



# IMPLEMENTING HEALTH IN ALL POLICIES

## DEMONSTRATING A HEALTH IN ALL POLICIES ANALYTIC FRAMEWORK FOR LEARNING FROM EXPERIENCES

Based on literature reviews from  
Africa, South-East Asia and the Western Pacific

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- For the Western Pacific Region (joint report prepared by Professor Sharon Friel); Ms Sarah Simpson, Ms Carmel Williams and Ms Deborah Wildgoose (mobility of Aboriginal people in South Australia); Ms Sarah Simpson (NCDs in Palau and helmet law in Viet Nam).

The boxed information in this document, containing information from the three regions, is drawn from the regional reports referred to above (unless stated otherwise). These reports are:

*Health in All Policies: Report on perspectives and intersectoral actions in the Africa Region*. WHO, 2013; *Health in All Policies: Report on perspectives and intersectoral actions in the South-East Asia Region*. WHO, 2013; and *Health in All Policies: Report on perspectives and intersectoral actions in the Western Pacific Region*. WHO, 2013.

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# Overview

## Why should the health sector work on a “Health in All Policies” approach?

Historically in public health a systematic approach to dealing with health problems in a population has frequently been advocated, with particular emphasis on social, environmental and economic factors and the different tiers of administration and governance.<sup>1</sup> The WHO Commission on Social Determinants of Health (SDH) made it clear that health issues have diffuse boundaries and health determinants are largely outside the direct scope of the health sector, and have deep societal roots. This leads to the obvious conclusion that these problems can hardly be solved exclusively by the actions of the health sector, or any other sector alone, and that they require intersectoral action.

This is one of the central arguments for working “together” with other sectors or having health impacts taken into consideration in the actions of other sectors, the so-called “intersectoral action for health” or, as now is being developed, the “Health in All Policies” (HiAP) approach. Yet, because intersectoral action can be effective in improving health generally, and ineffective in reducing inequities, an additional consideration is how Health in All Policies approaches can be developed to ensure reductions in health inequities.

## Understanding concepts

### How do we think about intersectoral action, “Health in All Policies”, health equity, and links with Universal Health Coverage?

A common definition was proposed for a “Health in All Policies” approach by the organizers of the 8th Global Conference on Health Promotion. It provides a common point of reference with which to begin in this paper:

*“... An approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity.”*

WHO working definition prepared for the 8th Global Conference on Health Promotion, Helsinki, Finland, 2013

Although this definition was based on a process of consultation,<sup>2</sup> in practice a common understanding of Health in All Policies is still being formed, and much of what can be learnt about how to implement Health in All Policies starts with a better understanding of intersectoral work or “action” for health, and from other fields of public sector management. Also, exploring understanding associated with concepts goes beyond comparing definitions. In general, it can be said that Health in All Policies is associated with intersectoral

action and the principle of analysing various sectors with a view to solving social problems affecting health and well-being. But the term has additional connotations depending on the assumptions adopted, and even, according to what is understood by the word “sector”. In some cases sector refers to levels of government, in others it refers to private for-profit and civil society sectors, and still in others as here, it refers to government policy areas.

Other terms such as “multisectoral action” have also gained frequency in health policy forums. For the purposes of the Global Conference on Health Promotion, multisectoral and intersectoral action terms were used as synonyms. However, multisectoral action can have the interesting connotation of public service agencies acting *simultaneously*. “Whole-of-government” is another term associated with intersectoral action that highlights public service agencies working together across portfolio boundaries to achieve shared goals as part of an integrated response.

Common and different elements characterize understanding of intersectoral action for different reasons – such as levels of development of a welfare state, culture and language, and history. Formulating common understanding is important as global discussions will increasingly focus on what is appropriate guidance for country implementation of a Health in All Policies approach. This analytic framework is designed to facilitate the development of a common understanding as countries discuss implementing effective governance for health and health equity. These topics were already the focus of follow-up to the Rio Political Declaration on Social Determinants of Health and the United Nations High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases in 2011, and the WHO 8th Global Conference on Health Promotion in Finland in 2013.

The analytic framework for Health in All Policies aims to elaborate a common set of concepts underpinning intersectoral work across countries and to identify those most relevant to implementing a Health in All Policies approach. It can also be seen as a checklist; it provides a systematic way for policy-makers to question how they are thinking about intersectoral problems and solutions and the role of health, and what this means for how they resolve to act in the future. The framework is specifically designed with a health equity lens – thus considering how addressing the social determinants of health may affect Health in All Policies implementation and the impact of Health in All Policies on equity. It has also been designed to review the barriers experienced by health practitioners in addressing the social determinants of health, and the role of health in intersectoral action to improve access to health services, which is so vital to advance Universal Health Coverage (UHC).



## Convergence on common concepts

This is the first time an analytic framework has been presented for policy-makers across a diversity of regions.<sup>3</sup> In general, in developing countries, reviews of literature on intersectoral action and Health in All Policies are lacking. Therefore three regions were supported by WHO, through a Rockefeller Foundation grant: Africa, South-East Asia, and the Western Pacific, to work on this challenge.<sup>4</sup> This paper is the first to illustrate how the cases and findings from these regions can be analysed using a common framework to review their intersectoral experiences.

While the framework itself builds on a review of conceptual literature and various processes documented elsewhere,<sup>5</sup> this publication uses the findings from additional literature reviews that were conducted using a consistent methodology to present relevant examples of the theoretical concepts on intersectoral action to policy-makers – the so-called “applied” analytic framework. It explains a way for policy-makers to digest and systematize experiences from the Africa, South-East Asia and the Western Pacific regions. While most of the literature reviewed focused on health sector actions and perspectives, some of the literature also revealed findings from other policy sectors and disciplines.

Short examples from these literature reviews, as well as interviews and in-depth case studies are used in this paper to enliven the communication of the concepts underpinning the analytic framework, but more detailed information on examples can often be found in the regional reports and specific case study reports. The analytic framework on intersectoral action has also been enriched by discussions at regional meetings in the lead up to the 8th Global Conference on Health Promotion. Further discussions round the implementation of a Health in All Policies approach will contribute to revising and refining the framework in the future.

In the first assessment the literature reviewed across all three regions revealed similar challenges presented by the lack of a common framework for analysing concepts associated with intersectoral processes. Expressions of these findings are extracted from the regional reports and are shown in boxes 1 to 3, which together articulate a need for a common framework.

### AFRICA REGION

BOX 1

“Currently available evidence shows that the HiAP approach is still at its infancy. From the literature search undertaken there were not many articles [...] specifically addressing HiAP at the national, provincial and local levels. The review found that the main focus is on documentation of national health policies rather than HiAP. However, it has noted that work across sectors by using HiAP can be effective. In this context, health ministries in the African Region recognize intersectoral action as a vehicle for moving forward cross-government action involving civil society, the private sector and wider communities to address key determinants of health ...”

*Health in All Policies. Report on perspectives and intersectoral actions in the Africa Region, 2013, and related background materials.*

### WESTERN PACIFIC REGION

BOX 3

“There is a very significant gap in the published literature in relation to action that addresses the social determinants of health and health equity. Most of the literature is issues and outcomes focused rather than on the processes of intersectoral action and Health in All Policies. This is not particularly surprising given the complexity of these policy issues and journals are unlikely to be interested in specific issues.”

*Health in All Policies. Report on perspectives and intersectoral actions in the Western Pacific Region, 2013, and related background materials.*

### SOUTH-EAST ASIA REGION

BOX 2

“Even though there may not be an explicit Health in All Policies approach, the majority of the South East Asia countries have intersectoral governance structures which can serve as important means to support translation of HiAP from policy principle to practice. There are also examples of intersectoral coordination at policy, project and community level. Among South East Asia member countries there are examples of collaboration between ministries of health and other ministries towards a shared goal and of integrated government response to particular issues – key characteristics of ‘whole-of-government’ approach. Within South East Asia Member countries there are examples of high level political engagement and strong coordination at the central government level which are key to successful implementation of HiAP.”

*Health in All Policies. Report on perspectives and intersectoral actions in the South-East Asia Region, 2013, and related background materials.*

# History: global and regional

In looking at intersectoral action historically, Kickbusch and Buckett<sup>6</sup> have identified three waves of horizontal governance that are relevant to intersectoral action: (1) Intersectoral action – Alma-Ata and primary care; (2) Healthy public policy; and (3) Health in All Policies. Figure 1 shows the historical development highlighting key points in the three waves of governance as viewed from a global public health perspective.

## Trends and opportunities for HiAP over time

Starting with the World Health Organization’s Alma-Ata Declaration 1978, there was a call on the health sector to direct its efforts beyond the delivery of acute hospital medicine. Calls were made to develop primary health care and public health to address factors that underpin health through intersectoral action, in particular in relation to determinants such as water, food, education and housing.

In the decade following Alma-Ata, the World Health Organization’s Ottawa Charter for Health Promotion (1986) called for healthy public policy, which took intersectoral action to key health concerns of modern societies such as environmental challenges, tobacco and alcohol legislation

and gender inequities. This constituted the second wave of action and implementation was developed in particular through the Healthy Cities Project and “settings” approaches such as health promoting schools and healthy workplaces. Healthy Public Policy further highlighted the need for accountability for health, laying the base for the rise to prominence of health impact assessments.

The third wave of intersectoral action for health developed during the Finnish Presidency of the European Union in 2006, wherein the Presidency called upon governments across Europe to ensure that health considerations were included in all government policies, coining the phrase Health in All Policies (HiAP). Building on the lessons learnt from the other approaches, it was formulated as “a dynamic and partnership based policy process”.<sup>6</sup> The Spanish Presidency of the European Union in 2010 launched a renewed appeal to health and equity in all policies.<sup>7</sup>

Beyond global milestones, it is interesting for regional policy-makers to analyse the historical context in each region. Figure 2 seeks to illustrate this analysis by drawing out recent region-specific historical influences on Health in All Policies, as seen from the perspective of the health sector.

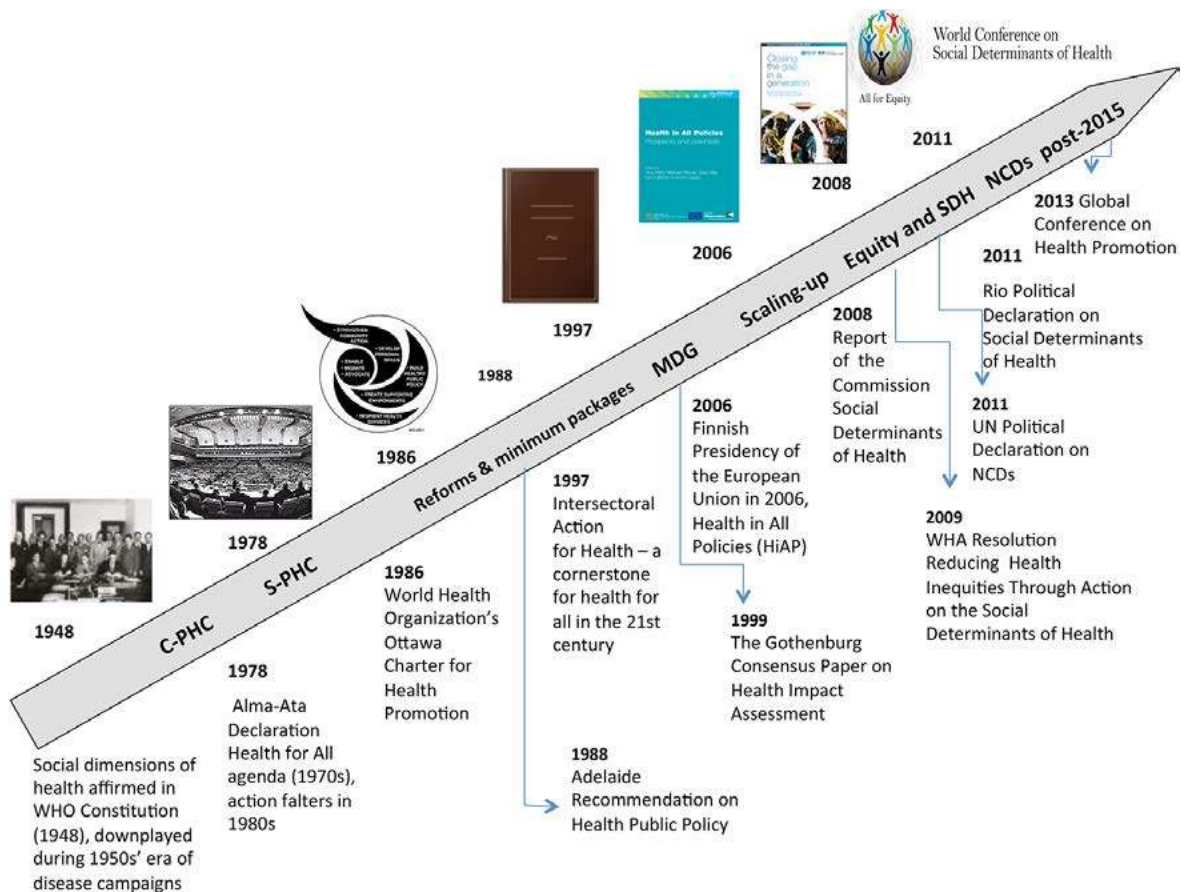


Figure 1. Trends and opportunities to build intersectoral action and Health in All Policies approaches.

	1999	2008	2010	2011	2012	2013
<b>Africa</b>	Southern African Development Community (SADC) protocol on the need for intersectoral approaches to health, especially for HIV/AIDS and STDs	The Ouagadougou Declaration on primary health care and health systems in Africa	A strategy for addressing the key determinants of health in the African region (based on CSDH recommendations, adopted by the Regional Committee Africa)	Brazzaville Declaration on NCDs	Strategy for health promotion in the African Region	Multi-stakeholder dialogue on addressing risk factors of NCDs  Regional meeting on Health in All Policies

	2005	2009	2011	2012–2013
<b>South-East Asia</b>	Bangkok Charter	Regional consultation on SDH – Colombo Call for Action on health equity in all policies	WHO-SEARO regional consultation on intersectoral actions addressing social determinants	Regional meeting on NCDs  Regional meeting on Health in All Policies

	1995	1998	2005–2011	2010	2011	2012–2013
<b>Western Pacific</b>	WHO – Yanuca Island Declaration – a vision of health for island nations	Healthy Island Plans of Action	WHO Multi-country Study on Women’s Health and Domestic Violence  United Nations Joint Programme on Gender Equality	Pacific Islanders Health Officers’ Association  International meeting on Health in All Policies	Taking Action to Address the Social and Environmental Determinants of Health Inequity in Asia Pacific	Regional meeting on NCDs  Regional meeting on Health in All Policies

Figure 2. Regional public health historical perspectives on intersectoral action and Health in All Policies.

## Definitions and concepts

### Health in All Policies

A strategy that allows the formulation of public policies in sectors other than health, which when applied can correct, improve or positively influence the determinants of health.

A systematic approach to taking into account the impacts of public policies on health determinants, including health systems, in order to realize health-related rights, to seek synergy across sectors and to improve accountability for the impacts of policies, and ultimately population health and health equity.

An initiative that focuses on influencing the health of the population and its determinants. A central element is cooperation between different relevant sectors within and beyond the domain of public health regarding aspects of health. The common goal is to improve, promote or protect health.

Examples of concepts highlighted as important in the definition:

- › Systemic and sustained approaches/strategies
- › Intersectoral win-win and efficiency
- › Impacting on determinants and health systems
- › Reach in public policy or beyond
- › Human rights
- › Political context and participation
- › Importance of communities
- › Importance of leadership
- › Monitoring the evolution and impact of policies

Source: compiled from responses to a public web-based consultation, facilitated by WHO, for a working definition for the 8th Global Conference on Health Promotion.



## Evolution of terminology use and interpretation

Language and meaning evolve over time and spatially. To test this one can discuss reactions to differently worded definitions of Health in All Policies – and the different connotations specific terminologies produce at any given time and region.

The definitions stress different concepts related to intersectoral action, including the need for a common goal across sectors, the existence of synergy, and the need for goals to be expressed more broadly or to be grounded in legal rights. Other concepts that were considered important for inclusion in the definition are also listed.

These differences in language are reflected in the regional literature reviewed, as well as in discussions with government health officials.

In the Africa Region experts emphasized that standard global definitions have been considered adequate and adopted in regional strategies. These include “intersectoral action” as defined by the Alma-Ata Declaration (1978) and Health in All Policies as defined by the Adelaide Statement on Health in All Policies (2010). In the 2012 regional meeting on Health in All Policies the importance of good governance, community participation and a shared responsibility across government were also important concepts. The concept of community participation and voice was also prominent in connection to ensuring political will. From a technical viewpoint, the use of existing health planning instruments was also discussed. The Statement on Health in All Policies produced following the meeting in Africa in May 2013 highlights these last points by quoting earlier commentaries by the Regional Director.

*“Health in All Policies is an essential instrument in tackling health determinants and risk factors through intersectoral collaboration, multidisciplinary actions and partnerships. Ultimately, Health in All Policies is an indispensable element of health systems strengthening that is vital for addressing priority public health conditions in the African Region. Therefore it is time for every sector to protect health through sound public policies.*

Luis Sambo. Towards global health equity: opportunities and threats. *Global Health Action*, 2012, 5:18842.

In the South-East Asia Region the Colombo Call for Action in 2009 uses the term “intersectoral action,” and calls for the establishment of national institutional mechanisms to coordinate and manage intersectoral action for health in order to mainstream health equity in all policies, and, where appropriate, by using health and health equity impact assessment tools. At the same time reference is also made to multisectoral action, as made prominent through the United Nations work on noncommunicable diseases (NCDs) and associated WHO resolutions. Examples illustrating this concept include ministries of health and other ministries contributing towards shared goals or of integrating government response to particular policy problems through a “whole-of-government” approach. The Statement on Health in All Policies, produced by the 2012 regional meeting on Health in All Policies highlights the importance of Health in All Policies to address health inequity and the importance of “the use of tools and mechanisms to reach common goals.” Again, this last framing refers to the concept of establishing common goals across policy sectors.

In the Western Pacific Region researchers observed that in discussions with health practitioners in 2012, many did not use the term Health in All Policies. Intersectoral work and multisectoral action were more common terms. In the area of health equity, concepts of intersectoral work emerged from prominent social determinants of health challenges such as gender-based violence, where health services were viewed as an entry point for other ministries to work on societal problems and human rights within a multisectoral response. On the other hand, multisectoral action came through in the health discourse surrounding addressing the challenges of NCDs. In general, health policy-makers signalled an understanding of how policies in other sectors affected health and also repeatedly stressed the importance of framing. This was reflected in comments about not using health-dominant language, using existing structures and opportunities, and not introducing HiAP as a completely new initiative.

# Analytic framework

## What use is an analytic framework?

To answer questions such as: how are we understanding what we are doing and what we could do better?

The lack of a common set of well-known concepts underpinning intersectoral action is a recurrent theme in public health. Neither is there an explicit theory on which to build a framework for analysis of which types of intersectoral action are applicable in different scenarios, and which actions address social determinants of health and thereby reduce inequalities and health inequities.<sup>8</sup> This has translated into little documentation and systematization of how intersectoral action is practised within health. Various expert groups convened by WHO have called for the establishment of a clearing house on cases to support the evidence base.

Complex processes, such as identifying the need for a Health in All Policies approach, and how to best improve health equity, require a framework to aid understanding and prioritization. Key features to be analysed in such a framework cover the relationships between actors, mechanisms for decision-making across government, the role of stakeholders from the private sector and the capacity of intervention design to address health equity, among others.

An analytic framework, as discussed in this paper, can contribute to addressing this gap and form the foundation for analysing opportunities for Health in All Policies approaches, in particular when the health sector aim is to address health inequities as this is an orientation of the framework. The framework can help planning policies and interventions undertaken with a HiAP approach because

it provides a diagnostic checklist. Applying the checklist to various options for beginning HiAP – whether they are based on existing mechanisms or new HiAP initiatives – will aid in analysing the strengths and weaknesses of proposed implementation plans.

While no single model for developing HiAP currently prevails, it is important to be explicit about, and to agree on, a common set of concepts and language that can facilitate the exchange of experiences and learning together.<sup>9,10</sup> The analytic framework presented here makes a contribution in this direction.

The analytic framework includes four stages:

- › Opportunities for initiation;
- › Key drivers of implementation;
- › Key domains of an equity lens (in policies and interventions); and
- › Key drivers of sustainability.

Each stage is described in the pages that follow, first theoretically, and then with examples from the three regions.

## Opportunities for initiation

An analytic framework to enhance comparability of understanding of processes needs to interrogate how policy agendas are taken up and thereby transform institutions. The first stage of the analytic framework refers to contextual factors that are commonly conducive to intersectoral work for health equity, in particular:

- › The policy change window; and
- › International influences.

## Policy change window (national and local contexts)

The policy change window involves what Kingdon (1984)<sup>11</sup> refers to as the “problem stream” (i.e. conditions or issues are recognized as a problem that requires a cross-government policy solution), the “policy stream” (i.e. how and whether a variety of actors influence the design of feasible and sustainable policy options), and the “political stream” (i.e. how and whether politically agreeable policies are adopted). The policy change window is strongly related to the process of obtaining political will and includes domestic political leadership and the organizational style of the government; as sub-national heads of government may be more powerful

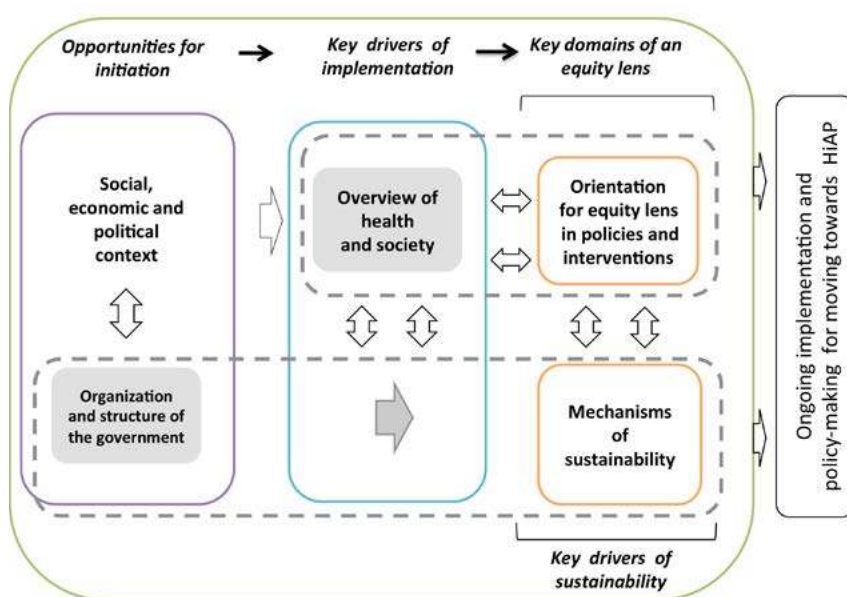


Figure 3. Analytic framework for intersectoral action and Health in All Policies with an equity lens.  
Source: Solar O *et al.* (forthcoming)

politically than national ministries of health. It is further important to reflect on the overall organizational model of the government in relation to: possible state fragmentation; welfare state model in operation; and administration levels involved. Fragmentation of the state tends to result in a vision that promotes sectoral work in silos, with little interaction between the different sectors and with limited knowledge of the work of other sectors, and, therefore, no joint assessment and developments of plans and policies. The welfare state model operating has a strong influence on a country's political processes and the predominant state ideology and public policies for health. Cultural and historical aspects of the social system exert powerful influences on patterns of social stratification, the nature of the welfare state policies and their degree of integration and thus on people's health opportunities. These are important themes for the analysis of intersectoral actions and opportunities for developing Health in All Policies. Initiatives to promote intersectoral actions to address health equity at local and sub-national levels can lead, complement or strengthen national intersectoral policy-making for health equity.

### International influences

Theoretically, policy transfer can also underpin the spread of policy ideas from one political setting to another. "Most studies have concentrated on studying the transfer between countries, here the transfer is assumed to be mediated through an international organization (WHO) to its Member States. Locating the transfer of [Health for All policy] in the context of existing public health policies and the wider political and social contexts of the countries in question offers one means to identify essential capacities, constraints and conditions for the adaptation of this particular policy innovation."<sup>12</sup> This aspect needs to be seen against the backdrop of increasing complexity in policy-making, spurred on by globalization and associated international policy responses from private industry consortiums as well as intergovernmental organizations.

### Key drivers of implementation

The second stage of the framework describes the keys drivers shaping the type of implementation (i.e. who the actors are and what they are doing):

- The vision of health and society that sets the context within which actors operate; and
- Relationships within or between governmental and non-governmental partners.

### Vision of health and society

This first important component is the vision of health and society that exists within the health and other sectors as well as in the broader population. This vision exerts influences over relationships between health and other sectors and the focus of action. If the vision of health is centred on the absence of disease then the focus of action will predominantly be on access to curative health care and technologies; if the health vision is that the absence of disease does not imply health, then the main focus will be on action in other sectors and social policies, and an integration of actions on social determinants of health will occur more automatically. Similarly, the perceived causes of the health problems will imply different roles for health in relation to other sectors across government. At the same time, the vision facilitates or limits civil society participation, from being merely informative through to real empowerment.

### Relationships within or between governmental and non-governmental partners

The type of relationships that health establishes with other government sectors ranges from emphasizing information sharing, to cooperation around particular activities, to coordination – involving loss of budget autonomy and to integration of policies, strategies and programmes.

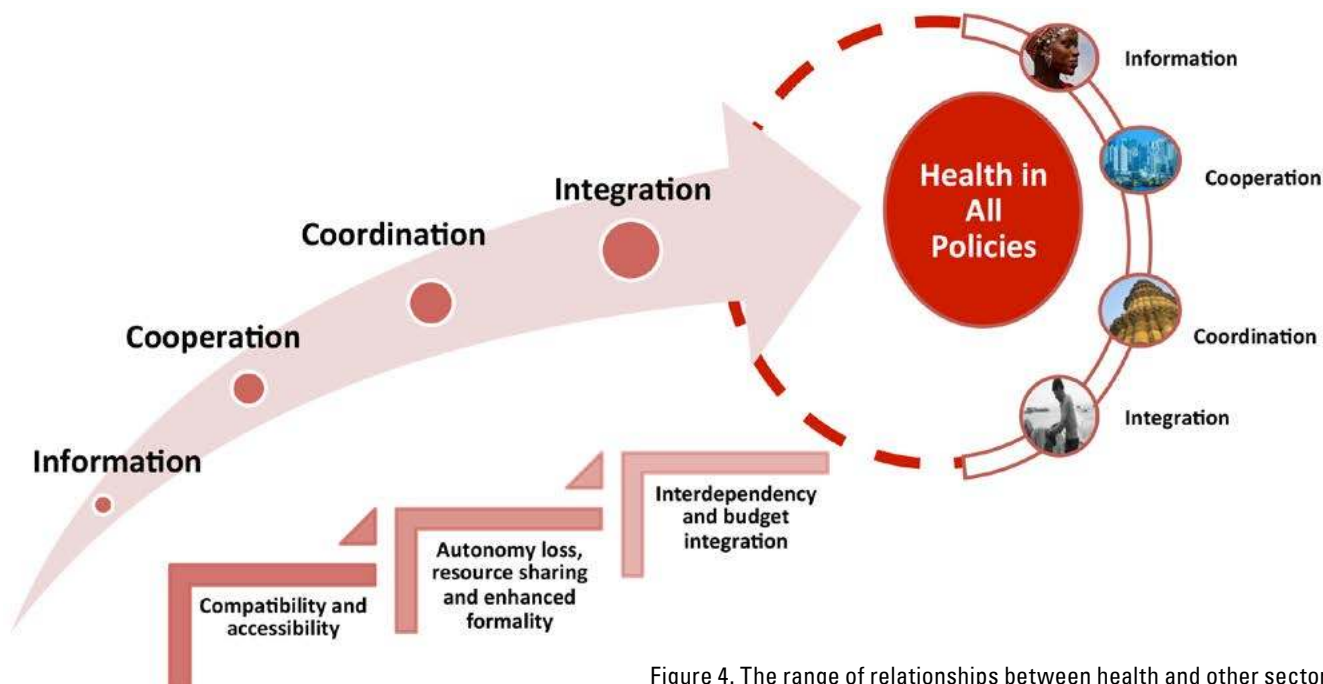


Figure 4. The range of relationships between health and other sectors.

## Key domains of an equity lens (in policies and interventions)

### Which intervention designs for “Health in All Policies” have a real impact on equity?

The third stage of the framework describes the focus and design of policies and programmes:

- › Entry point with regard to social determinants of health;
- › Universality of the approach;
- › Addressing equity gaps and gradients; and
- › Role of the health sector in the HiAP process.

### Entry point with regard to social determinants of health

If one considers that the social determinants of health inequities form an impact hierarchy from lower to higher, then the choice of entry point is important. Addressing different exposures to environmental contaminants would impact mid-stream while wages and workers bargaining power influencing access to resources that stratify health across groups in society would be a higher impact entry point. At the same time it is important to understand the origin of any given problem from different sectors’ perspectives, where evidence will be weighted differentially thus affecting decision-making.

### Universality of the approach

Policies fall along a continuum from universal to targeted approaches. “Targeting” assigns benefits to specific population groups. “Universalism” is defined as where: “the entire population is the beneficiary of social benefits as a basic right. ... Policy regimes tend to lie somewhere between the two extremes on a continuum, and are often hybrid.”<sup>13</sup> Specific management approaches result. These may strengthen intersectoral action in different ways. Joining up social services delivery in particular areas may result in universal policies being implemented via council or municipal level management. Another example is of strategies or approaches that target groups of peoples, such as poorer families or single mothers, having social units as the organizing mechanism for integrating sectoral work.

### Addressing equity gaps and gradients explicitly

A policy aimed at solely improving the health of a vulnerable group, without considering impacts on other parts of the population, is not strictly a pro-equity approach. The reduction of gaps or changing the gradient in health are not simply empirical issues – they relate to social solidarity and sustainability of policies in supporting social cohesion and human rights.

## Role of the health sector in the HiAP process

Clearly, using a Health in All Policies approach implies a role for the health sector at some point, however, it is not necessarily always most effective for the process to be led by the health sector. In adapting to existing processes in any given context it is important to identify the other primary sectors and groups involved and the role health can play.<sup>14</sup>

## Key drivers of sustainability

### Practice is not linear

Budget integration can modify or influence the structures and organization of government.

Intersectoral dialogue can influence the equity lens and design of policies and programmes for addressing the social determinants of health.

The fourth stage of the analytic framework describes how to analyse key drivers for sustaining intersectoral action in the context of Health in All Policies approaches and helps policy analysts and health workers to identify aspects that they need to check before and during the process of HiAP and intersectoral work in order to improve sustainability. These drivers are also important tools and mechanisms to be aware of in assessing best opportunities for increasing Health in All Policies actions:

- › Mandates – structures, organization and budgets;
- › Tools and mechanisms to strengthen interchange between sectors and;
- › Knowledge and skills of stakeholders.

The fourth stage of the framework includes factors that help shape the continued roll-out of intersectoral action once there is commitment to an HiAP approach. These factors may present entry points for increased Health in All Policies actions. The factors include formal mechanisms for influencing relationships between different sectors and financing the implementation; decision-making support tools for assessing impacts and evaluating progress of specific intersectoral work; and capacity building to support the knowledge and skills of stakeholder to build HiAP.

However, practice is not linear. For example, the pattern of relationships between sectors may change during the process of implementation; or the result of joining government sectors or budget integration may modify or influence the structure and organization of government, promoting vertical and horizontal integration; or mechanisms sustaining intersectoral dialogue may influence the equity perspective and the vision of health held across sectors.





## Country experiences

Examples of how the analytic framework can be used to examine real-life experiences are provided in the next section and are based on information from literature reviews and interviews conducted from countries in three regions of WHO: Africa, South-East Asia and the Western Pacific.



**BOX 5**

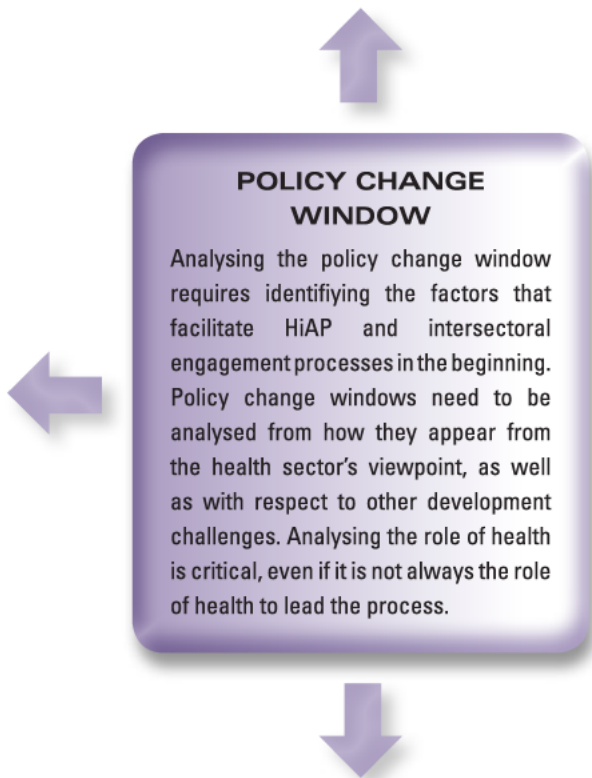
**AFRICA – KENYA, PRIMARY HEALTH CARE, COMMUNITIES AND NATIONAL EVIDENCE-LED POLICY PROCESSES**

People living in poverty are at increased risk of mental illness. A National Mental Health Strategic Plan was proposed in 2004 to afford a higher profile to this issue. An evidence-led process was supported to this end by the Kenyan Government and the United Kingdom’s Department for International Development. The evidence process fed dialogue. To reflect emergent thinking, the Mental Health Act of 1983 was amended in 2007. While this national process took place, NGOs collaborated at district level to raise awareness of mental health in communities. These dialogues, which included primary health care services, triggered programmes including training programmes. This case illustrates the various factors that come together to bring about policy change including societal norms, health programming and legislative instruments.

**BOX 4**

**SOUTH-EAST ASIA – ENVIRONMENT AND INTERSECTORAL WORK**

Intersectoral action gained importance in Thailand due to: increasing occurrence of health problems caused by environmental hazards such as air pollution, pesticide contamination, improper waste treatment etc.; and concerns about the health impacts of development projects such as large dams, coal-fired power plants and transnational gas pipelines and highways.<sup>15</sup>



**BOX 6**

**WESTERN PACIFIC – SOUTH AUSTRALIA AND THE OPPORTUNITY OF A STATE DEVELOPMENT PLAN**

Health in All Policies in South Australia has been influenced by the following four essential factors:

- A high level mandate from central government;
- An overarching policy framework which can accommodate review of health considerations “health lens analysis” in diverse programme areas;
- A commitment to work collaboratively and in partnership across agencies; and
- A strong evaluation process.

The health system is struggling with escalating health care costs, the growing burden of an ageing population and an increasing incidence of chronic disease. At the same time the evidence base has been clearly documenting that the best opportunities to change the dynamics that influence health lie outside the direct control of the health sector. The social determinants of health provide the social, economic and environmental levers to influence population health outcomes. South Australia’s Strategic Plan (SASP to all South Australian government agencies), with its 98 targets under six main objectives, provided for comfortable alignment with and an entry point for addressing the social determinants of health.<sup>16</sup>

BOX 7

### WESTERN PACIFIC VIEWS

When asked if they thought that the debates of politicians in the region have influenced leadership in favour of Health in All Policies work, each interviewee noted the importance of having calls for intersectoral action from politicians, because it reinforced the mandate for intersectoral action and HiAP approaches in specific countries. Being able to demonstrate that their own country was aligned with international movements was important to build pride in action domestically. Membership of cross-country initiatives/ministerial meetings helped push countries to be accountable for their actions in addressing the social determinants, therefore promoting HiAP action within the country.



*In South Australia, The fact that the UN is talking about multisectoral action through the high level NCD meeting in 2011 is important for central government here in South Australia. It shows that we are doing something innovative, that it is worthwhile, and that we're not out there on our own. It helps keep the ideas resonating in Australia. South Australia is considered to be amongst a good group, holding our heads well in that international context.*



*Health in All Policies. Report on perspectives and intersectoral actions in the Western Pacific Region, 2013, and related background interviews.*



### INTERNATIONAL INFLUENCES

The role international influences plays on national governments initiating intersectoral work ranges from normative influences of international agencies, to direct budget funding of bilaterals, to other factors affecting global diplomacy such as trade between countries and regions, or the desire for reputation as international leaders in particular areas of social or economic activity.



BOX 8

### SOUTH-EAST ASIA'S REGIONAL CONSULTATION ON SOCIAL DETERMINANTS OF HEALTH

Member States of WHO have affirmed their commitment to improving social determinants of health during various regional consultations. A Regional Consultation in Sri Lanka in 2007 led to the development of the Regional Strategic Framework on Intersectoral Actions addressing Social Determinants of Health. The "Colombo Call for Action" emerged from the *Regional Consultation on Social Determinants of Health: Addressing Health Inequities* held in Sri Lanka in February 2009. Under this Member States were urged to mainstream health equity in all policies, empower individuals and communities and advocate for good governance and corporate social responsibility.



### A STRATEGY FOR ADDRESSING THE KEY DETERMINANTS OF HEALTH IN THE AFRICAN REGION

BOX 9

In the World Health Assembly in 2013, Gabon spoke on behalf of countries in the WHO African Region (47 Member States), citing the relevance of previous World Health Assembly resolutions (WHA62.14 accepting the Commission on Social Determinants of Health report) and WHA65.8 (endorsing action areas in the Rio Political Declaration on SDH), and emphasized that implementation must involve building capacity in national health systems.

In responding to World Health Assembly resolutions, the Regional Office for Africa has established a programme on determinants and risk factors in order to accelerate the response to the main determinants associated with priority public health conditions. The Regional Office for Africa analysed the main social determinants of health and the causes of the rise in noncommunicable diseases in Small Island Developing States (Cape Verde, Sao Tome and Principe, Seychelles and Mauritius) and Madagascar in the Region.

## Key drivers of implementation

BOX 11

### AFRICA – VISION OF HEALTH IN SOCIETY AND CURATIVE HEALTH SERVICES

One can argue that the main health emphasis in the general populations in Africa embraces a curative health vision, possibly because of the range of services the population has been exposed to. Researchers have noted:

*“Preventive health utilization in sub-Saharan Africa is almost nonexistent, especially among the poor. The reasons include but are not limited to poverty, the lack of health facilities (especially in remote villages), a poor network of roads and transportation, and the population’s limited educational background. These and other numerous factors discourage health service utilization unless individuals are very sick and almost at the point of death.”<sup>17</sup>*

BOX 12

### AFRICA – COLLECTIVE RESPONSIBILITY FOR HEALTH – AS SEEN FROM THE AGRICULTURAL SECTOR

Responding to a vision of health, as viewed from another sector, can shape the way health engages intersectorally. The Comprehensive Africa Agriculture Development Programme (CAADP) is an African Union programme that aims “to eliminate hunger and reduce poverty through agriculture. CAADP brings together key players – at the continental, regional and national levels – to improve coordination, share knowledge, successes and failures, to encourage one another, and to promote joint and separate efforts to achieve the CAADP goals.” By 2015, African leaders hope to see “a more equitable distribution of wealth for rural populations.”

In a policy dialogue on agriculture, hosted by the African Union’s New Partnership for Africa’s Development (NEPAD), a minister for agriculture described malnutrition as a social and intersectoral problem in his call for different sectors, including health, to work together. The minister also put forward an economic argument: “Malnutrition significantly reduces labour productivity in agriculture and other sectors. The situation will persist if the quantity and quality of the food produced is not improved.”

<http://www.nepad.org/>

BOX 10

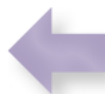
### SOUTH-EAST ASIA – STRUGGLING FOR A PROMOTIVE VIEW OF HEALTH

The field of health promotion has been advocating for multisectoral actions for more than two decades. The Bangkok Charter for Health Promotion in 2005 addressing global determinants of health called for “All for Health”, describing how “active health promoting schools, hospitals, communities, workplaces and cities play important roles in raising health concerns among the public.” Yet public health commentators note contradictions for the population, “Curative [health care] is far more attractive among voters rather than promotion and prevention. A large amount of budget will be allocated without any objection by non-health as well as curative-based medical professionals.”



### VISION OF HEALTH AND SOCIETY

The vision of health held by different actors and the broader society, including how it is maintained and whether it is seen as a collective or individual responsibility, shapes the expectations of different actors in the policy solution.



BOX 13

### WESTERN PACIFIC – MALAYSIA’S SOCIETAL CHALLENGES

How the vision of societal challenges shapes the role of health can be seen in the case of Malaysia. The health sector in Malaysia sustained a long period of intersectoral policy engagement linked to the New Economic Policy adopted in 1971. The economic policy focused on the eradication of poverty and the restructuring of society to achieve this end. With this focus, the health sector’s specific engagement was to address health for the poor and other disadvantaged groups. Population level disease profiles were also an important issue for the health sector (infectious diseases, malnutrition) but with a focus on water and sanitation conditions and the health of mothers and children. The inequitable distribution of health resources and facilities was a third focus for the health sector.<sup>18</sup>



## WESTERN PACIFIC – PALAU’S EXPERIENCE OF USING INFORMATION TO TRIGGER ACTION IN AN EMERGENCY POLICY FRAMEWORK – THE CASE OF NCDs

In Palau, the more traditional concept of the welfare state addressing determinants is set aside in favour of an “emergency” approach to working across sectors in the case of NCDs. With the seventh highest rate of overweight and obesity in the world, Palau’s President issued an executive order to declare a state of emergency on NCDs. It took the issue of NCDs to the National Emergency Committee that deals with disasters and emergencies for the nation. The first summit was organized by this committee in 2012 and supported the development of a multisectoral national strategic action plan. This initiative followed a decade of campaigning and information by health on the NCD epidemic and implications for health, society and the economy.



### TYPE OF RELATIONSHIPS WITH OTHER SECTORS – INTERGOVERNMENTAL

Collaboration can be usefully described according to the degrees of interdependence between sectors.<sup>19,20</sup> Intersectoral relations based on information sharing are more prevalent when visions of health are more narrowly focused on curative services. Societies and governments adopting broader visions of health tend to ensure health is addressed in all policies implicitly or through specific integrated programmes where separate traditional sectoral ministries are less autonomous.



### SRI LANKA’S EXPERIENCE CONTRASTS INTEGRATION AND COOPERATION ACROSS GOVERNMENT

Accounts of Sri Lanka’s experience in addressing health determinants through intersectoral action illustrate different approaches to collaboration. With high-level political commitment for the social welfare programme from 1950 to 1970 successive governments accorded high status to the social sector portfolios: health, education, development, agriculture and food. This meant a high level of integration in policy challenges and solutions, which required fewer topic-specific coordination mechanisms. Portfolios were assigned to the senior politicians.<sup>21,22</sup> The cabinet system ensured that all important policy decisions were taken collectively and was therefore the forum in which inter-ministerial coordination took place. During this period the cabinet did not establish any special inter-ministerial mechanisms such as cabinet committees. It was only in the 1980s that the government introduced a system of devolution by establishing the Provincial Councils.<sup>21</sup> The only intersectoral mechanism that functioned during this period was the District Coordinating Committee presided over by the Government Agent—the senior most administrative officer in a district. This committee had representatives from all the government departments that were functioning in a district including health, education, agriculture and transport.

Pandav MS (2012), input to *Health in All Policies. Report on perspectives and intersectoral actions in the South-East Asia Region*, 2013.



### AFRICA – COOPERATION AND COORDINATION BETWEEN HEALTH AND ENVIRONMENT

Joint planning committees are recommended in national models for intersectoral cooperation between health and the environment under the regional inter-ministerial agreement, the Libreville Declaration on Health and the Environment.

## AFRICA – IMPLEMENTATION SUCCESS AND COMMUNITY INVOLVEMENT

The literature for the Africa Region describes structures in place to facilitate social participation, such as public health advisory and hospital management bodies. Yet it also describes how community decisions are not always respected. Analysts observe that public participation is in many cases “used” to validate or legitimize health professionals’ actions. In some cases, the use of participation was described as helping “to fill gaps in understanding of the implementers” about underlying social determinants of health including exploring intervention approaches. On the other hand, studies noted that implementation failure was higher when the local community was not involved.

In the case of malaria, analysts noted, *“Although environmental management was historically coordinated by authoritarian/colonial regimes or by industries/corporations, its successful implementation as part of an integrated vector management framework for malaria control under democratic governments can be possible if four conditions are observed: political will and commitment, community sensitization and participation, provision of financial resources for initial cleaning and structural repairs, and inter-sectoral collaboration. Such effort not only is expected to reduce malaria transmission, but has the potential to empower communities.”*<sup>23</sup>

### TYPE OF RELATIONSHIPS WITH CIVIL SOCIETY (SOCIAL PARTICIPATION)

The vision of health in society can also shape the type and degree of public participation, in addition to the demands on policy-makers for health promotion and preventive services. In turn, the vision of health can have a strong influence on the relationship between government and civil society organizations, and other mechanisms for social participation. Relationships with civil society range from information sharing to involvement in decision-making. Education, income generation and gender equality are important prerequisites for empowerment through participation.

### WESTERN PACIFIC – NGOS HAVE A ROLE IN INFORMATION SHARING AND TRAINING

In China, Hong Kong Special Administrative Region, family training and involvement to support care of relatives with schizophrenia after deinstitutionalization is seen by the health sector as important.

In Viet Nam the Asia Injury Prevention Foundation (AIPF) plays an important role in the distribution of free helmets and training at schools. They have also promoted motorbike standards for children’s helmets, with Viet Nam one of three countries in the world to have such standards.

### SOUTH-EAST ASIA – INVOLVEMENT IN DECISION-MAKING THROUGH NATIONAL HEALTH ASSEMBLIES IN THAILAND

Community participation is central to the functioning of the People’s Health Assembly in Thailand, a process forming part of the overall approach to Health Impact Assessment (HIA) and Health in All Policies. In 2009 the National Health Commission set up the National Principles and Criteria for HIA public scoping to ensure the quality of public participation in the process. Based on the National Principles and Criteria for HIA public scoping, government agencies and project owners must provide essential information about the project, especially the possible positive and negative impacts on local determinants of health, 15 days before public scoping and also allow another 15 days for public consultation. An individual or group of people shall have the right to acquire information and an explanation of the underlying rationale from state agencies prior to permission or performance of a programme or activity which may affect someone’s health or that of their community, and shall also have the right to express their opinions on such matters (Section 67 of the Constitution of the Kingdom of Thailand BE 2550 (2007)). Government agencies and the National Health Commission Office must provide technical support and resources for local people to conduct their own parallel HIA study, called community HIA, to provide different viewpoints and ensure that all relevant evidence will be used in the decision-making process.

Pandav MS (2012), input to *Health in All Policies. Report on perspectives and intersectoral actions in the South-East Asia Region*, 2013.



## Key domains of an equity lens (in policies and interventions)

BOX 20

### WESTERN PACIFIC – UNIVERSAL, DOWNSTREAM AND MIDSTREAM SDH, NOT SPECIFICALLY TO ADDRESS HEALTH EQUITY

In Malaysia health equity is not the primary driver for intersectoral work unless it falls under specific goals or targets held by the other agency. “I can say it’s not the main, big focus. Across ministries and agencies from different sectors, only a few have health components or health aspects in their day-to-day work. Under the Committee of Health they have a Committee on Food and Food Safety, for example, and a few other ministries like Agriculture (in relation to food and food safety), or the Ministry of Trade. For me it [health equity] is not the key motivation for different sectors to participate unless they have some specific goals or targets.”

*Health in All Policies. Report on perspectives and intersectoral actions in the Western Pacific Region, 2013, and related background interviews.*

BOX 21

### AFRICA – WELFARE SECTORS – EMPHASIZE TARGETING, DOWNSTREAM AND MIDSTREAM SDH AND MONITORING VULNERABLE GROUPS IN CASH TRANSFER PROGRAMMES

In Mozambique a cash-transfer programme, also known as a “food subsidy”, is a monthly cash-transfer to extremely poor citizens to ease the combined negative effects of war, natural disasters and the structural adjustment programme. The grant targets women-headed households with five or more children and no other person of working age living in the same household, orphans, street children, victims of natural disasters, and “socially excluded” people. The cash-transfer programme has contributed to poverty reduction among urban beneficiaries, though rural coverage remains poor.

### ENTRY POINTS FOR SOCIAL DETERMINANTS OF HEALTH (SDH), UNIVERSALISM AND EQUITY

The contents of the policies and plan are crucial. This point refers to which aspects of social determinants are included: is the emphasis on downstream or on more structural social determinants of health? At the same time the coverage orientation – universal, vulnerable group or targeting – influences the likely equity outcomes. Monitoring will be set up according to the type of equity being addressed.

### SOUTH-EAST ASIA – SRI LANKA – UNIVERSAL, MIDSTREAM SDH, AND THE ROLE OF HEALTH EQUITY

BOX 22

Past analyses of Health for All policies in Sri Lanka<sup>21</sup> showed commitment to universal social welfare policies in relation to: health services, education, land development, agriculture and food. However these policies had no specific explicitly formulated aims to address health equity and measure change.

This lack of focus on equity is contrasted with the approach piloted by the health sector, with support of WHO, through local level Lighthouse Projects in 2010–12 where analyses of health equity according to social determinants is a key lever for recommending actions. These projects focused on marginalized areas and interpret health equity in the light of access to health care, and are focused on analysing SDH as causes of health inequities and in designing responses.

In a “community approach”, settings were used to study: access to health care in rural areas; social capital’s impact on access to health services in urban slums; and addressing social determinants for NCD prevention and control in “estate” settings.

*WHO Social Determinants of Health Lighthouse Project Narrative Report, 2012*

BOX 23

### SOUTH-EAST ASIA – HEALTH LEADING IN TOBACCO CONTROL POLICIES AND NEGOTIATING TO SHAPE NUTRITION OBJECTIVES ACROSS SECTORS

In Bhutan the Ministry of Health chairs the Tobacco Control Board, which is tasked with fulfilling obligations under the WHO Framework Convention on Tobacco Control and its protocols. The work of the Board is mandated by the Tobacco Control Act of Bhutan, which authorizes coordination with other government agencies with regard to their sectoral activities.

In India, the high level inter-ministerial task force leading the work on tobacco is also led by health.

In Nepal actions are led by other sectors, including those aimed at addressing food availability, affordability, access, and quality of food. A multisectoral planning framework was used to define strategic objectives, interventions, expected outputs, estimated budget and monitoring indicators for each sector. Here, health is more involved in shaping plans rather than coordinating activities of existing plans.



### ROLE OF HEALTH IN THE POLICY CYCLE

**Leader:** issues where the health sector has both the knowledge about effective measures and the means to control them (preventive services, equitable health systems);

**Negotiator:** issues where the health sector has the knowledge about effective measures but does not control the arena or the means to implement the measures (health promotion in schools – physical activity, healthy school meals);

**Partner:** determinants of health where the health sector has knowledge about the adverse health impacts of other sector policies, but where the health sector itself neither controls the means for implementation nor has the exact knowledge about how measures should be framed (inclusion in the labour market, reducing social inequalities in learning in schools, etc.).<sup>14</sup>



BOX 24

### WESTERN PACIFIC – HEALTH AND PARTNERS IN IMPLEMENTING VIET NAM'S HELMET LAWS FOR TWO-WHEELERS

In Viet Nam efforts, led by the Transport Ministry chairing the National Transport Safety Committee and reporting to the Prime Minister, saw health in the role of co-negotiator and partner. Health's responsibility was for hospital surveillance. With regard to the other ministries, among others, transport was responsible for drafting the legislation, and the culture and information ministry was responsible for social marketing. Evaluations of the measures to improve helmet usage overall showed sustained positive impacts.



BOX 25

### AFRICA – HEALTH AS PARTNER IN MICROFINANCE INITIATIVES

In Ghana the Freedom from Hunger Microfinance Initiative (MFI) and the Grameen Ghana Microfinance Institutions involve health as a partner. Health's role focuses on training and education to poor women from rural areas.

**WESTERN PACIFIC – INFORMAL OR FORMAL, EXISTING OR NEW STRUCTURES**

BOX 26

**Informal structures:** in the Western Pacific interview respondents were asked to comment on the need for formal structures and mechanisms for intersectoral engagement (e.g. statutory inter-departmental review groups, parliamentary committees, legal instruments). Most interviewees noted that both formal and informal structures are needed.

**Old and new:**<sup>18</sup> in assessing the role of intersectoral structures in malaria control, researchers noted that new structures orientated to working with other sectors to monitor outbreaks facilitate better results: "... in Mati, where a central unit was created for weekly surveillance of notifiable disease cases, health agencies and health workers collaborated closely with local government units ... and also with the education department and mining sector, on disease vector control."

**AFRICA – COMMON PRIORITIES FOR INTER-MINISTERIAL BOARDS AND COMMITTEES**

BOX 27

Prioritizing mental health formed part of the health sector reforms and policies in Kenya between 2005 and 2010. As part of this process the Ministry of Health, at national level, led a policy process involving ministries from other sector including police, prisons, schools, child protection and social welfare. These sectors with a major interest in mental health were represented on the Kenya Board of Mental Health.

**MANDATES OF STRUCTURES, ORGANIZATION AND BUDGET**

Structures that affirm or establish mandates are important for balancing power in particular as health is frequently a ministry with less power in lower income settings. These structures can also help with organizing work and ensuring budgets, e.g. liaising for planning and priority setting, liaising for developing policy solutions, and for obtaining budgets or resource approval from different sectors.

**SOUTH-EAST ASIA – EXISTING STRUCTURES**

BOX 28

"Existing intersectoral governance structures serve as important mechanisms for multi-sectoral coordination. These include Parliamentary committees; Cabinet committees; Inter-departmental committees and processes for stakeholder engagement (citizens, industry etc.).

In India and Sri Lanka there are Ad hoc Committees and the Standing Committees and Parliamentary Committees. Ad hoc Committees are appointed for a specific purpose and cease to exist on finishing the assigned task.

In Timor-Leste the National Parliament has nine specialist Parliamentary Committees including Comissão Saúde, Educação, Cultura, Veteranos e Igualdade de Género for Health. These consist of a President and representatives from various Party Benches."

Pandav MS (2012), input to *Health in All Policies. Report on perspectives and intersectoral actions in the South-East Asia Region*, 2013.

### SOUTH-EAST ASIA – INDICATORS THAT HELP BUILD BRIDGES BETWEEN DIFFERENT SECTORS

“In Bhutan the Gross National Happiness (GNH) Commission was established in 2008 by merging the functions of the Planning Commission and the Committee of Secretaries. They developed the Gross National Happiness Index; it is a single number index developed from 33 indicators categorized under nine domains. The concept of GNH stands on four pillars: good governance, sustainable socio-economic development, cultural preservation, and environmental conservation.”

“In Timor-Leste the Geographical Index of Social Vulnerability (GISV) was developed by United Nations Mission in Transition (UNMIT) to promote adoption of a holistic development approach by highlighting inter-district differences. The GISV has three levels: the first level contains the deficits (habitat, access to social services such as health and education; access to assets; and employment). The second level is made of the dimensions of those deficits in terms of sectors. The third level includes the indicators and the normative values. Timor-Leste has also developed an “Intersectoral Action Framework for Wellbeing and Health”.

Pandav MS (2012), input to *Health in All Policies. Report on perspectives and intersectoral actions in the South-East Asia Region, 2013.*

### AFRICA – LACK OF MONITORING AND EVALUATION, BUT APPLYING INNOVATIVE SITUATION ASSESSMENTS

In the literature on African countries several research papers note the lack of monitoring and evaluation capacities and mechanisms, especially those that include attention for social determinants of health or the health impact of policies in other sectors. With regard to intersectoral assessment tools, there is one notable good example, called the situation analysis and needs assessment (SANA) tool<sup>26</sup> which aims to:

- Provide a framework and technical tools to countries in order to help them undertake their situation analysis and needs assessment for the implementation of the Libreville Declaration;
- Facilitate harmonization of methodologies, procedures, indicators and tools for country situation analyses and needs assessments;
- Facilitate identification of national priorities; and
- Facilitate the implementation of existing national development plans ensuring a more comprehensive consideration and integration of health and environment issues.

### TOOLS AND MECHANISMS TO STRENGTHEN INTERCHANGE

A wide variety of mechanisms and tools may aid intersectoral engagement itself, which can increase the efficaciousness of initiatives.<sup>24</sup> Tools that assist in evaluating impacts or progress with intersectoral work make invaluable contributions to the sustainability of intersectoral action and Health in All Policies.<sup>25</sup> Health impact assessment and lenses are some of the typical tools used during decision-making and policy or programme design. Less commonly available are joined-up monitoring and assessment tools for intersectoral interventions. Evaluation processes can function to facilitate or hinder coordination and interchange between different sectors.

### WESTERN PACIFIC – MEASURING SUCCESS IN TERMS OF EFFECTIVE PARTNERSHIPS AND HEALTH MORTALITY AND MORBIDITY

The Health Lens Analysis (a structural approach to intersectoral collaboration at the heart of South Australian HiAP) for mobility, safety and well-being for Aboriginal people in South Australia evaluates success in terms of the understanding of other sectors of the linkages of their policies with the social determinants of health. Health is also able to monitor and evaluate changes in mortality and morbidity as a result of new approaches to drivers' licensing for Aboriginal people.



### AFRICA – LACK OF SKILLS IN OTHER SECTORS AT THE LOCAL LEVEL

In Johannesburg, South Africa, the case studies in the literature indicate how other sectors too lack skills in intersectoral work for social development. These skills are critical for the implementation of UHC. *“Social development directorates at local authority level are also required to align their strategies and plans with local needs and priorities. In order to bridge the gap between municipalities and communities, community development workers employed at local authority level are envisaged to be the link between local government and communities. However, evidence-based social development planning remains ineffective. This is due in part to a knowledge and skills gap in this area, including a lack of baseline data and indicators to monitor progress over time. Social development units are unclear about their roles in poverty reduction and how to implement intersectoral plans and social development programs.”*<sup>27</sup>



### KNOWLEDGE AND SKILLS OF STAKEHOLDERS

A wide variety of mechanisms and tools can be used to strengthen the knowledge and skills of stakeholders. In this sense intersectoral processes that specifically build in, or create structures or platforms for dialogue, can aid the development of understanding of the pathways to health.

Processes such as social participation, but also monitoring and evaluation, are said to be hampered by poor knowledge in both health and other sectors, and financial and personnel shortages. For example, if people do not know their rights, or have no knowledge of the topic, they do not participate or they will not develop social norms that support changes to policies in other sectors to improve health and health equity.



### WESTERN PACIFIC – LACK OF KNOWLEDGE ON HIAP

Several of the public health workers interviewed in the Western Pacific commented on a lack of knowledge surrounding HiAP, why it is necessary and its potential outcomes. Demonstrating the importance of Health in All Policies to other sectors will be an important step in facilitating HiAP initiatives. They also recommend that the term “social determinants of health” needs to become “integrated” into the language used across all sectors; from that foundation of understanding, the message can be taken on board at the highest decision-making levels.



### SOUTH-EAST ASIA – EAST TIMOR EXAMPLE OF MONITORING

The Intersectoral Action Framework (IAF) for well-being and health (a framework for action) was formulated in 2005 in East Timor as an inter-ministerial strategy that uses an integrated primary health care approach. The strategy identifies the key diseases in East Timor and then links them with “key determinants” (social determinants) of health. The proposed IAF is supposed to provide direction for joint government and community action but its status as a policy tool is not yet certain. The key components derived through this process may yet offer insights for how health can use knowledge of interlinkages for capacity building and intersectoral dialogue within planning processes. The components included:

- Reduction in negative environmental determinants of health and well-being (water, air, sanitation, food supply and quality);
- Treatment of illness, prevention initiatives and interventions for common disabilities;
- Improving knowledge, skills and competencies for individuals and groups;
- Enabling better use of and improving access to essential resources to those in need; and
- Strengthening social support mechanisms, practices and policies.



## Key messages

Moving forward, country discussions on the topic of implementing Health in All Policies escalated in the lead-up to the WHO 8th Global Health Promotion meeting in June 2013. This report contributes to these deliberations.

The proposed framework analyses the understanding of Health in All Policies by breaking down the concept into a systematic list of stages and domains that have relevance for intersectoral action and implementation. These should not be confused with steps for implementation – which need to be spelt out in implementation plans, and for which the WHO Health in All Policies Framework for Country Action is constructed. Rather, this analytic framework articulates concepts and questions to be asked prior to or during implementation.

### Checklist

As such, the framework acts as a kind of checklist (see Table 1). The usefulness of checklists is well known. In this case, a checklist on the concepts behind our understanding of the term “Health in All Policies” can facilitate clearer discussions by making assumptions explicit, and avoiding any unintentional bias – for example, not considering the vision of health in other sectors. On the other hand, it also helps to make explicit the unknowns – such as how failure to invest in knowledge and skills may threaten the sustainability of Health in All Policies.

### Key lessons

Thus far the analysis of literature reviewed according to the domains listed in the analytic framework has yielded interesting insights. Some of these insights have been documented in previous literature reviews,<sup>28</sup> but never with a specific focus on developing countries. Key lessons are summarized below.

Material compiled for the proposed analytic framework thus far indicates that it could have validity across diverse countries and regions, including for developing countries. Limitations observed in the peer-reviewed literature reviewed have made it possible to get a clearer picture of some of the questions to be answered by the analytic framework, while others will require further reviews, in-depth case studies and dialogue in order to gain further understanding of opportunities for Health in All Policies.

#### a. How do we communicate this approach to other sectors?

Literature from many of the countries did not use the term Health in All Policies. Most of the peer-reviewed literature was focused on intersectoral action. Interviewed officials recommended not introducing HiAP as a new approach, rather it should be presented as a quality improvement tool. In this context, HiAP would build on existing ways of working and framing action. While indications are that many policy-makers have understood that all sectors have the potential to affect a population's health, there is also a predominant understanding of health actions associated with health care delivery. Also policy-makers do not have a clear vision of the

role of health and other sectors when making a call to work for health equity. Some recommended not using health-dominant language in working with other sectors.

#### b. What opportunities exist for beginning HiAP?

From the health sector's perspective the reviews and interviews describe a close link with primary health care when there is a strong will to develop the HiAP approach from the local level. In addition reports describe the NCD action plans as providing important opportunities. These opportunities need further investigation via more case studies and discussions in regional meetings.

#### c. What organizational structure is it necessary to develop?

Importantly, regional experiences suggest developing processes using existing structures and opportunities, or at least not thinking solely of creating new structures. Of key importance in organizational structure is allowing space to facilitate interchange between different sectors.

#### d. How do we maintain the sustainability of HiAP processes?

Facilitating factors were mainly identified in relation to developing and sustaining partnerships. At a policy level intersectoral action (ISA) partnerships require good quality information to support the selection of strategies, priorities and interventions that are relevant to the country, and continued high-level political commitment backed up by adequate resources and adequate participation of local communities.

#### e. What are the main barriers to be addressed?

Siloed structures and funding separated for sector specific activities are described as barriers. The ability to see and coordinate activity beyond these silos in order to gain a holistic view of issues is required from policy-making, down to service delivery levels.

Additional barriers identified were lack of knowledge or understanding of what HiAP is and why it is necessary and what the outcomes would be.

The lack of a specific mandate and framework for HiAP policies was also cited as a significant barrier to the long-term sustainability of such initiatives.

#### f. How does HiAP contribute to addressing equity?

Coherence between the components of an equity focus of action requires further study, for example to gain a better understanding of the mechanisms through which the components of equity goals and the management strategies can be developed and how they work in each sector involved.

Much intersectoral action in the Western Pacific Region is not explicitly focused on health inequities. Despite being characterized by action on societal factors rather than health the equity angle is not obvious.

## g. What is the health sector's role in the HiAP process?

The role of the health sector is an issue that needs to be analysed in depth. At this stage it is not possible to deepen this aspect of the analytic framework, but questions have arisen that must be studied. For example, the leadership of non-health sectors in cases where agendas are driven by a call for social equity or improved state efficiency rather than health equity could be examined.

It is important to analyse the relationship between the structures for intersectoral action and the focus of the work, i.e., whether a group of public policies is involved or if the focus is narrower. Different focuses could give rise to different organizational patterns and different roles for health.

Table 1. Checklist for assessing experiences

	Criteria	Descriptions	Best HiAP	
Opportunities for initiation	Policy change window	Political will high	X	
		Political will low		
	International influences	Favour HiAP, health equity	X	
		Do not favour HiAP, health equity		
Key drivers of implementation	Vision of health (used by health sector and others)	Closer to social indicators	X	
		Closer to absence of disease		
	Relationships within governmental partners	Integration	X	
		Cooperation – coordination	X	
		Informative		
	Levels of administration of the government involved	All levels of government	X	
		Only national and federal/state		
		Only local level		
	Relationships between government and non-government actors (civil society)	Involving in decision-making/priority setting	X	
		Information sharing		
Key domains of an equity lens (in policies and interventions)	Entry points to address social determinants of health	Structural and intermediary social determinants of health	X	
		Only intermediary social determinants of health; life style or working and housing conditions		
		Not including SDH, or has a sole emphasis on access to health services		
	Coverage approach	Universal or mixed	X	
		Targeted only		
	Equity as an explicit targeted outcome of HiAP	YES	X	
		NO		
	Main approach to address equity	Gradient	X	
		Gaps		
		Vulnerable groups		
	Role of health in the policy process	Policy development	X	
		Implementation		
		Monitoring and evaluation		
Key drivers of sustainability	Mandates of structures, organization and budget	Formal or informal structures and mandates	YES	X
			NO	
		Integrated budget or pooling of resources	YES	X
			NO	
	Tools and mechanisms to strengthen interchange between sectors	Solid information base to analyse equity and HiAP for monitoring and evaluation	YES	X
			NO	
		Use impact assessment	YES	X
			NO	
	Knowledge and skills of stakeholders	Personnel with appropriate public health training and negotiating skills	YES	X
			NO	
		Good knowledge of the policy-making system and structures	YES	X
			NO	

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