of strengthening health promotion, preventive services, public health, and social care [25]. This includes engaging partners from other sectors and identifying opportunities for collaboration and seeking synergies to improve health system performance, outcomes and sustainability.

In this task we were interested in examining both collaborations within the health care sector (intra sectoral collaboration) and also between health and non-health sectors (intersectoral collaboration). Improved health care collaboration is promoted as one the key strategies for health care reform. However, in the context of health promotion, it is very difficult to examine intra sectoral collaboration as separate from intersectoral collaboration. The large scale health promotion programs undertaken by Joint Action CHRODIS-PLUS partners typically address social determinants and aim for wide reach that include vulnerable at-risk groups. In these types of comprehensive health promotion programs, intra sectoral and intersectoral collaboration co-exist and their effects cannot be easily disentangled. Given the focus in CHRODIS-PLUS Work

Package 5 on analysis of health promotion and disease prevention strategies that are primarily national in nature, intersectoral collaboration is heavily emphasized in this task.

Intersectoral collaboration

Since the Ottawa Charter [26] introduced the importance of intersectoral collaboration for health and reduction of health inequalities, numerous studies have been published. A variety of terms and definitions has been used for the collaborative work in the public health and health care: intersectoral action, intersectoral action for health [1], intersectoral cooperation [27], intersectoral collaboration [28, 29] and intersectoral partnerships [30]. The terms are often being used interchangeably. In his review, Dubois et al searched for a consensual definition for the intersectoral work but could not find this definition [1]. They built their own definition based on the structure What: *what is the action* (process, collaboration, coordination), Who: *who are the actors conducting the collaboration* and Why: *what are the goals or objectives of the action*? Their definition for intersectoral action for health is: *recognized relationship between a part or parts of the health sector with a part or parts of another sector that has been formed to take action on an issue to achieve health outcomes or (intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone [1]*. This intersectoral collaboration can take place on different levels [31]:

- *horizontal collaboration* between sectors within health sector and between health and non-health sectors
- *vertical collaboration* between different levels of government, geography or organization

Collaboration with many parties is important for success in health promotion and reduction of health inequalities but is also challenging. It is important to build on what is already known about the important elements for intersectoral collaboration. Danahar [31] identified successful elements for intersectoral collaboration aiming to reduce health inequalities such as a powerful shared vision of the problem and what success would look like; strong relationship among partners (effective mix) ; leadership, both in advancing shared purposes, sustaining the collaboration and adequate resources; efficient structures and processes to do the work. Similar elements are shown in the study which focused on the collaboration with the primary health care: enhance staff satisfaction, define and sell program goals, professional capacity, establish flexible legal and structural framework, build trust, promote collaboration as competency, develop nationals goals through organic participatory processes, align structural incentives according to program goals, create organizational synapses through information technology, develop innovative monitoring and evaluation schemes [32]. Storm *et al.* [33] identified five steps as basis for Health in All Policies (HiAP): involvement of the appropriate policy sector in public health, harmonization of objectives across, coordinated use of policies and actions by relevant policy sectors, formalised collaboration and experience amongst relevant policy sectors and favourable contextual factors.

Many factors are contextual [32], but some general facilitating elements for intersectoral collaboration can be derived: shared vision of problems to be addressed, strong relationship among partners,

mutual and joint benefits/win-win, resources and funding, communication, involvement of community and target group, leadership, capacity building/ training, time to build a relationship and macro level context (e.g. changes on system level). These general elements provided base for the online questionnaire. Along with these important elements of intersectoral collaboration we were interested in the processes behind these success factors. How do you get a win-win situation within health care and between health care and other sectors? Do you have instruments or tools which enable the collaboration? These enabling factors and barriers will be the focus of this report and are translated into recommendations on how to achieve intersectoral collaboration.

Joint Action CHRODIS PLUS

The Joint Action CHRODIS PLUS (2017-2020, http://chrodis.eu/) aims to support European countries to improve the ***prevention*** of chronic diseases as well as their ***management***, by piloting and implementing innovative approaches that have proven to be successful in other countries or settings. To enable this, the CHRODIS PLUS partners have defined several work packages that *either* focus on implementation of health promotion and disease prevention (HPDP) strategies related to chronic diseases (WP5) *or* on (further) implementation of integrated care approaches within the health system -and preferably in collaboration with other sectors- to manage chronic diseases and their consequences for individuals and societies (WPs 6, 7 and 8). Work Package 5 on health promotion and disease prevention has involved analysis of primarily national programs, with intersectoral collaboration playing a prominent role, whereas intra sectoral collaboration plays a more prominent role in Work Packages 6 and 7.

Objectives

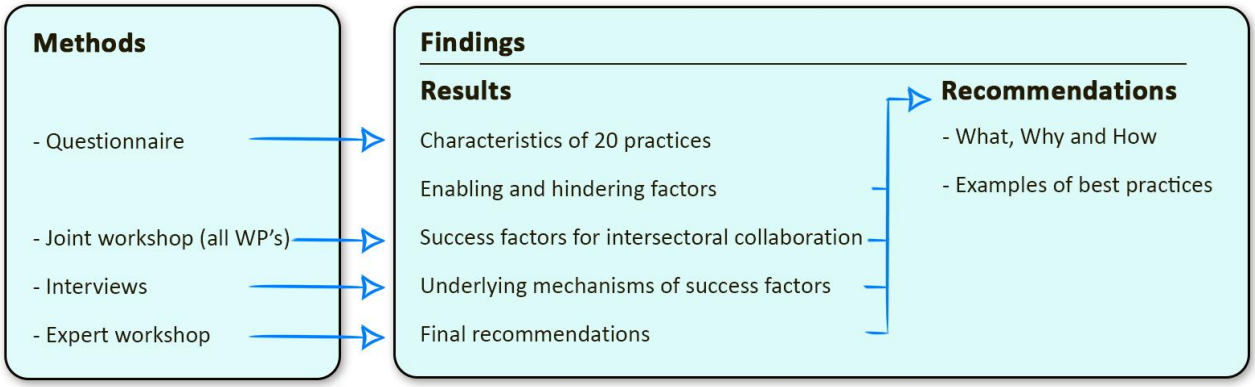
The aim of WP5 task 3 is to stimulate and strengthen health promotion activities by identifying success factors for intersectoral collaboration within and outside health care. This includes social care, education, employment, and other sectors.

In this report, we present cross-cutting success factors for intersectoral collaboration identified through the analysis of twenty different European good practices in health promotion and disease prevention, both in national and community settings. These were collected by 22 partners from fourteen countries participating in WP5 of CHRODIS PLUS. In the Methods section each phase of the study is described in more detail. Next, the results of each phase are presented, including the final recommendations together with illustrative examples from the good practices (see Findings section). In the Discussion we reflect on these findings, place them in an international context, reflect on the methodology of the study and draw conclusions (see Conclusions).

Methods

To identify best/ good practices on intersectoral collaboration, the National Institute for Public Health and the Environment in the Netherlands developed together with the partners from Finland and Hungary an online questionnaire. Data collection and analysis to identify success factors for intersectoral collaboration involved different phases:

1. **Online questionnaire** regarding intersectoral collaboration in health promotion practices
2. **Joint Workshop** examining intersectoral collaboration in health promotion interventions
3. **Semi-structured interviews** to provide in-depth insight into intersectoral collaboration in health promotion interventions
4. **Drafting of recommendations** for successful intersectoral collaboration and **expert workshop** to finalize these recommendations.



Phase 1: Online questionnaire regarding intra and intersectoral collaboration in health promotion practices

To identify best/ good practices on intersectoral collaboration the National Institute of Public Health and Environment (RIVM) in the Netherlands developed, together with the partners from Finland and Hungary, an online questionnaire (see Appendix 1). This questionnaire was created based on a review of the literature regarding intersectoral collaboration in health promotion and the criteria for best practices of the Steering Group of Health Promotion and Disease Management (https://ec.europa.eu/health/non_communicable_diseases/steeringgroup_promotionprevention_en).

In April, 2018 CHRODIS+ WP 5 task 3 Partners received a link to the online survey. Each partner was asked to select good health promotion interventions in their own country that exemplified effective intra and/ or intersectoral collaboration and to fill out the questionnaire for each intervention. In some cases, best practices were selected, these are practices that were validated as best practice and in other cases good practices (not validated). We use the term good practices for all practices in this report.

The questionnaire asked the partners **to identify good practices** involving so-called horizontal collaboration within healthcare and between the broader health system and other sectors, as well as their

enablers and barriers. In the survey, definitions for the key concepts were provided with examples in order that all start from the same conceptual framework (see definitions in the introduction), and criteria were explained that need to be fulfilled to qualify as best practice, and examples of best practices and innovative practices were given. Criteria were for example: intervention characteristics, effectiveness, transferability and sustainability. In total, data from twenty health promotion interventions in fourteen countries were received and analysed.

For the analysis of the questionnaire we developed a classification score first. The elements included in this list were derived and adapted from the multiple choices questions in the questionnaires and derived from the literature. Two experts in health promotion coded the textual data obtained from the online survey. The final coding was agreed by consensus. In cases where consensus could not be reached, a third expert was consulted. The frequency of the scores were presented in tables. At this stage the partners were asked for feedback and suggestions for further analyses (such as more illustrative examples from practices).

Phase 2: Workshop examining intersectoral collaboration in health promotion interventions

In May 2019, CHRODIS PLUS Partners from all Work packages participated in a workshop lead by Work Package 5 on intersectoral collaboration in health promotion. Seventy-five professionals from different sectors, including health care, employment, and public health / health promotion, attended. Three different health promotion interventions, one disease management practice and a national program from five countries were presented to 75 participants for discussions aimed at formulating success factors and recommendations on intersectoral collaboration. Three practices (Healthy Overvecht (NL2), Vesote Lifestyle Counseling, Health Promotion for people at risk of cardiovascular disease and diabetes) were practices which were included in Table 1b (see findings). Two practices came from other sources: Integrated care for People with chronic wounds[11] was a practice from another Work Package (WP7) to increase interaction among members of the partnership. Hungary was the host country of the workshop and presented the National Obesity Plan[12] as key note presentation and example of intersectoral collaboration on national level. Participants from different sectors, including health care, employment, and public health / health promotion, were involved.

At the workshop, an experienced facilitator, familiar with the results of the Phase 1 online survey, led a discussion about the role of intersectoral collaborations in the intervention. Success factors enabling effective intersectoral collaboration were identified during the small group discussions focusing on the five above mentioned examples. With three questions the facilitator helped the groups to formulate recommendations to improve intersectoral collaboration. These questions were:

- Have you heard interesting tips /examples to improve the collaboration process on national /local level (depending on the practice)?

[11] **Integrated care for people with chronic wounds:** implemenation of a model to integrate care within and outside healthcare for people with chronic wounds. The program entails preventive visits by nurses, new programs e.g. physical activity for elderly people and for people with type 2 diabetes in the health promotion centres and collaborarton with social care institutes (Slovenia).

[12] **National Obesity Plan**: National plan with a mix of interventions to prevent overweight and obesity: for children and adults (Hungary).

- Does this information about success factors help your collaboration process on national level /local level?
- What are your recommendations for task 5.3 on national level/ local level?

The data collected during the workshop on success factors and recommendations (see Appendix 3) were coded by two experienced experts in health promotion using the Phase 1 data as a guide.

Phase 3: Semi-structured interviews to provide in-depth insight into intersectoral collaboration in health promotion interventions

Although we clearly identified several important factors for intersectoral collaboration from the questionnaire, we had little information about what actions or steps might be needed in order to achieve these success factors. A semi-structured interview guide was developed in order to further explore strategies to carry out intersectoral collaboration in health promotion interventions effectively. The aim of the interview was to identify the underlying mechanisms of the success factors, in other words, to understand how the success factors worked in each intervention. Enabling and hindering factors were examined, as well as ways to overcome barriers that arose during the intersectoral collaboration process.

From the original twenty practices in Table 1 six health promotion interventions in four countries were identified for in-depth case study analysis representing different type of programs (national and community) and topics (overweight, smoking cessation, healthy lifestyle and integrated medical and social care: JOGG (Netherlands), Healthy Overvecht (Netherlands), Vesote Lifestyle Counseling (Finland), Tobacco Cessation Services (Finland), Smoke-free Hungary (Hungary), Lombardy Workplace Health Promotion Network (Italy). See Table 1 for specific details on these interventions. Three of the six practices were also discussed during phase 2.

CHRODIS PLUS Work Package 5 task 3 partners interviewed the professional most familiar with the selected health promotion intervention in their native language. After the conclusion of the interview, an English summary of the data collected was provided. Three RIVM researchers analysed the information in the interview summaries concerning the promoting and hindering factors and how to facilitate or compensate for such factors. Each interview was analysed by two researchers and in case of any discrepancies in coding a third researcher was used to reach consensus. Using the list of factors identified in the Phase 1 questionnaire, associated information was coded into recommendations. In case of doubt, the assistance of the third investigator was asked. The final coding was established by consensus. This coding was checked and agreed upon by the other Work Package partners.

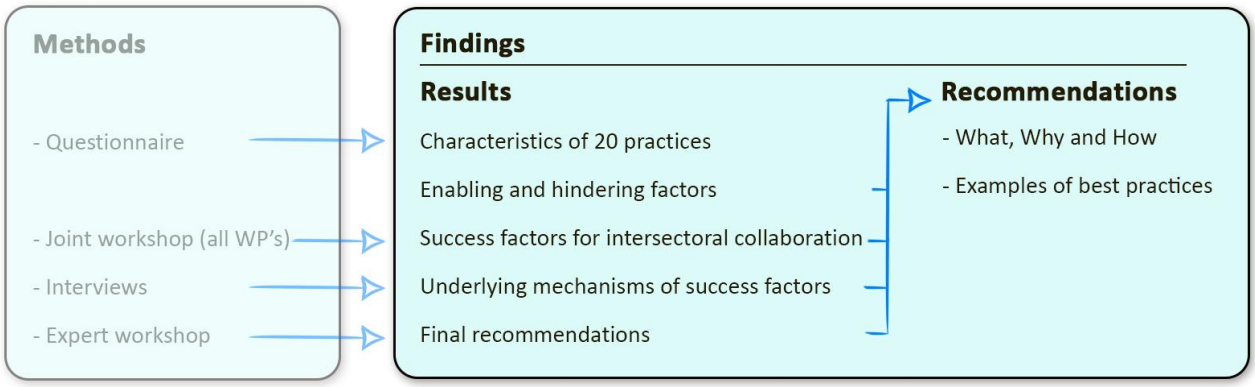
Phase 4: Drafting of recommendations for successful intersectoral collaboration and expert workshop to finalize these recommendations

The coded recommendations from the interviews and workshop were combined. Recommendations were clustered by theme by three researchers and consensus was reached on these clusters. Then these clusters were sent to the other Work Package partners. One of the clusters was split up based on feedback, and consensus was reached again. This process led to the six main recommendations. Then for each recommendation the rationale (Why?) and the actions/ steps (How?) were described. Also, for each

recommendation an example is given based on the interviews. This example describes in more detail one or more of the actions/ steps listed under the 'How'. These draft recommendations and supporting data were sent to the Work Package leaders and co-task leaders for feedback. Consensus was reached on some adaptations in these six recommendations in which both the rationale (Why?) and the actions/ steps (How?) could be detailed and illustrated with an example from the Phase 3 semi-structured interviews.

The draft recommendations were discussed and finalized with all CHRODIS PLUS Work Package partners at a second workshop in 2020. Because of the outbreak of COVID-19, the planned in-person workshop was not feasible, and we organized an online meeting to finalize the recommendations presented in this report in May 2020. In preparation of this workshop an online questionnaire was sent to all participants. They were asked whether they thought the draft recommendations (including the Why and How) were feasible or needed adaptations. Additionally, prior to the workshop two experts, one in integrated health care and one in intersectoral collaboration outside the health care sector, were asked to reflect on the draft recommendations. The feedback of both partners and experts were summarized and adaptations were made to the recommendations accordingly, which resulted in the addition of a 7th recommendation. Prior to the workshop a document with the feedback and track changes and a clean document with the recommendations were sent to all participants. The aim of the workshop was to finalize the recommendations; an experienced facilitator debated the last points of discussion brought in by the participants to reach consensus (see Appendix 4).

Findings



Characteristics of the selected health promotion interventions

General characteristics of the health promotion interventions

The Phase 1 online survey resulted in data from twenty health promotion interventions in fourteen countries. Table 1 describes each intervention, its type and duration, and its aim(s) and target population. In short, most of the interventions (N=17) focused on both health promotion and specific disease prevention, with only three interventions solely addressing health promotion. The health promotion interventions aimed to improve unhealthy lifestyle factors such as unhealthy diet, smoking, sedentary lifestyle, alcohol misuse and stress. Improving health literacy and reduction of health inequalities were also targeted. Of the total 20 interventions almost all (N=16) were national programs and long-lasting, with a typically duration of more than five years (Table 1). These programs consisted of a mix of discrete health promotion strategies such as community interventions, policy actions, integrated approaches, capacity building and/or training. Since most programs consisted of a mix of interventions, the degree of collaboration was considerable. Half of the interventions worked together with three or more disciplines within the health care. Eight collaborated with more than six sectors outside the health care sector and seven engaged in intersectoral collaboration with three to five sectors outside the health care sector. Four interventions collaborated with two other sectors. One intervention did not specify this information about collaborating disciplines or sectors. Because of the wide range of practices there was also a wide range of collaborating parties such as ministries (Health, Education, Family Youth and Social Welfare, Social sector, Employment, etc.) at national level; private organizations such as food industries; (primary) health care and public health organizations, patient organizations such as Lung foundation or Diabetes Association or senior clubs, local authorities, hospitals, schools, public health institutes, school of public health, etc. Of the twenty practices three marked in the survey that they were intra sectoral collaborations. Closer examination of the data of these practices showed us that two involved intersectoral collaboration as well – one with collaboration between school and child health services/ primary care and the other with collaboration between geriatric clinics and social welfare clinics and senior centers/ clubs. Only one practice primarily targeted collaboration within the health care sector (Finland, tobacco cessation). This program focused on collaboration among hospitals, mental health care, and NGOs in public health, with the

involvement of NGOs crossing sectors. Moreover, we have compared their enablers and barriers to the ones of the other practices and there seems to be no difference in the factors mentioned. Furthermore, some of the other 17 practices involve inter-disciplinary collaboration within health care (i.e. intra sectoral collaboration) alongside intersectoral collaboration. Because the data gathered provided insight primarily into recommendations for intersectoral collaboration, intersectoral collaboration was viewed as a key ingredient to reach health promotion and disease prevention aims. Therefore, the analysis and resulting conclusions in this report emphasize intersectoral collaboration.

Table 1. Overview of good practices on Health Promotion (see also Appendix 2)

	Practice	Topic and Themes	Type	Target group	Collaboration
1	**Young people at a healthy weight (JOGG)** Netherlands: **NL1** 2010- ongoing *Interview*[1]	Health promotion: overweight, physical activity, reduction of health inequalities and healthy nutrition	• National program • Community intervention • Policy action • Integrated approach • Training and capacity building	Children aged 0-19 years and intermediary groups (e.g. teachers, sport coaches, business partners, health professionals)	>6 sectors 3 disciplines
2	**Healthy Overvecht:** Integrated medical and social basic care Netherlands: **NL2** 2006- ongoing *Workshop*[2] *Interview*[1]	Health promotion and disease prevention: lifestyle factors, health literacy, wellbeing, reduction of health inequalities and social problems	• Community intervention • Integrated approach	All inhabitants of the neighbourhood, most having a low social economic status.	3-5 sectors >6 disciplines
3	**Prevention of cardiovascular system and respiratory system diseases - using Comprehensive Geriatric Assessment** Poland: **PL1** 2018- 2019	Health promotion and disease prevention: wellbeing, prevention of diseases of the cardiovascular and respiratory system and reducing the health risks of older people	• Policy action • Regional program (local program)	People aged 60+ and their carers.	3-5 sectors 4-5 disciplines
4	**National Health Plan / Plano Nacional de Saúde** Portugal: **PT1** 2012-2020	Health promotion and disease prevention: overweight, physical activity, alcohol prevention, smoking, self-management, health literacy, wellbeing, reduction of health inequalities	• National program • Community intervention • Policy action • Integrated approach	General Portuguese population and health Professionals	More than 6 sectors >6 disciplines
5	**Tobacco Cessation Services for Patients with Mental Health Disorders and Substance Abuse** Finland: **FI1** 2017-2018 *Interview*[1]	Health promotion and disease prevention: smoking	• National program • Health Service Delivery • Policy action • Training, capacity building • Online intervention program	11 hospital districts are involved: a multi-professional tobacco cessation expert group has been established in all hospital districts	2 sectors 3 disciplines
6	**Healthy Aveiro Programme**	Health promotion and disease prevention:	• Community intervention	Groups experiencing	3-5 sectors 3 disciplines

	Practice	Topic and Themes	Type	Target group	Collaboration
	Portugal: **PT2** 2013- ongoing	health literacy, reduction of health inequalities	• Integrated approach	socioeconomic vulnerability, adverse health conditions, and/or have low health literacy.	
7	**Health promotion program for people with risk of cardiovascular disease and diabetes** Lithuania: **LT1** 2015- ongoing *Workshop[2]*	Health promotion and disease prevention: overweight, physical activity, alcohol prevention, smoking, self-management, health literacy and wellbeing	• National program	1) Persons at the age of 40-65 years selected for Prevention Program CVD"; 2) Adults, who are assigned to persons at risk.	3-5 sectors -
8	**Walking on the path of wellbeing** Italia: **IT1** 2012 –2014	Health promotion and disease prevention, physical activity and wellbeing	• Integrated approach	People with sedentary behaviour, in particular patients with chronic diseases and those over 65 years old.	6> sectors 3 disciplines
9	**VESOTE project** Finland: **FI2** 01-2017-12-2018 *Workshop[2] Interview[1]*	Health promotion and disease prevention: overweight, physical activity, heathy food and better sleep without medication	• National program • Health Service Delivery • Integrated approach • Training, capacity building	Physically inactive persons, persons suffering sleep problems, diabetics, coronary patients, overweight and obese patients	> 6 sectors > 6 disciplines
10	**The Strength in Old Age Programme** Finland: **FI3** 2005-ongoing	Health promotion: physical activity, health literacy, wellbeing and reduction of health inequalities	• National program • Policy action • Integrated approach • Training, capacity building • Online intervention program	Community-living 75+ persons with decreased mobility and intersectoral collaboration group	3-5 sectors 3 disciplines
11	**The Hygiene Week** Denmark: **DK1** 2009-2019 (every year)	Health promotion and disease prevention: self-management and health literacy	• National program • Community intervention • Health Service Delivery • Policy action • Integrated approach • Media campaign	General population	3-5 sectors 4-5 disciplines
12	**The Andalusian Strategy of Local Action in Health** Spain: **ES1** 2008 – ongoing	Health promotion and disease prevention: overweight, physical activity, alcohol prevention, smoking, self-management, health literacy, wellbeing and reduction of health inequalities, healthy aging, accident prevention, sexual and	• Community intervention • Policy action • Integrated approach • Training, capacity building • Intersectoral approach • Participation • Governance	General population of 778 municipalities of the Autonomous Community of Andalusia (Spain)	> 6 sectors 4-5 disciplines

	Practice	Topic and Themes	Type	Target group	Collaboration
		reproductive health, violence prevention, gender issues, environmental health, urban health			
13	**Gaining Health - making healthy choices** Italy: **IT2** 2007-ongoing	Health promotion and disease prevention: overweight, physical activity, alcohol prevention, smoking, wellbeing, reduction of health inequalities and nutrition	• National program • Community intervention • Policy action • Integrated approach	Life course approach: addressing all ages and all public and private environments.	> 6 sectors 3 disciplines
14	**Living Healthy** Croatia: **CR1** 2016 – 2022	Health promotion and disease prevention: overweight, physical activity, alcohol prevention, smoking, health literacy, wellbeing and mental health/child depression	• National program • Community intervention • Integrated approach • Training, capacity building	Life course approach: with a special focus on persons with heightened behavioural and biomedical risk factors	>6 sectors 3 disciplines
15	**Coordinated strategy and action in health promotion for school health care** Iceland**: IS1** 2006-ongoing	Health promotion and disease prevention: overweight, physical activity, alcohol prevention, smoking, self-management, health literacy, wellbeing and reduction of health inequalities	• National program	School-aged children (6-15 years old) as well as school nurses, teachers and other school personnel.	2 sectors 3 disciplines
16	**The process towards a smoke-free Hungary – Tobacco control in practice** Hungary: **HU1** 2011-ongoing *Interview*[1]	Health promotion and disease prevention: smoking	• National program • Policy action • Case study	Children, young adults and adults.	2 sectors
17	**Living with Diabetes: Education and Weight Management** Malta: **MT1** **2015**-ongoing	Health promotion and disease prevention: overweight, physical activity, self-management and health literacy	• National program	Overweight and obese patients who have type 2 diabetes.	-
18	**Roma health mediators** Serbia**: RS1** 2009 – ongoing	Health promotion and disease prevention: health literacy, well-being and reduction of health inequalities	• National program • Community intervention • Health Service Delivery • Training, capacity building	Roma ethnic minority population in Serbia.	3-5 sectors and < 2 disciplines-
19	**National Programme for Prevention of NCDs (noncommunicable diseases)** Bulgaria: **BG1** 2014-2020	Health Promotion and disease prevention: overweight, physical activity, alcohol prevention, smoking, self-management, health literacy and main NCDs.	• National program • Community intervention • Health Service Delivery • Policy action • Integrated approach	Life course approach: but especially focuses on women of reproductive age, workplaces, health professionals and	>6 sectors

	Practice	Topic and Themes	Type	Target group	Collaboration
			• Training, capacity building	individuals with low socioeconomic status	
20	**The Lombardy Workplace Health Promotion (WHP) Network** Italy: **IT3** 2014-ongoing *Interview*[1]	Health promotion and disease prevention: physical activity, alcohol prevention, smoking, food, work-life balance and road safety	• Integrated approach • Regional program	All company workers are involved (young adults, adults, male and female).	2 sectors

[1] *This practice has been interviewed for more in-depth information* [2] *This practice has been presented during the workshop*

Target groups of the health promotion interventions

The size and specificity of target populations varied considerably across interventions (Table 1). Some interventions targeted people from different age groups (e.g., infants, children, youth, adults, older adults) and/or their carers (e.g., parents, formal or informal caregivers). Many interventions sought to reach vulnerable or minority groups, such as people with low socio-economic status, immigrants, individuals with low health literacy, and those with high health risks (e.g., history of mental disorders and/or substance abuse, sleep problems, physically inactive or overweight, medical risk factors for specific diseases). To reach the target populations, interventions often targeted different groups of professionals, such as employers, educators, health and social professionals and policy makers.

Degree of intersectoral collaboration within the health promotion interventions

The degree of intersectoral collaboration was often related to the scope of the intervention, and specifically the target population to be reached by the health promotion intervention (Table 1). When the program aimed to reach a large range of the population, high intersectoral collaboration (e.g., more than six sectors and/or three disciplines) tended to be present. The Netherlands' JOGG Program, for instance, was highly intersectoral because they targeted the whole population of young people aged up to nineteen years and the intermediate groups such as private companies, youth health care, schools, sports, municipal health services and welfare. In contrast, interventions carried out in a specific setting collaborated with fewer sectors, although high multidisciplinarity was achieved. For example, Iceland's Program of Coordinated Action and Strategy of Health Promotion in School Health Care worked with two sectors and three disciplines. In general, programs aiming to reduce health inequalities tended to collaborate with six sectors or more.

Framework used for intersectoral collaboration

The majority (N=15) of the health promotion interventions used a framework for collaboration. There was considerable variation in the framework used. Frameworks mentioned were the legal framework (European, national or local laws), a national plan as a logic model with programs, project and activities or the strategy of the practice (e.g. strategy for social inclusion of Roma's). Other examples of frameworks were based on the way they had organized the collaboration such as a national platform set up from the Ministry of Health and

several other ministries, a membership organisation or networking methods. Finally, there were frameworks which described how to implement the work such as the four-domain model to provide care in a uniform way and the manual "How to become a healthy workplace".

Process and outcome evaluation of health promotion interventions

In almost all health promotion interventions (N=19) a process evaluation was performed, in twelve programs an outcome evaluation and six practices added participatory research (see table in Appendix 2). The details of the descriptions of the evaluations varied greatly. This, in part, was due to the fact that some of the interventions were national level initiatives and some were programs and projects with more specific objectives and results. The effects were described, for example, on the operating environment, organization or program, health care services, the targets' groups knowledge, attitude, wellbeing and health or their risk behaviour, customer satisfaction, the results of the professionals' work, trust on professionals etc.

Sustainability

Three questions addressed sustainability and funding of the good practice (GP) programs. In terms of the type of funding, eleven GPs indicated that they receive a mixed funding, and combinations of the following funding options were indicated: national government, municipality, health insurance, private funds, research fund, and other. Six GPs indicated that their program is funded by the national government. In terms of the duration of the funding cycle, nine GPs indicated that their funding period is more than four years, five GPs have a two-year funding, and two have a less than two-year funding cycle.

Transferability

Most of the health promotion interventions were considered transferable to another country. Two interventions have already been transferred internationally and one is in the process of implementation in another country: JOGG (From France to the Netherlands and now to Iceland), The Lombardy Workplace Health Promotion Network (Italy to Andalusia) and two interventions are currently being transferred nationally to other cities (Strength in Old Age programme, Finland and Healthy Overvecht, the Netherlands). Respondents elaborated on the transferability of the good practice and explained the reasons why the practices could be transferred to other countries, however, almost all cited that local characteristics, conditions and challenges need to be taken into consideration beforehand.

Key enablers and barriers for intersectoral collaboration

We combined the answers to the questions on most important factors and on key success factors to one table with Key Enablers (Table 2). A 'shared vision of the problem to be addressed and the successes of the collaboration' was mentioned as a key enabler most frequently. In the case of HR1, this meant that participants were aware of the importance and the definition of the problem, and were devoted to the same or similar goals. In the case of NL1, it was stated that an important starting point was that the collaboration contributed to the objectives and was credible. Respondents reported 'communication' most frequently as the key enabler

for collaboration in the intervention/ program as well. For example, in the case of PT2 this success factor concerned close communication between technical staff and several institutions, in the case of MT1 continuous communication via emails and phone calls, and in the case of IT1 effective communication regarding process and objectives. A 'win-win situation' was mentioned frequently as well, but no examples were given. Another key enabler that was mentioned frequently was 'there is uptake in structural processes (clarity about roles and responsibilities, availability of protocol)'. In the case of ES1, this concerned for example the use of a shared methodology and in the case of HR1 adequately split roles and responsibilities.

Table 2. Key enablers for collaboration

Key enablers	***Frequency (# of good practices)***	
A shared vision of the problem to be addressed and the successes of the collaboration	13	NL1, FI1, PT2, LT1, IT1, FI3, DK1, IT2, HR1, HU1, MT1, BG1, PT1
Communication	13	NL2, PT1, LT1, FI3, DK1, IT2, HR1, NL1, PL1, PT2, IT1, MT1,B G1
A win-win for partners in the collaboration (mutual and joint benefits)	11	NL1, PL1, FI1, PT1, PT2, ES1, DK1, IT2, IS1, RS1, IT3
There is uptake in structural processes (clarity about roles and responsibilities, availability of protocol)	9	LT1, DK1, HR1, NL1, PT1, FI1, IT1, ES1, HU1
Macro level context is taken into account (changes on system level)	8	NL2, FI1, FI3, IT2, PT1, LT1, ES1, RS1
Capacity e.g. enough personnel, personnel has enough time and qualified personnel	7	NL2, FI1, LT1, HU1, PT1, ES1, RS1
Trust between collaboration partners (e.g. trust between health sector and welfare sector)	7	NL1, NL2, PT1, LT1, FI3, HR1, IS1
Recruitment of diverse partners (effective mix)	6	NL1, PT1, IT2, HR1, IS1, HU1
The intervention has a strong leadership in advancing shared purposes	6	NL2, PT2, ES1, PT1, FI3, IT3
There is support and uptake in policies	6	PL1, LT1, HR1, PT1, FI3, IT2
Funding	5	NL2, FI1, LT1, HU1, PT1
The community and the target group are involved from the start	5	FI1, LT1, FI3, ES1, PT1
There was time to build a relationship (contains also building personal relationships)	4	NL2, IT2, PT1, DK1
Sustaining the collaboration; adequate, sustainable and flexible resources	4	PT2, IT1, PT1, IT3
There are strong relationships among partners	3	IS1, HU1, PT1
Building upon existing collaboration structures	3	LT1, HR1, PT1
Motivation of professionals	2	NL2, MT1
Outward-looking culture: e.g. gaining insight in each other's work and position, sharing work places	2	PL1, NL2
Experience and knowhow	2	NL2, PT1
Other key enablers (mentioned once)	9	-

Barriers

'No support and uptake in policies' was mentioned most frequently by respondents as an important barrier (Table 3). For example, in the case of IT2 the tax and price policies of tobacco products, are measures recognized to be effective in achieving the goal of gradually reducing the number of smokers, but in Italy they are still conditioned by the maintenance of tax revenue and not determined in a view to prevention and health protection. HU1 also mentioned 'no support and uptake' of health promoting measures in policies as a barrier. They cited the example of Smoke Free Hungary- Tobacco control in practice. In this case, in the preparatory phase of the legal background representatives of the hospitality and tobacco industry started a media campaign to oppose a new bill calling for the implementation of specially designated indoor smoking areas, equipped with ventilation. In the case of CR1 the main obstacle was the legal frameworks of the Republic of Croatia that are not adjusted or user friendly for withdrawing European Social Fund funding for the Healthy Living-project.

In a fifth of the health promotion interventions, 'no shared vision' was mentioned as barrier. For example, in the case of DK1 the professionals considered the existing practice as good and didn't want to change their behaviour. It was also mentioned that people from different sectors have a different view on things (IS1). Respondents of four interventions claimed 'no capacity' and three 'no funding' as an important barrier but there was no clarification of these barriers. In another three interventions 'no trust' was mentioned as a hindering factor. In the case of NL1 there was limited trust of the public citizens in the public-private partnerships. NL1 stated to be well aware that cooperation with business partners requires extra care and transparency from both sides. For example, you have to be open and clear about the interests of the parties involved.

As the barriers mentioned in the survey were mostly the inverse of the key enablers we decided to put the focus on the key enablers in the next phases of the study.

Table 3. Identified barriers for collaboration

Barriers	***Frequency (# of good practices)***	
There is no support and uptake in policies	6	PT2, FI3, ES1, IT2, HR1, HU1
No shared vision of the problem to be addressed and the successes of the collaboration	4	NL2, PT1, DK1, IS1
No capacity e.g. not enough personnel, personnel has not enough time and no qualified personnel	4	PT1, ES1, HR1, RS1
No funding	3	NL2, ES1, HR1
No trust between collaboration partners (e.g. trust between health sector and welfare sector)	3	NL1, IT1, DK1
No recruitment of diverse partners (no effective mix)	2	FI3, IT2
There was no time to build a relationship	2	NL2, FI3
The intervention has no strong leadership in advancing shared purposes	2	FI3, ES1
Lack of knowledge of health and health care system in the other domains	2	NL2, PT2

Barriers	*Frequency (# of good practices)*	
Bureaucracy	2	FI3, HR1
Negative attitudes of professionals	2	FI3, DK1
Not sustaining the collaboration; no adequate, sustainable and flexible resources	2	PT1, MT1
There is no uptake in structural processes (no clarity about roles and responsibilities, no availability of protocol)	2	NL2, MT1
Other barriers (mentioned only once)	13	-

Drafting of recommendations by identifying key success factors and exploring underlying mechanisms

The key enablers of intersectoral collaboration identified in the online survey were first verified by CHRODIS PLUS Work Package participants attending the Phase 2 workshop (Appendix 3 Summary of Minutes of workshop May 13, 2019 in Budapest). Additional success factors were raised during the workshop discussions, including the use of champions and use of external policy directives (e.g., Sustainable Development Goals) to align intervention objectives. Next, we performed semi-structured interviews in Phase 3 to achieve an in-depth examination of the key enablers in six interventions. That is, enablers for successful intersectoral collaboration were probed in ways that elicited specific strategies to achieve or "bring to life" a particular enabler.

The key enablers and mechanisms were then clustered by theme and translated into draft recommendations. During analysis, a hierarchy was created. Specific recommendations identified to achieve certain enablers were also steps to reach another more generic recommendation on a higher abstract level. For example, we placed the recommendations *Capitalise on existing partners and available collaboration networks* and *Involve community/target group from the start* under the 'how' of the more generic recommendation to *Create an effective mix of different partners with diverse backgrounds and skills*. After reaching consensus about the clustering, the hierarchical order of the recommendations and illustrative examples with the co-leaders, work package leader and a collaborating partner we formulated six main recommendations describing a rationale for the recommendation and steps to achieve these recommendations.

The draft recommendations were sent to experts and partners for feedback. After this consultation we added one recommendation: *Connect collaboration goals with key policies and search for political support* because both experts and one partner considered this recommendation as one of the most important recommendations, that should be mentioned separately and not under the 'how' of another recommendation. Based on the comments of the experts and the partners we formulated the final recommendations. Under supervision of an experienced facilitator all partners agreed on the final recommendation during the meeting with one slight change in the recommendation we had added. This change was the addition of **'while actively advocating'** for political support. It is not enough to align with existing policies in a passive way; it is also

important to try to engage actively to influence policies to ensure a stronger focus on and support for health promotion activities. The final recommendations are presented in Table 4.

Table 4. Seven Recommendations for Effective Intersectoral Collaboration with the Rationale and Steps to Implement the Recommendation

1. Connect collaboration goals with existing key policies, while actively advocating for political support

Why?

Political support is a prerequisite to get resources allocated for the implementation and for the sustainability of health promotion programmes. In order to gain political support collaboration goals should be aligned with key policies.

How?

- Ensure that the planning documents contain the references to important policies
- Align with health system goals
- Make use of existing system changes

Example: Local Action in Health (RELAS), Andalusia, Spain (2008-ongoing)

The Autonomous Community of Andalusia (Spain) is carrying out the comprehensive strategy known as *Local Action in Health* (RELAS), which entails a thorough process to stir up alliances within the Andalusian municipalities, with their mayoralty, government boards, stakeholders and, above all, their citizens. It is a common space for the contribution and cooperation among all parts involved, and it represents the Andalusian public commitment to back up the intersectoral collaboration for health in all the territories.

In order to implement the *Health in All Policies* approach, a local work-plan (the *Plan of Local Action in Health*) is conceived, built and carried out upon the contribution of all possible partners involved and taking into special consideration the participation of citizens. They all take an active part in all phases of the preparation of the Plan of Local Action in Health. This Plan of Local Action in Health is the basic instrument comprising the planning, management, and coordination of all the actions that are relevant to public health in the municipality.

It is recommended to elevate this Plan of Local Action to the Municipal Plenary, as this is an exercise of government and consensus among all the political forces represented in the municipality, and it would further guarantee the appointment of the necessary resources for an established period of 4-5 years.

2. Define a shared vision of the problem to be solved aligned with organisational goals

Why?

Commitment of all partners is crucial for successful collaboration. Agreeing on the problem to be solved and defining a shared vision of how to solve the problem helps to create this commitment and results Furthermore, such a discussion allows professionals from different organisations, and sectors, to develop a common language to talk about the main issues and potential solutions.

How?

- Appeal to a shared sense of urgency to solve a problem or to shared interests
- Agree on intersectoral collaboration as one of the solutions of the problem
- Achieve actual mutual understanding of norms, values and roles and create trust
- Use a visionary leader who is accepted by all parties
- Engage an experienced facilitator / coordinator

Example: Healthy Overvecht, Integrated medical and social care, the Netherlands (2006-ongoing)
The collaboration was developed in a deprived neighbourhood in Utrecht (Utrecht Overvecht), in response to the needs of primary health care professionals in this neighbourhood (e.g. general practitioners, physiotherapists, midwives, Youth Health Care Services, Municipal Public Health Services team, and district nurses). They felt a great deal of work pressure and indicated that the situation was not sustainable. There was a shared feeling of urgency among professionals, the municipality, and other organisations to solve this problem together. They defined a shared vision of how to solve these problems, e.g. they agreed to all use the same interview model (4D model) for their patients. This is a model to methodically map the patient's problems. While filling out the 4D model, the professional looks together with the patient at what is going well in the domains of body, mind, social and relations/network, and what problems there are. They also created direct lines of communication across sectors. Professionals from the social domain (e.g. social workers and neighbourhood teams), who now also use the same interview model for their clients, share information with primary health care professionals, taking advantage of the substantial overlap in clients/patients. This makes their work more efficient and alleviates work load. At present, the collaboration has a 'quadruple aim': improving the perceived health of patients, the efficiency of care, the quality of care, and job satisfaction of the professionals involved. Due to the success of Healthy Overvecht, it is now being piloted in twelve other deprived neighbourhoods in the cities of Utrecht, Rotterdam, Amsterdam and the Hague through December 2020.

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3. Create an effective mix of different partners with diverse backgrounds and skills

Why?
To be able to reach the target group effectively, all relevant parties that could influence the health behaviour of the target group should be involved in the collaboration.

How?

- Identify and involve strategic partners with access to and/or experiences with the target group
- Capitalise on existing partners and available collaboration networks
- Allow ample time for building new relationships
- Involve representatives of the target group and community from the start
- Use standard methods for stakeholder mapping.

Example: The Lombardy Workplace Health Promotion (WHP) Network, Italy (2011- ongoing)
The Lombardy WHP Network is a member of the European Network for Workplace Health Promotion and it builds multi-stakeholders partnerships and collaboration at horizontal and vertical levels, mixing up public and private sectors. It aims to join efforts of employers, employees and society, to improve health and welfare in the workplace. The main partners to initiate the formal collaboration in order to create sustainable actions were: Sodalitas Foundation (National Partner Organization of CSR Europe), Confindustria Lombardia (associations of companies), trade unions and the regional healthcare system

at its different organisational and structural levels. Also, the community and target groups were involved from the start in the collaboration process and the programme implementation at the workplaces. A manual for companies that join the network recommends involving employees and other key roles from the beginning, to plan their programme and select good practices based on their specific needs. Other partners can be involved at different levels: associations of professionals, non-profit organisations (with special reference to social/sport activities promotion associations or with expertise on specific health issues e.g. smoking cessation), municipalities, scientific societies and universities. Due to the collaboration project the healthcare system gained more skills in interacting with other sectors of society (e.g. companies), recognising its own limits in influencing certain multi-faceted determinants of health.

4. Build bridges between sectors and disciplines through effective leadership

Why?

Leadership is essential and closely tied to strong working relationships and a transparent process for collaboration. Effective leadership fosters trust and good working relationships between collaboration partners.

How?

- Identify a local champion who can be the leader or can support the leader
- Use different types of leaders or leadership for different phases of the collaboration
- Recruit a dedicated person with proven leadership and coordination abilities:
  - who understands the language of 'others'
  - with good project- and process management skills
  - who uses information systems and technologies to ensure effective communication and information exchange

Example: The process towards a smoke-free Hungary – Tobacco control in practice (2011-ongoing)

The Prime Minister of Hungary is dedicated to the anti-tobacco cause. He was adamant that signing international legislations is not enough, it also needs to be implemented. Since then, guidelines, protocols and recommendations were given to provide guidance on tobacco control, such as the Framework Convention on Tobacco Control of the WHO. There is also a dedicated person, who possesses the necessary information and expertise in the field which enables him to act as a coordinator. This person, who despite the high turnover of professionals in the field, has been present for 30 years and has been the one constant in tobacco control. He serves as the coordinator between the supporting departments, ministries and non-governmental organizations.

He has been working as a health promotion programme manager of the national health programme and co-ordinates activities in Hungary in connection with smoking prevention and cessation. As Head of the Hungarian Focal Point for Tobacco Control, his main tasks include: making plans in the short, medium and long term related to tobacco control, making professional, methodological guidelines, recommendations on public health and health development. He is responsible for the elaboration of professional programmes' methodologies, creating and maintaining a database of laws, provisions and of instructions for their use; supervising the collection of social, economic and health indicators related to tobacco consumption; conducting research; fulfilling organisational tasks and coordination.

In addition, he is the inventor and the leader of the Smoking Prevention Programme for Kindergarten Children (age 3-6) which has been introduced in one third of all the kindergartens in Hungary and the Smoking Prevention Programme for Primary School Children (age 6-10) which has been running in one

quarter of elementary schools in the country. In connection with these programmes he leads the activities of producing and developing special health education materials. He is also one of the leaders of the professional co-ordination of the activity of the national network of the National Public Health and Medical Officer's Service in connection with smoking.

This collaboration has strengthened other health promotion activities beyond tobacco control.

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5. Keep collaboration partners in all sectors engaged

Why?

Crucial for the success of the collaboration is keeping the partners engaged by informing, motivating and entrusting them, thus sustaining the commitment of all partners.

How?

- Formalise the collaboration by making clear agreements about roles and responsibilities of the partners
- Create a win-win situation for partners in the collaboration (mutual and joint benefits)
- Form designated communication liaisons, e.g. to provide information to participants of the collaboration, arrange meetings, manage a website and/or create regular newsletters
- Give professionals ownership, via a bottom-up approach
- Motivate the professionals involved, e.g. by offering feedback on progress towards shared vision
- Celebrate even smaller short term advancements while aiming for long-term, sustainable success
- Organise face-to-face meetings when possible to help people from different sectors and disciplines get to know each other also on informal and personal level

Example: VESOTE project, Finland (2017-2018)

The VESOTE program reinforces and develops effective and target-based lifestyle guidance in social and health care. The development activities emphasize physical activity, nutrition and sleep. The final goal of the program is for Finns to be more physically active, sit less, eat a varied and healthy diet and sleep better.

The municipalities of Northern Ostrobothnia signed a joint plan for strengthening cooperation between social and health care actors and between social and health care and other actors. The primary target group was those of working age - obese adults and arterial patients - as well as those at high risk for developing arterial disease. The project created new cooperation groups and strengthened the activities of existing ones. Active communication was a success factor. At the beginning of the project, a communication plan was developed, which received the approval of the development manager in hospital district. Communication was goal-oriented. Project leaders sought out the tools and the help of communication experts. Visibility in regional media was obtained; in fact, there were several different channels including a local magazine and Facebook. The project resulted in new perspectives and expertise for health professionals it is hoped that cooperation will continue in the future. Many different actors have promised to participate in the long-lasting partnership, and their will to act has strengthened. The initiative to set up a lifelong learning center has been established.

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6. Use a planned/systematic approach suitable for all partners

Why?

Using a systematic approach that is based on scientific evidence and on experiences from the past will improve the implementation of the collaboration in each sector. Moreover, this systematic approach should allow all partners to combine their health promotion efforts and enhance the effectiveness of the programme.

How?

- Identify a theoretical framework or model that can be used by different sectors
- Identify a theoretical framework or model that can be adapted to local context
- Strengthen the collaboration as iterative and adaptive processes
- Share and learn from experiences
- Involve experts and others with experiences in similar efforts
- Replicate, and adapt if necessary, best practices that have been shown to result in successful outcomes.

Example: Young People at a Healthy Weight (JOGG), the Netherlands (2014-ongoing)

JOGG is a programme based on a previous project in France (EPODE), but has evolved since then. The objective of JOGG is to allow children to grow up in good health using an integrated approach at both the national and local level to target overweight. JOGG advocates a local approach in which parents and health professionals, shopkeepers, companies, schools and local authorities all join forces to ensure that young people remain at a healthy weight. The Dutch JOGG approach consists of five pillars: political and governmental support; cooperation between the private and public sector (public private partnership); social marketing; scientific coaching and evaluation; linking prevention and health care. Although the programme has some pre-determined (five pillars) elements, it can be adapted to the local context. Over 140 municipalities and 30 social organisations and companies have joined JOGG. JOGG is a learning organisation and maintains contact with its partners to discuss the progress of the collaboration. If necessary, agreements are adapted or terminated. In addition, an independent institute monitors what efforts JOGG has undertaken to commit towards their objectives.

7. Ensure there are sufficient resources to sustain the collaboration

Why?

To establish a sustainable collaboration, it is important that resources, such as dedicated time, qualified personnel and funding, are and remain available. The distribution of these resources should be transparent and fair to all partners.

How?

- Describe necessary and obtained resources to facilitate a transparent distribution among the partners
- Allocate (working hours of) personnel to collaboration
- Provide training to managers and professionals
- Acquire or build upon structural resources (e.g., human resources or funding)
- Communicate about the cost-saving or effective results

Example: Tobacco Cessation Services for Patients with Mental Health Disorders and Substance Abuse (Finland 2017-2018)

Filha had an initial project idea, and when the appropriate funding mechanism became available (a government programme to disseminate good practices) it enabled the project to start. The project

sought to identify what had been done in hospital districts on the subject of tobacco cessation among mentally ill patients and patients with substance abuse problems in order to develop regionally-appropriate activities. The ultimate goal was to improve the help to quit smoking for mentally ill smokers and patients with a history of substance abuse. Hospital districts developed their own models where collaboration has been realised between primary and secondary care, as well as with NGO's: The part-time regional worker, who was especially assigned to this project in every participating hospital district, discussed with and trained the staff in different departments together with Filha. He also collaborated with local NGO's who had contacts with experts by experience. Courses were organised in the hospital districts and a 2-hour on-line course was available. It was agreed that staff would attend these courses. The regional worker visited the different departments in secondary as well as primary care in the hospital district and convinced the workers to attend the courses. He/she discussed practical issues with the workers around providing tobacco cessation services and helped them resolve issues that arose. Some hospital districts recognise the value of this project and are allocating their own resources to fund a regional worker, now that the project has ended.

Discussion

Discussion

- Reflection on the results
- Methodological considerations
- Conclusions

Reflection on the results

In this report the success factors of intersectoral collaboration of a wide range of good practices on health promotion and disease prevention from fourteen countries across Europe are presented. We selected the interventions using the criteria of the Steering Committee on Health Promotion and Disease Management. Some of the interventions were already part of the best practice database of the Steering Group (e.g. JOGG, Gaining Health, Making Healthy Choices and Lombardy Workplace Health Promotion Network) indicating that independent evaluators assessed the practice details and approved it as an example of a sustainable and successful program (best practice portal).

Of the 14 countries taking part in the Joint Action that were involved in this on Health Promotion and Disease Prevention, 6 were from Eastern Europe (e.g. Bulgaria,Serbia, Lithuania). This is a strength of the present results, as data on health promotion in Eastern European countries tends to be less prominent in scientific literature. Similar types of practices were presented and were national programs combined with local programs. All had similar barriers and enablers.

The recommendations that resulted from this study are in line with literature [21, 30, 32]; Corbin (2018) suggests nine core elements that constitute positive partnership processes. In the present study, the seven recommendations and implementation strategies incorporate almost all aspects of Corbin's nine recommendations. Recent work of INHERIT 2019, in which triple win cases (identifying ways of living, moving and consuming that protects the environment and improve health and well-being) were collected, showed similar results [27]. They defined 10 elements of good practice on intersectoral collaboration : *Develop a Triple win mindset; Establish international, national or local priorities; Embed initiatives in international, national or local priorities; Bring together sectors around a common interest; Engage people and communities of interest for co-creation; Ensure that initiatives are inclusive; Explore effective or new ways to secure long-term funding; Integrate ways of evaluating initiatives; Identify strengths and positive feedback loops; Embed the triple win from an early age* [27]. As the project addressed the reduction of health inequalities as one of the main targets there was also a recommendation about inclusiveness of practices. This element is not explicitly addressed in our recommendations.

The aim of the Joint Action was to identify practices in which the intersectoral collaboration was important for effective health promotion activities. We were interested in the collaboration and health promotion activities within the health care (for example smoking cessation for patients with mental health disorders) and collaboration outside the health care (Lombardy Workplace Health Promotion Network). We received only a few practices which addressed collaboration within the health care sector. As there is more and more debate

in the European countries about the necessity for a change from focus on care towards more prevention and health promotion because of the contribution in decreasing the costs [34] we would have expected more practices. There were nevertheless practices collaborating with primary health care and social care (Healthy Overvecht, Roma health mediator). Healthy Overvecht is decreasing the costs of care vis-a-vis comparable neighbourhoods in Utrecht by implementing the shared vision of the four domain model (which also addresses social determinants).

The value of a planned and systemic approach to implementation of the health promotion intervention was identified as a recommendation for successful intersectoral collaboration in the current study. For example, the Dutch JOGG approach consists of five elements: political and governmental support; cooperation between the private and public sector; social marketing; scientific coaching and evaluation; linking prevention and health care. Although JOGG has some pre-determined elements, it can be adapted to the local context and adjusted based on the monitoring results of an independent institute. This coincides with ample literature indicating that the use of a framework is an important basic element for collaboration (WHO 2018) and Dubois (2015) defined several frameworks supporting collaboration [1, 32]. A framework permits a common understanding of an approach and provides a structure to evaluate how different factors (e.g. conditions for success) connect with each other. Although several frameworks exist, no one framework emerges from the literature as a gold standard [1]. Frameworks are used for different functions. Some are used for research aims (Bergen model), to list conditions for success [35], to identify potential key mechanisms [36] , or to develop a comprehensive list of coordinated action [37]. In the present study, conditions of success derived from published studies [31, 32] were used a base for the questionnaire. Most interventions in this study used a framework, but no frameworks were identified by the participants as valuable to guide the intersectoral collaboration specifically.

Leadership was identified by participants in this study as another enabling factor and recommendation for intersectoral collaboration. Because this study included a large number of national health promotion interventions with regional components, the benefits of national leadership were highlighted by participants. For instance, *The Smoke-Free Legislation of Hungary* had a dedicated Minister who was responsible for the establishment of the law, and this was considered to be one of the key factors in the success of the law. Guglielmin (2018) distinguished between local and national leadership, but the role of regional and local leadership within national health promotion programs did not emerge from the data collected in this study [38]. Regardless of the level of action, Corbin (2018) suggests that there are several forms of leadership, but all leaders must have the ability to inspire trust, install confidence, be inclusive of diverse partners, and be collaborative and transparent in the decision making process [21].

Building upon existing structures and collaborations was mentioned as an important factor. In the Netherlands for example a lot of new health promotion programs for schools use the existing structure of the Healthy School Network and don't need to work on new collaboration. As health challenges increase in complexity, multi-level and multi-disciplinary health promotion interventions will become the norm. In this regard, capitalization on existing networks will likely become more and more important over time. Improving and strengthening existing health and decreasing health inequalities is complex and permanent collaboration

structures are needed to permit timely response to these challenges. While the focus of health promotion programmes may be different (e.g. overweight, fall prevention, physical activity), the approaches that must be taken should, in general, be similar. Successful implementation of these programmes require an established prevention structure, independent of the topic, which is spearheaded by the local or regional government. For example in Finland, the Health Care Act (Health Care Act) prescribes coordination and collaboration around health and welfare promotion for local authorities. In addition, they should cooperate with other public organisations as well as with private enterprises and non-profit organisations. Often municipalities have a 'wellbeing group' that consists of experts from different sectors of the municipality, and its main function is to collaborate and set common goals and measures for wellbeing and health of their population. Future research is needed on building these kinds of permanent structures or networks.

Methodological considerations

To identify the good practices and the enabling factors for intersectoral collaboration we have chosen for an online questionnaire and two workshops. With this approach we expected to find more and diverse practices. During analyses and the discussions with partners in the first workshop, we noticed that information was missing about *how* to achieve the success factors (and recommendations). That is, the question remained which strategies or steps do you need to implement the recommendation to achieve successful intersectoral collaboration? Therefore, we additionally performed six in depth interviews with the practice owners of different type of programs (national /local and diverse topics).

Barriers were part of the questionnaire and were also discussed in the interviews. However, we might have introduced some bias by first asking for enablers and then for barriers in the sense that some respondents tended to bring up the inverse of the previous mentioned enablers. For a next study we would suggest adapting the order of the questions or interviewing at least two people from the same good practices (one on enablers and one on barriers) to address this bias.

In preparation of the second workshop, we invited two experts on intersectoral collaboration for feedback on our recommendations. The experts agreed on and recognized the recommendations but also provided feedback based on their expertise. The main comment was that context is a very important factor that will influence the implementation of a recommendation. For example, a recommendation on leadership will differ in different contexts (e.g. national and local). For the implementation of the recommendations more insight is needed into the inhibiting or enabling factors within different contexts. A method that does more justice to this diversity in context and thus broader applicability of the recommendations is the realist evaluation method. An example of this method is presented in review on integrated care, health care, social care, and wider public services of Steenkamer, et al. [39]. They presented eight guiding principles with insight into strategies (in our study the HOW), the necessary context (in our study the example) and the extracted theory that underlie the recommendation (in our study the WHY). We have chosen to describe one specific context (the example) per recommendation, but if we had used the method of realist evaluation, we should have had more information on inhibiting and enabling contexts which are important for the implementation of the recommendation. Moreover, when starting a new initiative for intersectoral collaboration it is important

to do a context-analysis first to identify which recommendations are the most viable to implement in that specific context.

Finally, the seven recommendations are interdependent. They do not stand alone and the implementation of these recommendations and the related strategies is also dependent of the phase of the collaboration process (just starting or already running for a couple of years). You need different kinds of people for the different phases. Unfortunately, we had hardly any practices in the starting phase. Most of our practices were long term programs or initiatives which were long-lasting, or coming to an end or had already ended. We had planned a small pilot for the implementation of the recommendations in a project that should have started in February 2020, but because of the outbreak of COVID-19 this pilot could not continue. As a result, most of our data collected concerns the final phase of a collaboration process.

Conclusions

In the framework of the Joint Action CHRODIS PLUS, Task 5.3 examined twenty health promotion and disease prevention programs from all over Europe. Experiences associated with successful intersectoral collaboration were synthesized to determine cross-cutting barriers and enablers and generate a set of seven recommendations. Each recommendation includes concrete steps to implement the recommendation and was found, in general, to be in line with the literature. The recommendations include: connecting with existing policies and advocating for political support, defining a shared vision, creating an effective mix of different partners, encouraging effective leadership, keeping collaboration partners engaged, using a planned systematic approach, and ensuring sufficient resources to sustain the collaboration. These recommendations and their implementation strategies will be used by CHRODIS PLUS partners to enhance intersectoral collaboration and consequently strengthens health promotion activities in intervention programs across Europe.

1. Connect collaboration goals with existing key policies, while actively advocating for political support: *Political support is a prerequisite to get resources allocated for the implementation and for the sustainability of health promotion programs. In order to gain political support, the collaboration goals should be aligned with key policies*
2. Define a shared vision of the problem to be solved aligned with organisational goals: *Commitment of all partners is crucial for successful collaboration. Agreeing on the problem to be solved and defining a shared vision of how to solve the problem helps to create this commitment.*
3. Create an effective mix of different partners with diverse background and skills: *To be able to reach the target group effectively, all relevant parties that could influence the health behaviour of the target group should be involved in the collaboration.*

4. Build bridges between sectors and disciplines through effective leadership: *Leadership is essential and closely tied to strong working relationships and a transparent process for collaboration. Effective leadership fosters trust and good working relationships between collaboration partners.*
5. Keep collaboration partners in all sectors engaged: *Crucial for the success of the collaboration is keeping the partners engaged by informing, motivating and entrusting them, thus sustaining commitment of all partners.*
6. Use a planned/ systematic approach suitable for all partners: *Using a systematic approach based on scientific evidence and on experiences from the past will improve the implementation of the collaboration in each sector. Moreover, this systematic approach should allow all partners to combine their health promotion efforts and enhance the effectiveness of the programme.*
7. Ensure sufficient resources to sustain the collaboration: *To establish a sustainable collaboration it is important that resources, such as dedicated time, qualified personnel and funding, are and remain available. The distribution of these resources should be transparent and fair to all partners.*

References

1. Dubois, A.; St-Pierre, L.; Veras, M. A scoping review of definitions and frameworks of intersectoral action. *Cien Saude Colet* **2015,** *20*, (10), 2933-42.
2. For People under 75, Two Deaths out of Three in the EU could Have been Avoided. Available online: https://ec.europa.eu/eurostat/news/news-releases (accessed on 3 November).
3. GBD 2016 DALYs and HALE Collaborators. Global, regional, and national disability-adjusted life-years (DALYs) for 333 diseases and injuries and healthy life expectancy (HALE) for 195 countries and territories, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet* **2017,** *390*, (10100), 1260-1344.
4. Horton, R. The neglected epidemic of chronic disease. *Lancet* **2005,** *366*, (9496), 1514.
5. European Commission. *European Disability Strategy 2010–2020: A Renewed Commitment to a Barrier-Free Europe*; European Commission: Brussels, 2010.
6. European Commission. *The 2014 EU Summit on chronic diseases*; European Commission: Brussels, 2014.
7. Palmer, K.; Marengoni, A.; Forjaz, M. J.; Jureviciene, E.; Laatikainen, T.; Mammarella, F.; Muth, C.; Navickas, R.; Prados-Torres, A.; Rijken, M.; Rothe, U.; Souchet, L.; Valderas, J.; Vontetsianos, T.; Zaletel, J.; Onder, G. Multimorbidity care model: Recommendations from the consensus meeting of the Joint Action on Chronic Diseases and Promoting Healthy Ageing across the Life Cycle (JA-CHRODIS). *Health Policy* **2018,** *122*, (1), 4-11.
8. Proper, K. I.; van Oostrom, S. H. The effectiveness of workplace health promotion interventions on physical and mental health outcomes - a systematic review of reviews. *Scand J Work Environ Health* **2019,** *45*, (6), 546-559.
9. Bergstrom, C.; Jensen, I.; Hagberg, J.; Busch, H.; Bergstrom, G. Effectiveness of different interventions using a psychosocial subgroup assignment in chronic neck and back pain patients: a 10-year follow-up. *Disabil Rehabil* **2012,** *34*, (2), 110-8.
10. Busse, R.; Blümel, M.; Scheller-Kreinsen, D.; Zentner, A. *Tackling Chronic Disease in Europe. Strategies, Interventions and Challenges*; WHO Regional Office for Europe: Copenhagen, 2010.
11. Global Status Report on Noncommunicable Diseases 2014. Available online: https://apps.who.int/iris/bitstream/handle/10665/148114/9789241564854_eng.pdf;jsessionid=4376CBE48A81DE2AADFE07ADEDCF1D6B?sequence=1 (accessed on 14 July).
12. Stange, K. C. The problem of fragmentation and the need for integrative solutions. *Ann Fam Med* **2009,** *7*, (2), 100-3.

13. Fortin, M.; Dubois, M. F.; Hudon, C.; Soubhi, H.; Almirall, J. Multimorbidity and quality of life: a closer look. *Health Qual Life Outcomes* 2007, *5*, 52.
14. Marmot, M.; Allen, J.; Boyce, T.; Goldblatt, P.; Morrison, J. *Health equity in England: The Marmot Review 10 years on*; Institute of Health Equity: London, 2020.
15. Alford, V. M.; Ewen, S.; Webb, G. R.; McGinley, J.; Brookes, A.; Remedios, L. J. The use of the International Classification of Functioning, Disability and Health to understand the health and functioning experiences of people with chronic conditions from the person perspective: a systematic review. *Disabil Rehabil* 2015, *37*, (8), 655-66.
16. Eckersley, R. Beyond inequality: Acknowledging the complexity of social determinants of health. *Soc Sci Med* 2015, *147*, 121-5.
17. McKee, M.; Stuckler, D.; Zeegers Paget, D.; Dorner, T. The Vienna Declaration on Public Health. *Eur J Public Health* 2016, *26*, (6), 897-898.
18. Wagner, E. H. Chronic disease management: what will it take to improve care for chronic illness? *Eff Clin Pract* 1998, *1*, (1), 2-4.
19. Woolf, S. H. Necessary But Not Sufficient: Why Health Care Alone Cannot Improve Population Health and Reduce Health Inequities. *Ann Fam Med* 2019, *17*, (3), 196-199.
20. Axelsson, R.; Axelsson, S. B. Integration and collaboration in public health--a conceptual framework. *Int J Health Plann Manage* 2006, *21*, (1), 75-88.
21. Corbin, J. H.; Jones, J.; Barry, M. M. What makes intersectoral partnerships for health promotion work? A review of the international literature. *Health Promot Int* 2018, *33*, (1), 4-26.
22. Mattessich, P. W.; Rausch, E. J. Cross-sector collaboration to improve community health: a view of the current landscape. *Health Aff (Millwood)* 2014, *33*, (11), 1968-74.
23. Leonardi, M.; Scaratti, C. Employment and People with Non Communicable Chronic Diseases: PATHWAYS Recommendations and Suggested Actions for Implementing an Inclusive Labour Market for All and Health in All Sectors. *Int J Environ Res Public Health* 2018, *15*, (8).
24. Vlachou, A.; Stavroussi, P.; Roka, O.; Vasilou, E.; Papadimitriou, D.; Scaratti, C.; Kadyrbaeva, A.; Fheodoroff, K.; Brecelj, V.; Svestkova, O.; Tobiasz-Adamczyk, B.; Finnvold, J. E.; Gruber, S.; Leonardi, M. Policy Guidelines for Effective Inclusion and Reintegration of People with Chronic Diseases in the Workplace: National and European Perspectives. *Int J Environ Res Public Health* 2018, *15*, (3).
25. Johansson, H.; Stenlund, H.; Lundstrom, L.; Weinehall, L. Reorientation to more health promotion in health services - a study of barriers and possibilities from the perspective of health professionals. *J Multidiscip Healthc* 2010, *3*, 213-24.

26. World Health Organization. *The Ottawa Charter for Health Promotion*; World Health Organization: Ottawa, 1986.

27. Bell, R.; Khan, M.; Romeo-Velilla, M.; Stegeman, I.; Godfrey, A.; Costongs, C.; Taylor, T.; Morris, G.; Staatsen, B.; van der Vliet, N.; Kruize, H.; Anthun, K. S.; Lillefjell, M.; Espnes, G. A.; Chiabai, A.; de Jalón, S. G.; Quiroga, S.; Martinez-Juarez, P.; Máca, V.; Zvěřinová, I.; Ščasný, M.; Marques, S.; Craveiro, D.; Westerink, J.; Spelt, H.; Karnaki, P.; Strube, R.; Merritt, A.; Friberg, M.; Bélorgey, N.; Vos, M.; Gjorgjev, D.; Upelniece, I. *INHERIT: Creating Triple-Wins for health, equity and environmental sustainability: Elements of good practice based on learning from the INHERIT Case Studies*; EuroHealthNet: Brussels, 2019.

28. Anaf, J.; Baum, F.; Freeman, T.; Labonte, R.; Javanparast, S.; Jolley, G.; Lawless, A.; Bentley, M. Factors shaping intersectoral action in primary health care services. *Aust N Z J Public Health* 2014, *38*, (6), 553-9.

29. Corbin, J. H. Health promotion, partnership and intersectoral action. *Health Promot Int* 2017, *32*, (6), 923-929.

30. Roussos, S. T.; Fawcett, S. B. A review of collaborative partnerships as a strategy for improving community health. *Annu Rev Public Health* 2000, *21*, 369-402.

31. Danahar, A. *Reducing Health Inequities: Enablers and Barriers to Inter-sectoral Collaboration*; Wellesley Institute: Toronto, 2011.

32. World Health Organization. *Multisectoral and intersectoral action for improved health and well-being for all: mapping of the WHO European Region. Governance for a sustainable future: improving health and well-being for all*; World Health Organization: Copenhagen, 2018.

33. Storm, I.; den Hertog, F.; van Oers, H.; Schuit, A. J. How to improve collaboration between the public health sector and other policy sectors to reduce health inequalities? - A study in sixteen municipalities in the Netherlands. *Int J Equity Health* 2016, *15*, 97.

34. van der Vliet, N.; Suijkerbuijk, A. W. M.; de Blaeij, A. T.; de Wit, G. A.; van Gils, P. F.; Staatsen, B. A. M.; Maas, R.; Polder, J. J. Ranking Preventive Interventions from Different Policy Domains: What Are the Most Cost-Effective Ways to Improve Public Health? *Int J Environ Res Public Health* 2020, *17*, (6).

35. Harris, E.; Wise, M.; Hawe, P.; Finlay, P.; Nutbeam, D. *Working together: Intersectoral action for health*; Australian Government Publishing Service: Canberra, 1995.

36. Public Health Agency of Canada and World Health Organization. *Health equity through intersectoral action: An analysis of 18 country case studies*; Public Health Agency of Canada and World Health Organization: 2008.

37. Wagemakers, A.; Vaandrager, L.; Koelen, M. A.; Saan, H.; Leeuwis, C. Community health promotion: a framework to facilitate and evaluate supportive social environments for health. *Eval Program Plann* 2010, *33*, (4), 428-35.

38. Guglielmin, M.; Muntaner, C.; O'Campo, P.; Shankardass, K. A scoping review of the implementation of health in all policies at the local level. *Health Policy* 2018, *122*, (3), 284-292.

39. Steenkamer, B.; Drewes, H.; Putters, K.; van Oers, H.; Baan, C. Reorganizing and integrating public health, health care, social care and wider public services: a theory-based framework for collaborative adaptive health networks to achieve the triple aim. *J Health Serv Res Policy* 2020, 1355819620907359.

Appendix 1 Questionnaire Health Promotion and intra and intersectoral collaboration

Aim and instructions

This survey is conducted within the framework of the JA CHRODIS PLUS (http://chrodis.eu/) WP5 task 3 '**To support health promotion across the broader health system'**.

The purpose of task 3 is to stimulate and to strengthen health promotion activities by collaboration within the (primary) health care and outside the health care, such as social care and other sectors (education, employment, private sector, etc).

To this end, we kindly request your input **to collect factors that help to identify successful** collaboration within healthcare and between the broader health system and other sectors, as well as their **enablers and barriers**. In the survey, we provide **definitions** for the key concepts in order to all start from the same conceptual framework.

In order to have enough information, we kindly request you to answer the survey in depth. The survey contains questions in 6 categories:

- Relevance
- Intervention characteristics
- Effectiveness of the intervention
- Intersectoral collaboration
- Transferability
- Sustainability

The survey provides you with guided questions to describe help with the identification of important factors and criteria that can be ticked.

We kindly ask you to complete and submit the questionnaire before, but at the latest on,

May 15th 2018

You may pause and resume at a later time without any loss of data.

Resuming is possible using the code that is generated automatically after you pause.

The collected data will be treated confidentially and used solely for the purpose of the study.
The survey is conducted by the National Institute for Public Health and the Environment (RIVM), Bilthoven, The Netherlands (lead) in collaboration with the National Institute of Oncology (OOI), Budapest, Hungary (co-lead).

For further information or to signal any problem, please feel free to **contact** our survey team at:
Djoeke van Dale, djoeke.van.dale@rivm.nl, telephone +31629601801.
Annamaria Szabo, szabo.aniko@oncol.hu.

Thank you very much for your contribution.

Background information

See appendix for definitions and examples

1. Background information (appendix)

2. Definitions (appendix)

3. Examples (appendix)

Questionnaire Health Promotion and intra and intersectoral collaboration

General information and relevance

4. Your name:

5. Your email:

6. I agree on collecting, processing and publishing my personal data by CHRODIS PLUS and the European Commission, DG Health and Consumers.
If the data were collected from a third person I state that I received unambiguous consent from the data subject on using it for this purpose.
The purpose of the presentation of best practices is to provide to researchers, policy makers and all interested bodies, good practice in the area of Health Promotion and prevention of chronic diseases .
Submission of the data is made on voluntary basis, and there are no consequences by not doing so. Data are collected according to the Regulation (EC) No 45/2001 of the European
Parliament and of the Council of 18 December 2000 and you as a data subject have the right to have recourse at any time to the European Data Protection Supervisor.
☐

7. The intervention/program has among its objectives Health Promotion and the prevention of chronic diseases (e.g. addressing risk factors for Cardiovascular Diseases, Diabetes and Cancer).

- No
- Yes

8. Please indicate which kind of collaboration the intervention/program involves.

- Collaboration within the health care sector (3 or more disciplines)
- Collaboration with 2 or more other sectors than the health sector (such as employment, spatial planning, social care and private sector).

9. There is a contact person who can give information about the intervention/program and the process of collaboration

- No

- Yes,

10. Name of contact person:

11. Position:

12. Organisation:

13. Country:

14. Email:

15. Title of the intervention in English and native language:

16. Material available via:

17. Start date:

18. Completion date:

19 Topic of intervention/program is on:
- Health promotion
- Disease prevention
- Both

20 Theme of the intervention/program (combination of topics is possible):
Please use the additional area to complement missing topics
- Overweight
- Physical activity
- Alcohol prevention
- Smoking
- Self-management
- Health literacy
- Well-being
- Reduction of health inequalities
- ….

21 Type of intervention (combination of interventions is possible)
Please select all that apply and use the additional area for missing options.
- National program
- Community intervention
- Health Service Delivery
- Policy action
- Integrated approach (a mix of interventions on environmental, social, organisational and individual level)
- Training, capacity building
- Online intervention program….
- ……..

22 Collaboration within health care (checkbox)
Please count the total number of disciplines involved

- <3 disciplines
- > 4 and <5 disciplines
- >6 disciplines
- No intra-sectoral collaboration

23. Collaboration outside health care
Please count the total number of sectors involved

- < 2 sectors
- >3 and < 5
- 6 sectors
- No intersectoral collaboration

B. INTERVENTION CHARACTERISTICS

24. Problem
Please give a description of the problem the good practice example aims to tackle
……

25. Objectives
Please describe the objectives of the intervention/ program
……

26. Please give a short description of the target group
(for example obese children and their parents and intermediate target group such as school nurses, teachers, dieticians)
……

27. *Please describe how the target group and stakeholders have participated in the different stages of the practice (development, implementation).*

28. Method /approach of the intervention
Specify the design/ method - sequence of activities, frequency, intensity, duration, and recruitment method.
……

29. Budget
Please briefly describe the type of budget used (e.g. source of funding, budget management, duration, availability of a joint budget between sectors).

……

C. EFFECTIVENESS

30. The practice has been evaluated with a

- Process evaluation
- Participatory evaluation research

- Outcome evaluation
- No evaluation

31. The practice has been evaluated with
    - Internal
    - External
    - Both

32. What are the concrete results of the evaluation concerning intersectoral and intra-sectoral collaboration? ……..

D. COLLABORATION

In this section we are interested to collect information about the success factors of intersectoral and intra-sectoral collaboration. What are the enabling factors and barriers for the collaboration in your intervention/program?

33. Please describe the collaborating parties (organization and role) in the intervention/program.
……

34. Who initiated the collaboration?

- Health care sector
- Public Health sector
- Educational sector
- Environmental sector /spatial planning
- Social sector
- Health and social sector
- Private partner(s)
- Labour sector
- Cultural sector
- …….

35. Do you use a framework and or instruments for the collaboration?

- Yes……
- No……..
- If Yes, please describe the frame work / instruments

  ……

36. Which of the following elements of inter- and/or intra- sectoral collaboration has your practice achieved/incorporated?

- A shared vision of the problem to be addressed and the the successes of the collaboration
- A win-win for partners in the collaboration (mutual and joint benefits)
- The community and the target group are involved from the start
- There are strong relationships among partners and recruitment of diverse partners (effective mix)
- There was time to build a relationship
- The practice has a strong leadership both in advancing shared purposes and sustaining the collaboration; adequate, sustainable and flexible resources
- There is support and uptake in structural processes or policies (clarity about roles and responsibilities and building upon an existing structure)
- Funding and capacity
- Trust between collaboration partners (e.g. trust between health sector and welfare sector)
- Macro level context is taken into account (changes on system level)
- Communication
- Others ……..

37. Please indicate which of the above elements you *in general* consider most important factors for successful collaboration

……

38. What in your opinion are the key success factors of the collaboration in the intervention/program? ("How do you get them to work?")

……..

39. What barriers have you identified? And which do you have as a priority to tackle, to achieve greater success of the collaboration?

……..

40. What are the most important lessons you have learned about the collaboration and the success of the practice?

……..

E. TRANSFERABILITY (within country)

41. Is the practice implemented in another situation?

- No
- Yes, how many places (organisations, municipalities or regions)?

42. Does the practice have instruments (e.g. a manual with a detailed activity description and a communication plan) that allow for repetition/transfer?

- No
- Yes, namely

……

43. What were the main barriers to implementation?

- Personnel,
- Environmental barriers
- Managerial
- Financial
- Skill related
- Legal
- Other

44. Please describe above mentioned barriers are overcome?

……

45. In your opinion could the intervention/program be successfully transferred to other countries? Why/ why not?

F. SUSTAINABILITY

45. How is the intervention/program funded?

- National government
- Municipality
- Health Insurance
- Private funds
- Research fund
- Other

46. What is the duration of the funding? Duration funding

< 2 year
2
3
4
>4

47. Is future funding ensured?

Is the intervention/program embedded in a sustainable organisation and funding structure?

- No
- Yes
- Don't know

48 Please share any comments you have on the questionnaire or the intervention / program you described here

.....

Thank you very much!

Background information

Chronic diseases are the leading cause of mortality and morbidity in Europe. One of the strategies to decrease the burden of chronic disease in Europe is tackling the major risk factors such as sedentary lifestyle, alcohol abuse, smoking, unhealthy and diet. Disadvantaged groups are doubly affected by chronic diseases as they are often out of reach of health promotion activities. Reasons for infrequent uptake include the fragmentation of services and lack of integration within regular care. There is much evidence of the value of health promotion to health systems performance, outcomes, and sustainability. All mechanisms should champion the importance of strengthening health promotion, preventive services, public health, and social care.

Another reason for the difficulty to decrease the burden of the chronic diseases is the complex nature of chronic diseases. Wider social determinants are underlying causes of unhealthy behavior and the onset of chronic diseases. These social determinants of health are complex, dynamic, and interdependent. Given this interdependent nature of the determinants, inter- and intra-sectoral collaboration is necessary. The Health sector cannot solve such a complex problem alone (see the Ottawa Charter for Health Promotion). Therefore, collaboration between different sectors is urgently required to improve health across society.

The aim of this task is to stimulate and strengthen health promotion activities by collaboration within and outside health care. This includes social care, education, employment, and other sectors.

Definitions

Inter- and intra-sectoral collaboration is often defined as intersectoral action. This refers to actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector (WHO).
More recently the WHO promoted the concept of intersectoral action for health (IAH) as “a recognized relationship between part or parts of the health sector with parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone”.

Collaboration takes place on different levels. For example, horizontal collaboration occurs across sectors that are at the same level (Danahar, 2011):

- Between sectors within health (hospital, public health, community health centres, home care agencies, and a range of community agencies that deliver programs and services, also known as "intra-sectoral collaboration")
- Between health and non-health sectors (such as social services, transportation, housing, employment, private sector), also known as "intersectoral collaboration".

Vertical collaboration:

- Between different levels of government, federal, provincial or municipal or
- Geography (local, regional, provincial), or
- Within organizations (administrative levels/program division or direct care)

Which practices are we looking for?

The focus in this WP is on health promotion and disease prevention:

1. Practices with a collaboration within healthcare that address both the prevention and management of chronic diseases (Health Promotion and Disease Prevention (HPDP) as part of integrated care practices). Integrated care should include HPDP to prevent and manage chronic diseases proactively and strengthen patients' own role in decision-making and disease management.

Examples

- Diabetes prevention and screening in vulnerable populations of Lisbon (Portugal)
- Self-management programs that focus on lifestyle transformation
- Smoke free hospitals: a combination of policy measures (policy of no smoking on the property of the hospital), commitment of management, staff and personal, interventions (access to stop smoking services) and communication and consolidation of the policy.

2. Practices directed at collaboration *between the broader health system and other sectors* that provide opportunities for health promotion (HP) and chronic disease prevention (DP). HPDP approaches that involve other sectors have proven to be more effective in general, whereas collaborations between health and social services in particular provide good opportunities to reach more vulnerable and/or disadvantaged populations who usually do not participate in health promotion activities, as these people often only use health (and social) services when poor health and related problems have appeared.

Examples

- CHRODIS practices such as Healthy and active aging (Germany), Croi my action ((Ireland), Lombardy Workplace Health Promotion Network, Gaining Health Making Healthy Choices easier (Italy), JOGG

(the Netherlands) , Healthy Life Centre (Norway) http://chrodis.eu/wp-content/uploads/2016/01/Dissemination_brochure_02_WEB.pdf

- Smoking cessation intervention combined with stress prevention and support with debt problems.

Elements of intersectoral collaboration

There is a lot of literature about the important elements for collaboration in general and more specifically intersectoral collaboration aiming to reduce health inequalities. Using recent literature on collaboration in general (Bell, Kaats and Opheij, 2013), intersectoral collaboration (Danaher, 2011), collaboration of the primary health care and the sports sector (Leenaars, 2017), and health in all policies (Storm 2017) we identified several common factors important for the success or failure of a collaboration. In general, the crucial factors are relationships among partners, shared vision, leadership, resources, structure and process. More in detail we identified the following elements for intersectoral collaboration:

- Shared (powerful) vision of problem to be addressed and the successes of the collaboration
- Win-wins: mutual and joint benefits
- Community and target group involvement
- Strong relationships among partners and recruitment of diverse partners (effective mix) and time to build a relationship
- Leadership, both in advancing shared purposes and sustaining the collaboration; adequate, sustainable and flexible resources
- Support and uptake in structural processes or policies (clarity about roles and responsibilities and building upon an existing structure)
- Funding and capacity
- Macro level context (changes on system level)
- Communication

Along with these important elements of intersectoral collaboration we are interested in the processes behind these success factors. How do you get a win-win situation within health care and between health care and other sectors? Do you have instruments or tools which enabled the collaboration? These enabling factors and barriers will be the focus of this task and part of the questionnaire.

References

Bell J, Kaats E, Opheij W. (2013) Bridging disciplines in alliances and networks: in search for solutions for the managerial relevance gap. *Int. J. Strategic Business Alliances, Vol. 3, No. 1*

Dannaher A. *(2011)* Reducing Health Inequities: Enablers and Barriers to Intersectoral Collaboration, Wellesley Institute Toronto.

Leenaars KEF, Smit E, Wagemakers A, Molleman GRM, Koelen MA (2015) Facilitators and barriers in the collaboration between the primary care and the sport sector in order to promote physical activity. A systematic literature review. Preventive Medicine.

Storm I. (2016) Towards a HiAP Cycle Health in All Policies as a practice-based improvement process. Thesis, Vu University of Amsterdam.

Storm I, Hertog den F, Oers van H, Schuit AJ. How to improve collaboration between the public health sector and other policy sector to reduce health inequalities? – A study in sixteen municipalities in the Netherlands.

WHO (definition of intersectoral action)
http://www.who.int/social_determinants/thecommission/countrywork/within/isa/en/

Appendix 2 Table A1: Overview of the selected good practices

	Practice	Aim	Topic and Themes	Type	Target group	Collaboration	Evaluation
1	**Young people at a healthy weight** / Netherlands: **NL1** 2010- ongoing *Interview*[1]	To reverse the increasing trend of young people with overweight /obesity in the Netherlands through the JOGG themes: water, fruit and vegetables consumption and physical activity	Health promotion: overweight, physical activity, reduction of health inequalities and healthy nutrition	• National program • Community intervention • Policy action • Integrated approach • Training and capacity building	Children aged 0-19 years and intermediary groups (e.g. teachers, sport coaches, business partners, health professionals)	>6 sectors 3 disciplines	Process and outcome
2	**Healthy Overvecht: Integrated medical and social basic care** Netherlands: **NL2** 2006- ongoing *Workshop*[2] *Interview*[1]	To make the work of health professionals more sustainable through shifting focus from disease treatment and care to promoting healthy behaviour in Overvecht.	Health promotion and disease prevention: lifestyle factors, health literacy, wellbeing, reduction of health inequalities and social problems	• Community intervention • Integrated approach	All inhabitants of the neighbourhood, most having a low social economic status.	3-5 sectors >6 disciplines	Process and outcome
3	**Prevention of cardiovascular system and respiratory system diseases** and **Comprehensive Geriatric Assessment (CGA)** Poland: **PL1**	To increase the effectiveness of recognition and monitoring of cardiovascular system and lung obstructive diseases among elderly people using extended Comprehensive Geriatric Assessment.	Health promotion and disease prevention: wellbeing, prevention of diseases of the cardiovascular and respiratory system and reducing the health risks of older people	• Policy action • Regional program (local program)	People aged 60+ and their carers.	3-5 sectors 4-5 disciplines	Process

	Practice	Aim	Topic and Themes	Type	Target group	Collaboration	Evaluation
	2018 -2019						
4	**National Health Plan / Plano Nacional de Saúde** Portugal: **PT1** 2012-2020	To increase health promotion and protection, disease prevention and control, intersectoral collaboration, citizen empowerment, promotion of healthy environments, dissemination and implementation of good practices and strengthening of global health.	Health promotion and disease prevention: overweight, physical activity, alcohol prevention, smoking, self-management, health literacy, wellbeing, reduction of health inequalities	• National program • Community intervention • Policy action • Integrated approach	General Portuguese population and health Professionals	More than 6 sectors >6 disciplines	Process and outcome
5	**Tobacco Cessation Services for Patients with Mental Health Disorders and Substance Abuse** Finland: **FI1** 2017 – 2018 *Interview*[1]	To provide patients with mental health or substance abuse patients with better physical health through adequate tobacco cessation services.	Health promotion and disease prevention: smoking	• National program • Health Service Delivery • Policy action • Training, capacity building • Online intervention program	11 hospital districts are involved: a multi-professional tobacco cessation expert group has been established in all hospital districts	2 sectors 3 disciplines	Process, outcome and participatory
6	**Healthy Aveiro Programme** Portugal**: PT2** 2013- ongoing	To address unhealthy conditions, to prevent chronic diseases, to enrich the skill set of professionals dealing with multisectoral interventions, and to develop organisational models to implement this strategy.	Health promotion and disease prevention: health literacy, reduction of health inequalities	• Community intervention • Integrated approach	Groups experiencing socioeconomic vulnerability, adverse health conditions, and/or have low health literacy.	3-5 sectors 3 disciplines	Process
7	**Health promotion program for people with risk of**	To implement the prevention program in primary care centres and develop the collaboration between primary care centres,	Health promotion and disease prevention: overweight, physical activity, alcohol	• National program	1) Persons at the age of 40-65 years who participate in the "Program for the	3-5 sectors -	Process and outcome

	Practice	Aim	Topic and Themes	Type	Target group	Collaboration	Evaluation
	cardiovascular disease and diabetes Lithuania: **LT1** 2015- ongoing *Workshop[2]*	community and municipal public health bureaus.	prevention, smoking, self-management, health literacy and wellbeing		Selection and Prevention Measures of Persons Attributable to the High-Risk Group of Cardiovascular Diseases"; 2) Adults, who are assigned to persons at risk.		
8	**Walking on the path of wellbeing** Italia: **IT1** 2012 – 12-2014	To increase physical activity levels through an evidence-based action.	Health promotion and disease prevention, physical activity and wellbeing	• Integrated approach	People with sedentary behaviour, in particular patients with chronic diseases and those over 65 years old.	7> sectors 3 disciplines	Process and outcome
9	**VESOTE project** Finland: **FI2** 2017—2018 *Workshop[2]* *Interview[1]*	To adopt and reinforce effective and high-quality lifestyle counselling operational models.	Health promotion and disease prevention: overweight, physical activity, healthy food and better sleep without medication	• National program • Health Service Delivery • Integrated approach • Training, capacity building	Physically inactive persons, persons suffering sleep problems, diabetics, coronary patients, overweight patients and obese patients	> 6 sectors > 6 disciplines	Process and participatory research
10	**The Strength in Old Age Programme** Finland: **FI3** 2005-ongoing	To launch research-based health exercise for independently living elder adults (75+) with decreased functional capacity.	Health promotion: physical activity, health literacy, wellbeing and reduction of health inequalities	• National program • Policy action • Integrated approach • Training, capacity building • Online intervention program	Community-living 75+ persons with decreased mobility and intersectoral collaboration group.	3-5 sectors 3 disciplines	Process and outcome

	Practice	Aim	Topic and Themes	Type	Target group	Collaboration	Evaluation
11	**The Hygiene Week** Denmark: **DK1** 2009-2019 (every year)	To raise interest in population, in media and among decision makers to use hygiene to prevent infections - creating empowered, health literate citizens to (also) prevent AMR.	Health promotion and disease prevention: self-management and health literacy	• National program • Community intervention • Health Service Delivery • Policy action • Integrated approach • Media campaign	General population	3-5 sectors 4-5 disciplines	Process
12	**The Andalusian Strategy of Local Action in Health** Spain: **ES1** 2008 – ongoing	To bring public health on the local agenda of all existing municipalities in Andalusia.	Health promotion and disease prevention: healthy aging, accident prevention, sexual and reproductive health, violence prevention, gender issues, environmental health and urban health.	• Community intervention • Policy action • Integrated approach • Training, capacity building • Intersectoral approach • Participation • Governance	General population of 778 municipalities of the Autonomous Community of Andalusia (Spain).	> 6 sectors 4-5 disciplines	Process and participatory
13	**Gaining Health - making healthy choices** Italy**: IT2** 2007 -ongoing	To reduce the impact of common risk factors on the population with cancer, cardiovascular diseases, diabetes and chronic respiratory diseases.	Health promotion and disease prevention: overweight, physical activity, alcohol prevention, smoking, wellbeing, reduction of health inequalities and nutrition	• National program • Community intervention • Policy action • Integrated approach	Life course approach: addressing all ages and all public and private environments.	> 6 sectors 3 disciplines	Process and outcome
14	**Living Healthy** Croatia: **CR1** 2016 – 2022	To reduce the negative impact of behavioural, biomedical and sociomedical risk factors for the development and early onset of chronic NCDs and to inform, educate and raise awareness on the positive aspects of healthy lifestyles.	Health promotion and disease prevention: overweight, physical activity, alcohol prevention, smoking, health literacy, wellbeing and mental health/child depression	• National program • Community intervention • Integrated approach • Training, capacity building	Life course approach: with a special focus on persons with heightened behavioural and biomedical risk factors.	>6 sectors 3 disciplines	Process, outcome and participatory

	Practice	Aim	Topic and Themes	Type	Target group	Collaboration	Evaluation
15	**Coordinated strategy and action in health promotion for school health care** Iceland**: IS1** 2006-ongoing	To implement a coordinated strategy and action in health promotion for the school health care service in Iceland.	Health promotion and disease prevention: overweight, physical activity, alcohol prevention, smoking, self-management, health literacy, wellbeing and reduction of health inequalities	• National program	School-aged children (6-15 years old) as well as school nurses, teachers and other school personnel.	2 sectors 3 disciplines	Process and participatory
16	**The process towards a smoke-free Hungary – Tobacco control in practice** Hungary: **HU1** 2011-ongoing *Interview*[1]	To reduce illness, disability, and death related to tobacco use and second-hand smoke exposure by raising awareness and health education.	Health promotion and disease prevention: smoking	• National program • Policy action • Case study	Children, young adults and adults.	2 sectors	Process and outcome
17	**Living with Diabetes: Education and Weight Management** Malta: **MT1** 2015 -ongoing	To provide adult patients with diagnosed type 2 diabetes with the opportunity to undergo an educational and intensive weight management program delivered by a multidisciplinary team.	Health promotion and disease prevention: overweight, physical activity, self-management and health literacy	• National program	Overweight and obese patients who have type 2 diabetes.	-	Outcome
18	**Roma health mediators** Serbia**: S1** **2009-** ongoing	To improve health and quality of life of Roma population in Serbia.	Health promotion and disease prevention: health literacy, well-being and reduction of health inequalities	• National program • Community intervention • Health Service Delivery • Training, capacity building	Roma ethnic minority population in Serbia.	3-5 sectors and < 2 disciplines-	Process

	Practice	Aim	Topic and Themes	Type	Target group	Collaboration	Evaluation
19	**National programme for prevention of NCDs (noncommunicable diseases) - 2013-2020** Bulgaria: **BG1** 2013-2020	To promote population's health and improve quality of life by reducing premature mortality, morbidity and health outcomes due to major NCDs.	Health Promotion and disease prevention: overweight, physical activity, alcohol prevention, smoking, self-management, health literacy and main NCDs: Cardiovascular diseases, malignant neoplasms, diabetes, COPD	• National program • Community intervention • Health Service Delivery • Policy action • Integrated approach • Training, capacity building	Life course approach: but especially focuses on women of reproductive age, workplaces, health professionals and individuals with low socioeconomic status	>6 sectors	Process, outcome and participatory research
20	**The Lombardy Workplace Health Promotion (WHP) Network** Italy **IT3** **2014-ongoing** *Interview*[1]	To join efforts of employers, employees and society, to improve health and welfare in the workplace.	Health promotion and disease prevention: physical activity, alcohol prevention, smoking, food, work-life balance and road safety	• Integrated approach • Regional program	All company workers are involved (young adults, adults, male and female).	2 sectors	Process

[1] *This practice has been interviewed for more in depth information*
[2] *This practice has been presented during the workshop*

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Appendix 3 Key points subgroup discussions

Workshop Success factors on intersectoral collaboration

13 MAY 2019 Budapest

Results of the key points written on flipovers.

Healthy community Utrecht Overvecht (the Netherlands)

Defining success factors in the practice

- Introduction of common language
- Introduce new mindset of professionals
- Health and social care more closely related
- Intersectoral training at the start of the project
- Trust between person (clients /professionals and between professionals
- Multisectoral approach to solve this problem (wicked problems require wicked solutions)
- Political support at the start but bottom-up approach from general practitioners
- Focus on strengths of clients instead of limitations and strength of community
- Peer to peer training
- Creating a shared vision (with professionals together and take time to achieve)

Recommendations for collaboration at local level

- All need to agree that you are to change your way of working (governance, professionals)
- Set up of interdisciplinary teams (first step of collaboration) on strategic and professionals level
- Knowledge based decision making
- Align with the sustainable development goals, also at local level
- No target funds to make the experience possible

Health promotion program for people with risk of cardiovascular disease and diabetes in Lithuania

Defining success factors in the practice

- Communication (give feedback)
- Methodology of implementation
- Involving GP and availability of nurses
- Quality indicators
- Motivation of patients (higher the health literacy higher the motivation)
- There is a vision
- Special training for the nurses

Recommendations for collaboration at the national level

- Establish cooperation with patient organizations
- Dissemination of information (media, civil society)
- Involving all stakeholders (implementers) from beginning

- Share with other sectors (municipality, workplace, occupational health service)
- Sharing success stories

Integrated care for people with chronic wounds (Slovenia)

Defining success factors in the practice

- Establish an intersectoral implementation group (and conduct interviews beforehand to ask the personal barriers / vision for each member) and repeat these interviews during the whole period
- It is important to know that you work on a substantial topic/ problem; organise a world café with all important stakeholder to realize this
- Conduct a patient needs assessment
- Start with a patient case study and follow the route/ barriers. Discuss all the barriers you see and discuss this with the involved professionals/ stakeholders
- Use champions, they can motivate people

Recommendations for collaboration at the national level

- Establish a health counsel on local level with all the important stakeholders (provided by the national level)
- Follow the CHRODIS+ methodology for implementation
- Give examples of how to empower people
- Make it concrete and simple

Childhood obesity in Hungary

Defining success factors in the practice

- Establish a formal mechanism
- Identify stakeholders, involve them and motivate them
- Enough time to form a partnership
- Have a holistic/integrative approach to the problem
- Commitment from the decision makers
- Understand the interests of evidence to make your case to decision makers
- Find the ideal size of group on a national/local level
- Combine the top down-bottom up approach (have a balance)

Recommendations for collaboration at the national level

Sustainability
Common vision
Champions (engine)
Willingness of operational people
Self-organization of communities
Democracy
Trust in long term effect
Bottom-up
Soft recommendations

Quick wins
Different aims (climate change)
Commitment from decision makers
Manage all stakeholders
Formalise collaboration
Power
Provision in short term indicators
Top down
Mandatory regulations

Appendix 4 Minutes Workshop 18 May 2020

Work Package 5 Task 3 Online Workshop,18 May 2020

Participants: NIO (Hungary), Semmelweis University (Hungary), Coordinator ISCIII (Spain), EuroHealthNet (Belgium), THL (Finland), RIVM (Netherlands), Andalusian Ministry of Health and Families (Spain), Bizkaia Health Research Institute (Spain), Ministry for Health Government of Malta (Malta) , DORS (Italy) and ministry of health (Italy) (2x), Kauno Klinikos (Lithuania), IPHS (Serbia) and NCPHA (Bulgaria).

Moderator: Johan Melse (RIVM)

1. Welcome and introduction

Johan Melse started this meeting saying that this online workshop replaced the study visit and workshop that was supposed to be held in April 2020. This had to be cancelled due to the situation around COVID-19.

All participants shortly introduced themselves.

2. Towards final recommendations – Step 1 (recommendations in agreement and under discussion)

The first step was to identify the recommendations that needed further discussion. An inventory showed that recommendation 'align with key policies and search for political support' as well as 'encourage effective leadership' needed further discussion. All other recommendations were agreed upon.

Align with key policies and search for political support

Ingrid Stegeman of EuroHealthNet argued that the wording 'align' your intervention with policy is not sufficient in this case. The language is too passive, and leaves no room for action. While, if you cannot align with policies, you should try to adapt those policies, for example by including the health dimension in policies.

After some discussion of the wording, it was agreed that the new formulation of the recommendation is:

'Connect with key policies while actively advocating for political support'.

The practical case study that is used to elaborate this recommendation is the Andalusian example: *Local Action in Health (RELAS)*. Hungary comments that they prefer if their example on Tobacco Control is used with the recommendation 'to encourage effective leadership'. Djoeke and Hungary agree to discuss this after this meeting.

'Encourage effective leadership'
Djoeke mentions that the formulating of the wording has been changed after the written consultation. There are no objections to the reformulation, and so the formulation is agreed upon.

3. Towards final recommendations – step 2 (final discussion and formalization)

There is a discussion about the order of the recommendations. The order should be as logical as possible. Although the recommendations are interdependent, it makes sense to make it a natural order. In the introduction guidelines it should be clearly mentioned that all recommendations are interdependent.

The agreed order of the recommendations is:

1. Connect with key policies while actively advocating for political support
2. Define a shared vision of the problem and how to solve it
3. Create an effective mix of different partners
4. Encourage effective leadership
5. Keep partners engaged in the collaboration
6. Use a planned/systemic approach to implement intersectoral collaboration
7. Ensure there are sufficient resources to sustain the collaboration

4. Timeline for the report and presentation of the recommendations

Djoeke explains that the final report will be sent to EuroHealthNet half June 2020. RIVM will distribute the report to all partners on 28 May 2020. Partners can provide feedback before 8 June 2020. RIVM will finalize the scientific article that is based on this work together with THL, NIO, EuroHealthNet and Bizkaia Health Research Institute The manuscript will be submitted in July 2020. The final set of recommendations will be finished in an attractive lay-out at the end of July or beginning of August.

During the final CHRODIS+ assembly in October 2020 we will reflect on the process of the task.

A question is how do we ensure that the recommendations will be used after CHRODIS+ has ended. An option is to translate the recommendations to other languages, but this depends on the remaining budget. RIVM will be discuss this with the work package leaders (THL and EuroHealthNet).

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