World Health Organization

Second WHO Discussion Paper
(Version dated 16 February 2015)

First Draft of the Framework for Country Action Across Sectors for Health and Health Equity

Contents

Executive summary

The purpose of this framework is to respond to a request from the World Health Assembly in Resolution WHA67.12, which charges the Secretariat to prepare a framework for country action to support "national efforts to improve health, ensure health protection, health equity and health systems functioning, including through action across sectors on determinants of health and risk factors of noncommunicable diseases, based on best available knowledge and evidence". This framework aims to provide technical assistance to Member States in taking country-level action across sectors for improving health and health equity; such action includes the health sector's support to other sectors in developing and implementing policies, programmes and projects in their own remit, in a way that optimizes co-benefits (i.e. for all sectors involved).

The document explains what action across sectors means, why such action is needed, the underlying values and principles and how effective actions can be carried out across sectors. It also clarifies the various roles and responsibilities, and provides practical steps for taking action, and for monitoring and evaluation (M&E) of actions taken.

Action across sectors refers to policies, programmes and projects undertaken by two or more government ministries or agencies. It includes both purely horizontal action between ministries and agencies, and action across different levels of government. Key approaches include the "health in all policies" approach and the "whole-of-government" approach. Engagement with non-state actors who play a critical role in promoting action across sectors is essential; this is also known as multistakeholder action. .

Health action across sectors is necessary, because many factors that are key to health outcomes lie beyond the reach and control of the health sector. Such factors include the causes of, distribution of and risk factors for many diseases (both communicable and noncommunicable); inequitable access to care; and the social, economic and environmental determinants of health. Action across sectors is particularly important in low-income countries; for example, because of weak physical infrastructures in such countries, overemphasis on economic development, and limited capacity of and access to health systems. Action across sectors is a key part of sustainable health intervention in the context of the post-2015 development agenda.

Action across sectors can take many forms; for example, action might be initiated by the health authority, the head of government or local government; a new agency may need to be formed; or authorities outside of health may take the lead.

This framework was developed based on the WHO Discussion Paper ''Framework for country action across sectors for health and health equity'', which went through a web-based consultation from 29 Oct to 31 Dec 2014. It incorporates comments (see http://www.who.int/nmh/events/action-framework/en/) on the background paper, and is again open for comment from Member States. The main principles on which it is based are right to health, health equity, health protection and good governance and the need to safeguard public health interests.

There are six key components to implementing health action across sectors:

- Establish the need and priorities for action across sectors
- Establish an M&E and reporting mechanism
- Identify supportive structures and processes
- Frame the planned action
- Facilitate assessment and engagement
- Build institutional capacity (in the health sector, public health institutions, non-health ministries, and non-state actors and communities)

For each of these components, the framework provides a summary of what is needed and why, and then lists possible actions; each component is also illustrated by a case study.

It also outlines the roles and responsibilities of those involved; for example, the lead agency, the health sector, other government sectors, WHO, other UN organizations, the community and non-state actors. The document also discusses management of conflict of interest.

Three annexes provide examples of indictors for the “EQuAL” framework; the objectives, indicators, baselines and targets of the “Plan of action on health in all policies”; and examples of HiAP key result areas.

Background

In May 2014, the Sixty-seventh session of the World Health Assembly accepted Secretariat Report EB 134.54 on "Contributing to social and economic development: sustainable action across sectors to improve health and health equity (follow-up of the 8th Global Conference on Health Promotion)", and approved the associated Resolution EB 134.R8.

Resolution WHA 67.12, Operative Paragraph 3 (1) charges the Secretariat "... to prepare, for the consideration of the Sixty-eighth World Health Assembly, in consultation with Member States, UN organizations and other relevant stakeholders as appropriate, and within existing resources, a framework for country action, for adaptation to different contexts, taking into account the "Helsinki statement on health in all policies", aimed at supporting national efforts to improve health, ensure health protection, health equity and health systems functioning, including through action across sectors on determinants of health and risk factors of noncommunicable diseases, based on best available knowledge and evidence."

The resolution is based on a history of commitment from institutions and WHO Member States to achieving health and health equity, implementing universal health coverage, improving the social determinants of health, and combating both communicable and noncommunicable diseases (NCDs). It draws on various resolutions, statements and commitments adopted by WHO Member States, including the:

- 2011 Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases (A/RES/66/2) and the 2014 Outcome Document of the High-level Meeting of the United Nations (UN) General Assembly on the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of NCDs (A/RES/68/300);
- Outcome Document of the 2012 UN Conference on Sustainable Development: "The future we want" (A/RES/66/288);
- 2011 "Rio political declaration on social determinants of health" (WHA65.8);
- outcome documents of the WHO Global Conference Health Promotion Series from Ottawa (in 1986) to Helsinki (in 2013);
- UN General Assembly Resolution A/67/L.36 supporting universal health coverage; and
- 1978 "Alma-Ata declaration on primary health care".

Following on from Resolution WHA67.12, the 2014 outcome document of the High-level Meeting of the UN General Assembly on the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of NCDs (resolution A/RES/68/300) welcomed the request that the Director-General of WHO prepare the framework for country action as set out in Resolution WHA67.12. Working across sectors will be central to implementation of the post-2015 development goals currently being negotiated by Member States.

Section 1: Introduction

1.1 What is the purpose of the current framework?

This framework responds to the request in Resolution WHA67.12, and provides technical assistance to Member States in taking country-level action across sectors for improving health and health equity; such action includes the health sector's support to other sectors in developing and implementing policies, programmes and projects in their own remit, in a way that optimizes co-benefits (i.e. for all sectors involved).

The document explains what action across sectors means, why such action is needed, the underlying values and principles and, most importantly, how effective actions can be carried out across sectors at all levels of government. The framework clarifies the roles and responsibilities of different governmental and nongovernmental players, and provides practical steps and tools to facilitate implementation of action across sectors.

The framework can be used to address a specific health issue, or to establish a more comprehensive, systematic approach to ensuring action across sectors for health and health equity.

1.2 What is action across sectors?

Action across sectors refers to policies, programmes and projects undertaken by two or more government ministries or agencies. It includes both purely horizontal action between ministries and agencies, and action across different levels of government. Traditionally, the health sector has taken a lead in action across sectors for health and health equity; for example, through the "health in all policies" approach[1] and the "whole-of-government" approach.[2]

Substantial health gains can also be obtained through an explicit effort from sectors outside health, as outlined below in Section 1.3. Therefore, it is important for the health sector to support other sectors in developing and implementing policies, programmes and projects within their own remit that optimize co-benefits. Thus, in this framework, action across sectors also refers to "multisectoral action".[3]

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[1] ***Health in all policies (HiAP)*** is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergy and avoids harmful health impacts. It aims to improve population health and health equity. It also improves accountability of policy-makers for health impacts at all levels of policy-making, and emphasizes the consequences of public policies on health systems, and on determinants of health and well-being. See "Helsinki statement on health in all policies". Geneva: WHO

[2] ***The whole-of-government approach*** is one in which public service agencies work across portfolio boundaries, formally and informally, to achieve a shared goal and an integrated government response to particular issues. It aims to achieve policy coherence in order to improve effectiveness and efficiency. This approach is a response to departmentalism that focuses not just on policies but also on programme and project management. See "Connecting government: whole of government responses to Australia's priority challenges". In: Australian Public Service Commission (APSC) [website]. Canberra: APSC, 2004 (http://www.apsc.gov.au/publications-and-media/archive/publications-archive/connecting-government, accessed 2 October 2014).

[3] ***Multisectoral action*** is action between two or more sectors within the public sector. This term is generally interchangeable with "intersectoral action".

Engagement with non-state actors who play a critical role in promoting action across sectors is essential; this is also known as "multistakeholder action".[4]

1.3 Why is health action across sectors necessary?

Health action across sectors is necessary, because many factors that are key to health outcomes lie beyond the reach and control of the health sector. Such factors include the causes of, distribution of and risk factors for many diseases (both communicable and noncommunicable); inequitable access to care; and the social, economic and environmental determinants of health. Also, action across sectors is needed to ensure health protection and health systems functioning; both of which are essential for improving health and health equity.

A few examples of how health is affected by actions beyond the health sector are the:

- decline of road deaths as a result of a set of measures in, for example, safer road design and motor vehicle safety;
- reduction in cardiovascular disease and stroke due to a reduction in dietary salt intake;
- decline in mesothelioma by regulations against the use of asbestos
- decrease in mortality from diarrhoea because of improved access to clean water and sanitation; and
- increase in life expectancy due to additional years of education.

Action across sectors has proven to be an effective way to address specific health issues, throughout the life course most notably in tobacco control and in combating HIV/AIDS. It is also highly effective in health-emergency situations, which usually require the rapid participation and cooperation of various sectors (e.g. health, security and emergency responders, trade and industry, education, housing, environment and travel).

Action across sectors is needed in all countries, but is particularly important in low-income countries. Some of the reasons for this are the weak physical infrastructures in such countries (e.g. lack of or inadequate supply of clean water and waste management); lack of social protection; overemphasis on economic development; weak regulation and legislation for the prevention and control of NCDs, and for protection of people and the environment; and limited capacity of and access to health systems.

Action across sectors is a key part of sustainable health intervention in the context of the post-2015 development agenda.

[4] ***Multistakeholder action*** refers to action by actors outside the public sector, such as nongovernmental organizations (NGOs) and the private sector. See Paragraph 37 of the "Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases" (A/RES/66/2).

1.4 What forms does health action across sectors take?

Action across sectors can take multiple forms:

- the **health authority** initiates actions, with participation from one or more ministries or agencies, and focusing primarily on improving health and health equity (this is the most common form of action);
- the **head of government** initiates action on an outbreak or emergency, with all ministries participating most of the time (this form of action is often used to combat disease outbreaks or manage health emergencies);
- a **new government entity** is established (or an existing government entity is used) to oversee and promote collaboration among different ministries, to address a priority public health concern (this form of action is common in national or local responses to HIV/AIDS);
- **authorities outside health** assume the lead agency role, as has occurred in the prevention of road deaths and injuries, where the road transport authorities have become increasingly willing and capable to assume the lead role: there are many examples of this form of action; for example, in environmental protection agencies taking action on environmental hazards including air pollution; and
- action is initiated at the **local government level**; it is increasingly common to find various sectors working together to address one or more public health and health equity issues through community-based or setting-based health promotion activities (e.g. healthy cities[5] and health-promoting schools).

1.5 How was the current framework developed?

To develop this framework, WHO first reviewed existing frameworks for action on related topics, produced by WHO and other international organizations. Some of the common elements of these frameworks are a background, definitions, values and principles, and specific actions. Many frameworks also include case-studies and links to tools for use in the development, implementation or evaluation of national action plans. WHO also reviewed past documents related to Resolution WHA67.12 (i.e. the resolutions, statements and commitments listed in the Background section).

In the next step, WHO used the review findings to produce a background paper, and then shared it with Member States for comment. The comments submitted were collated and used to inform this current draft, which is again open for comment.

1.6 What are the next steps?

This first draft of the framework will be released by 16 February 2015, and will be available for web-based consultation until 3 March 2015.

[5] *Types of healthy settings*, WHO (http://www.who.int/healthy_settings/types/cities/en/)

The draft framework for country action will be revised in light of the comments on this document and those on the discussion paper that have not yet been addressed by the Secretariat. Technical support for the revisions will be provided by a technical reference group at a meeting to be held on 5-6 March 2015. The revised draft (i.e. the second draft) will be submitted for consideration by the Sixty-eighth World Health Assembly in May 2015.

The key findings from the web-based consultations (see http://www.who.int/nmh/events/action-framework/en/) will be collated and made available online, to increase transparency and shared learning. A key objective of this process is to elicit input from Member States, UN organizations and other intergovernmental organizations, relevant NGOs and selected private sector entities to the design and development of the framework for country action.

This discussion paper will also be widely disseminated to Member States, UN organizations and non-state actors through existing networks such as the UN Interagency Task Force on the Prevention and Control of NCDs and the WHO Global Coordination Mechanism on the Prevention and Control of NCDs, as well as regional and international forums and web platforms.

Section 2: Proposed framework for country action across sectors for health and health equity

2.1 Core values and principles

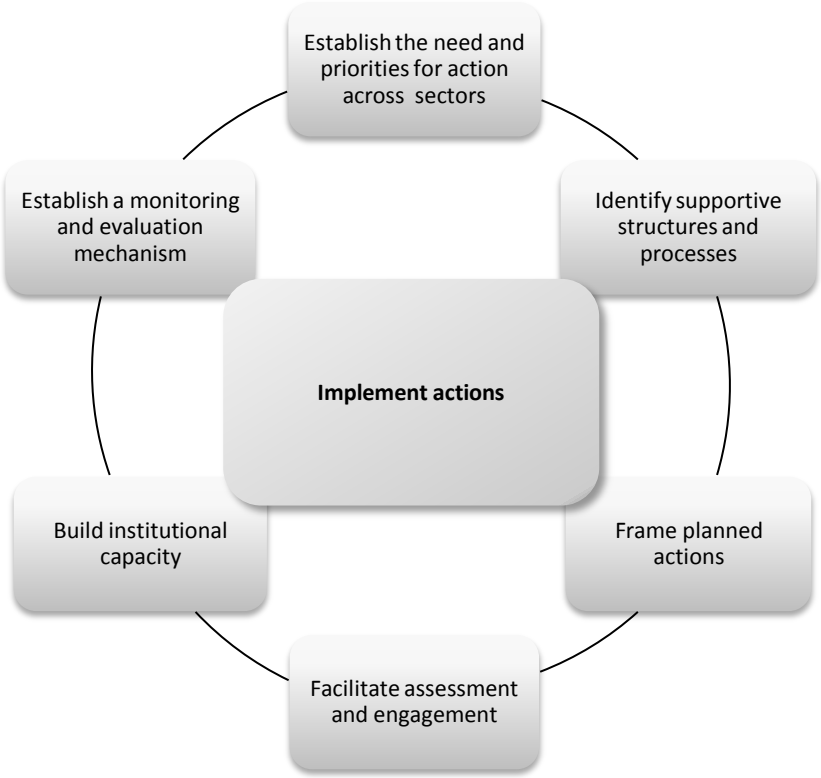
The main values and principles on which the framework is based are listed below:

- ***Right to health****:* This is in line with the WHO Constitution: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." The right to health applies equally to all stages of life.
- ***Health equity****:* Equity in health can be addressed when there is a focus on the causes of the disparities that persist. Vulnerable populations need to be given special attention.
- ***Health protection****:* Disease prevention and health promotion is a key responsibility of governments, and legislation, rules and regulations are important instruments to protect people from social, economic and environmental threats to health.
- ***Good governance****:* Accepted principles of good governance include *legitimacy*, grounded in the rights and obligations conferred by national and international law; *accountability* of governments towards their people; *participation* of wider society in the development and implementation of government policies and programmes; and *sustainability* to ensure that policies aimed at meeting the needs of present generations do not compromise the needs of future generations.
- ***Safeguard of public health interests****:* To safeguard such interests it is necessary to avoid undue influence by any form of conflict of interest, whether real, perceived or potential.

2.2 Proposed components for action

There are six key components that countries need to address in implementing effective health action across sectors, as shown in Figure 1 and discussed below. These components are not fixed in order or priority. Countries should adapt and adjust the components based on the country's specific social, economic and political contexts.

Figure 1 Key components to implement health action across sectors



Key component: Establish the need and priorities for action across sectors

Establishing the need for action means determining what the needs are and how they might be addressed. Establishing priority is about setting the public agenda – not simply giving importance to action across sectors for health and health equity, but also keeping such action high on the agenda. To these ends, gaps in health and services (particularly for those in a disadvantaged position) must be revealed, and what works must be made known. It is also important to support other sectors in developing and implementing policies, programmes and projects within their own remit that optimize co-benefits.

Listed below are some of the actions that can be taken to establish needs and priorities:

- *Ensure that there is high-level political will and commitment* – this requires advocacy, to raise awareness that achieving health and health equity is a key responsibility of all of government; that health is an outcome of all policies; and that health contributes to broader societal and policy goals such as economic growth and sustainability.
- *Build a case for action across sectors* – increasing the awareness of decision-makers, civil society and the public about how policies from different sectors of government can affect health and health equity; demonstrating how the engagement of key non-state groups and communities can enhance the results of taking action; brining a focus on the benefits to other sectors by working with the health sector; and communicating the costs of inaction.
- *Actively engage the community*.

- *Use political mapping* – this can identify members of government who would be supportive and influential in ensuring the commitment of other sectors.
- *Identify areas of common interest*, and existing intersectoral structures and frameworks that can be strengthened to improve the efficiency of work.
- *Prioritize actions* – this could be based, for example, on the significance of the issue to health, health systems collaboration or health equity; the alignment with government priorities; the existence of feasible, evidence-based solutions to address the issues; available resources; or ethical criteria.

Reducing tobacco demand in Turkey

Turkey was the first country to attain the highest level of coverage in all of the WHO "best-buy" demand-reduction measures for reducing tobacco prevalence. In 2012, the country increased the size of health-warning labels to cover 65% of the total surface area of each tobacco or cigarette packet. Tobacco taxes cover 80% of the total retail price, and there is currently a total ban on tobacco advertising, promotion and sponsorship nationwide. The result of these concerted efforts has been a significant decrease (13.4% relative decline) in the smoking rates of a country that has a long tradition of tobacco use and high smoking prevalence. This progress is a sign of the Turkish government's sustained political commitment to tobacco control, exemplifying collaboration between government, WHO and other international health organizations, and civil society.

Extracted from the Global status report on noncommunicable diseases 2014 p 58http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf

The WHO Urban Health Equity Assessment and Response Tool (Urban HEART)

Urban Health Equity Assessment and Response Tool (Urban HEART) is used by many countries to engage communities in documenting health inequities and their determinants, and in formulating responses to redress the inequities. It provides an opportunity for policy and decision makers from different sectors at national and local levels to identify and analyse inequities in health between people living in various parts of cities, or belonging to different socioeconomic groups within and across cities and to cooperate in using this evidence to identify and prioritize effective interventions for tackling health inequities. The core elements of HEART are: sound evidence, intersectoral action for health and community participation. HEART proposes planning and assessment strategies and provides a series of indicators. The tool comes with a user's manual and a workshop training manual which is complemented by set of PowerPoint presentations.URBAN HEART is a result of collective effort between and city and national officials from across the world. The tool was pilot tested in 11 cities around the world which provided important inputs. The tool is available in all WHO official languages at http://www.who.int/kobe_centre/publications/urban_heart/en/

Key component: Establish a monitoring, evaluation and reporting mechanism

Mechanisms for M&E and reporting on progress provide evidence for what works and for best practice. Each sector is probably already responding to its own M&E key performance indicators and deliverables; thus, it would be creating additional tasks for stakeholders if they were asked to set out M&E for indicators for intersectoral coordination, intervention and implementation. However, examples of indicators can be drawn from those being developed by WHO for monitoring intersectoral influences on equity in health and universal health coverage (Annex 1), and in the "Plan of action on health in all policies" (Annex 2).

Listed below are some of the actions that can be taken to establish mechanisms for M&E and reporting:

- *Start M&E planning early* in the process and, where appropriate, develop an evaluation framework.
- *Incorporate M&E throughout the process* of taking action (see Annex 3 for examples of possible key result areas).
- *Establish the baseline, targets and indicators*, as appropriate. For the intersectoral action, these can be formal indicators and performance targets (on health status; on health inequities and their determinants; and on health action). Alternatively, a country can use a more flexible case-studies approach based on its specific situation and needs (it is best to use existing governance-related M&E structures and frameworks where possible).
- *Obtain data that can provide estimates for the different subpopulations*, especially for the most vulnerable.
- *Carry out agreed M&E activities* according to agreed schedules.
- *Ensure that reporting mechanisms are not too onerous* for the participants, to avoid compromising the actual work of implementation.
- *Disseminate results and lessons learnt* to all participating sectors, in order to provide feedback for future policy and strategy rounds.

PAHO Plan of action on health in all policies

The Member States in the WHO Regional Office for the Americas/Pan American Health Organization (AMRO/PAHO) adopted the 2014–2019 "Plan of action on health in all policies" (CD53/10)18 at the 53rd Directing Council in September 2014. This plan of action is based on the six strategic lines of action, consistent with the WHO "Health in all policies (HiAP) framework for country action". Countries in the WHO Region of the Americas are highly diverse; hence, each country will implement the plan of action according to its own specific context. Nevertheless, the adoption of this plan is a first step in securing a mechanism that will monitor progress on HiAP in a systematic manner. The plan sets out a total of 12 indicators, and includes baselines and targets.

Key component: Identify supportive structures and processes

In this context, a *structure* is a platform for actors from different sectors to interact. It can be a collection of people designated for a function or purpose such as a committee or an interagency network. It does not need to be a physical infrastructure but can be a service provider or a collection of interrelated services, such as a public health institute. A *process* is interaction and communication, including power dynamics and influences, between actors.

Listed below are some of the actions that can be taken to identify structures and processes:

- *Strengthen the ministry of health* in terms of its capacity to identify and engage with different government sectors, WHO and other UN organizations, communities, NGOs, social movements and civil society in actions initiated by the health sector. It is important to identify and initiate dialogue with motivated leaders and champions, and with individuals who contribute to decision-making or policy implementation, within different sectors.
- *Identify the most appropriate lead agency* to manage, take forward and account for the action across sectors for a given topic (e.g. in an action to reduce diarrhoea in children, this might be the ministry of the environment). Also, ensure that the agency has the necessary human resources to carry out the coordination work needed, examine existing collaboration frameworks across sectors, and explore the possibility of integrating health and equity aspects in those dialogues.
- *Create realistic and functional structures for communication and for working across sectors* (or using existing structures where available – examples are shown in Table 1), with clear terms of reference and responsibilities. These structures could be topic specific or broad enough to tackle multiple issues. At the national level, experience from different countries indicates that structures work best if it is chaired by the prime minister or president.
- In those countries where there is a decentralized government structure, *consider existing inter-territorial coordination mechanisms*, ensuring that regional and local entities are involved in the process.

Table 1 Examples of structures to foster collaborative work across sectors[6]

Structures	Description	Example
Interministerial committees	Composed of representatives from various governmental sectors. Usually horizontal (i.e. similar administrative levels – national, subnational, district), but sometimes vertical. Can include nongovernmental organizations (NGOs), private sector and political parties; and can be permanent, be time limited, have generic tasks or be ad hoc and centred around a specific task.	Advisory Board for Public Health (Finland) Intersectoral Commission of Employment (Peru) Intersectoral Commission for the Control of Production and Use of Pesticides, Fertilizers and Toxic Substances (Mexico) Health in All Policies Task Force (California, United States of America) National Commission for Implementation of Framework Convention on Tobacco Control and its Protocols (CONICQ) (see case-study)
Expert committees	Comprising experts from public sector structures, academic institutions, NGOs, think tanks or private sector; often created ad hoc around a specific task; composition can have a political balance.	Presidential Advisory Council for Pension Reform (Chile)
Support units	Unit within ministry of health or other ministries with a mandate to foster intersectoral collaboration.	Health in All Policies Unit (South Australia, Australia)
Networks	Flexible coordination mechanism composed of institutional partners.	Canterbury Health in All Policies Partnership (Canterbury, New Zealand)
Merged or coordinating ministries	Ministries with a mandate that includes several sectors or responsible for intersectoral coordination.	Ministry of Social Affairs and Health (Finland) Ministry of Health and Family Welfare (India) Department of Social Development (South Africa)
Public health institutes	Public institutes with capacity to monitor public health and its determinants, and to analyse policies and their potential health implications across sectors.	See International Association of National Public Health Institutes

[6] "Helsinki statement on health in all policies." Geneva: WHO

Operationalizing innovative funding for the treatment of HIV AIDS

Kenya has depended heavily on external funding for HIV for many years. Donor funds are expected to decline beginning of 2013 as a result of the global financial crisis and new donor priorities. A significant funding gap is emerging.

In order to tackle the funding gap, Kenya has established a High Level Steering Committee for Sustainable HIV Financing. The Steering Committee is supported by a technical working group focused on the development of a National HIV Sustainable Financing Strategy, which has been generating proposals for sustainable domestic financing of the HIV response. The key proposal is the establishment of an HIV and Non-Communicable Diseases Trust Fund that would pool additional public and private resources. The current proposal is for the allocation of 0.5% to 1% of government ordinary revenues to the Trust Fund, which may enhance its income by additional innovative financial strategies such as an airline levy. Over time, as other funding sources become available, this public money could be diverted to fund health-related priorities through the Mid Term Expenditure Framework, or the expansion of the National Health Insurance Fund as it evolves into a social health insurance scheme. The revenue in the Trust Fund should represent an increase in Kenyan Government HIV spending. It has been calculated that this will fill 70% of the HIV funding gap between 2010 and 2020, and 159% of the gap between 2020 and 2030 (25). A Cabinet memorandum containing this proposal has twice been submitted for discussion. Treasury is currently considering the option.

Extracted from Efficient and Sustainable HIV Responses: Case studies on country progress-UNAIDS 2013

Note: Further details of the Trust Fund and sustainable domestic financing can be found on Kenya AIDs Strategic Framework 2014/2015 – 2018-2019
http://www.nacc.or.ke/attachments/article/460/KENYA%20AIDS%20STRATEGIC%20FRAMEWORK(KASF).pdf

Key component: Frame the planned action

Action plans can be stand-alone, or incorporated into existing action plans or strategic documents. The lead agency will initiate the planning with the collaboration of the intersectoral established structure, whether that be a committee, a working group or some other structure.

Listed below are some of the actions that can be taken to frame the planned action

- *Identify and review the data available for a given issue* – this will include a legal and policy analysis, and a summary of available evidence-based interventions.
- *Identify existing action plans, policy documents and mandates* of the different sectors involved – to identify synergies and develop a common plan to improve health and health equity.
- *Define and agree on* objectives, targets, indicators, population coverage, roles and responsible agencies and individuals, timelines, resources, a contingency plan and an M&E plan.

- *Ensure adequate human and financial resources* – although an increase in staff members might not be necessary, change in job practices might be required.
- *Develop a strategy to identify, prevent or counteract conflicts of interest*.
- *Develop a strategy to report the results* and give adequate feedback to all sectors involved, and to the general public.
- *Develop an M&E strategy*.

Ecuador: The national good living plan

Ecuador's Plan Nacional para el buen vivir (National Plan of Good Living, or NPGL) has become the roadmap for the development and implementation of social policies in Ecuador, with the full backing of the highest political authority. The concept of Good Living is based on a broad definition of health. Health is one of a set of specific sectoral work plans, each of which has to be consistent with national strategy and priorities. The health sector work plan is guided by the social determinants of health approach, and its goals are realized through the Development Coordinating Ministry, which supervises the Ministries of Health, Labour, Education, Inclusion, Migration, and Housing. Between 2006 and 2011 when the Programme was implemented, social investments increased 2.5 times; the proportion of urban homes with toilets and sewage systems increased from 71% to 78%; rural homes with access to collection of waste increased from 22% to 37% and health appointments in the public service sector increased by 2.6 per 100 inhabitants.

Extracted from Health in all policies: Framework for country action. 2014 p 10
http://apps.who.int/iris/bitstream/10665/112636/1/9789241506908_eng.pdf?ua=1

Key component: Facilitate assessment and engagement

Active participation by both state and non-state actors as well as people in the wider community is essential throughout the assessment and engagement process. The agency responsible for conducting the assessment will depend on the type of assessment needed. In some cases, an independent body may need to be engaged for this task. Key activities include assessing patterns of and contributors to health inequities; assessing epidemiology of health issues, and the impact of current or future public policies on health and health equity; and engaging key groups and communities. Assessing and communicating the health implications of adopted policies and those that are planned or contemplated will help to increase engagement.

Listed below are some of the actions that can be taken to facilitate assessment and engagement:

- *Assess the health impact of policies* – for example, using health and health equity impact assessment, health and health equity lens analysis, and policy audits and budgetary reviews.

- *Create an inclusive policy-making process* that includes key individuals, civil society groups and community leaders who are likely to be impacted by existing or proposed policies. These people or groups should be invited to give their opinion on the health benefits or adverse consequences of the policy, and their suggestions for improvement. Formal engagement tools can include health assemblies, citizen juries, town hall discussions, deliberative meetings or individual consultations. Internet-based tools such as discussion forums and social media are good alternatives.
- *Identify individuals involved in decision-making* or policy implementation, and invite them to engage in the dialogue to understand their priorities and recommendations.
- *Explore available mechanisms for scrutiny* within the legislative process, such as oversight committees, public hearings, issue-based groups and coalitions, and public health reports to legislature.

Health impact assessments in Thailand

Health Impact Assessment (HIA) is a process which helps decision making by predicting the consequences for health of choosing different options in terms of policies, plans, and projects ... Many policies … including investment in infrastructure and industrial development — have caused negative health effects on local people. Without a process for proper public participation, many conflicts have arisen around almost all large government projects throughout the country …The legal status of HIA in Thailand is quite well developed. Three pieces of legislation governing HIA are the Thai Constitution, the National Health Act and the Enhancement and Conservation of National Environmental Quality Act. HIA can be conducted in three forms: project HIA (combine with EIA/ EHIA or separate HIA); policy HIA and HIA as a social learning process. Development at Map Ta Phut has been a driving force for HIA. Local people worked with a committee set up to solve implementation of the relevant section of the Thai Constitution (section 67 paragraph 2). Rules and regulations and other related documents were established including rules for preparation and consideration of EHIA; lists of projects/activities which have been notified as possibly seriously harmful to community; roles of independent organization in providing opinions on such projects/activities.

Extracted from ''Development of health impact assessment in Thailand: recent experiences and challenges'' by Wiput Phoolcharoen, Decharut Sukkumnoed & Puttapong Kessomboon (2003) and from ''Health Impact Assessment: Past Achievement, Current Understanding, and Future Progress'' by John Kemm (2012)

Key component: Build institutional capacity

Promoting and implementing action across sectors is likely to require the acquisition of new knowledge and skills by a wide range of institutions, professionals (health and non-health) and people in the wider community. Institutional capacity refers not only to the expertise of individual practitioners but also to existing policy commitments; availability of funds, information and databases for planning and M&E; and organizational structure. Technical exchanges between institutions is an effective way for building institutional capacity

Listed below are some of the many readily available approaches that can be taken to build institutional capacity in different sectors.

For the health sector

- *Train or support health professionals* to acquire the requisite knowledge and skills to engage with other sectors, and effectively communicate the need for action across sectors for improving health and health equity (communication skills are essential to communicate findings to policy-makers and community members; to engage with other sectors to increase interest in health outcomes; and to learn about the goals and interests of other sectors).
- *Strengthen leadership skills within health* and other sectors to foster intersectoral action, cross sector collaboration, partnerships and so on.
- *Develop case-studies* that demonstrate the co-benefits of engaging with health issues for other sectors; multidisciplinary knowledge and teams can assist in formulating such studies.
- *Encourage interactions* between health-focused academics and personnel from health ministries, to build capacity for action across sectors.

For public health institutions

- *Reinforce the capacity of the institutions to carry out multidisciplinary research* on the health of populations and of determinants of health, and use the research data to advocate for policy change. This approach should include systematic collection and analysis of health data, policy analysis and development of solutions to any issues identified.
- *Enhance the ability of the institutions to provide assistance to other sectors*.

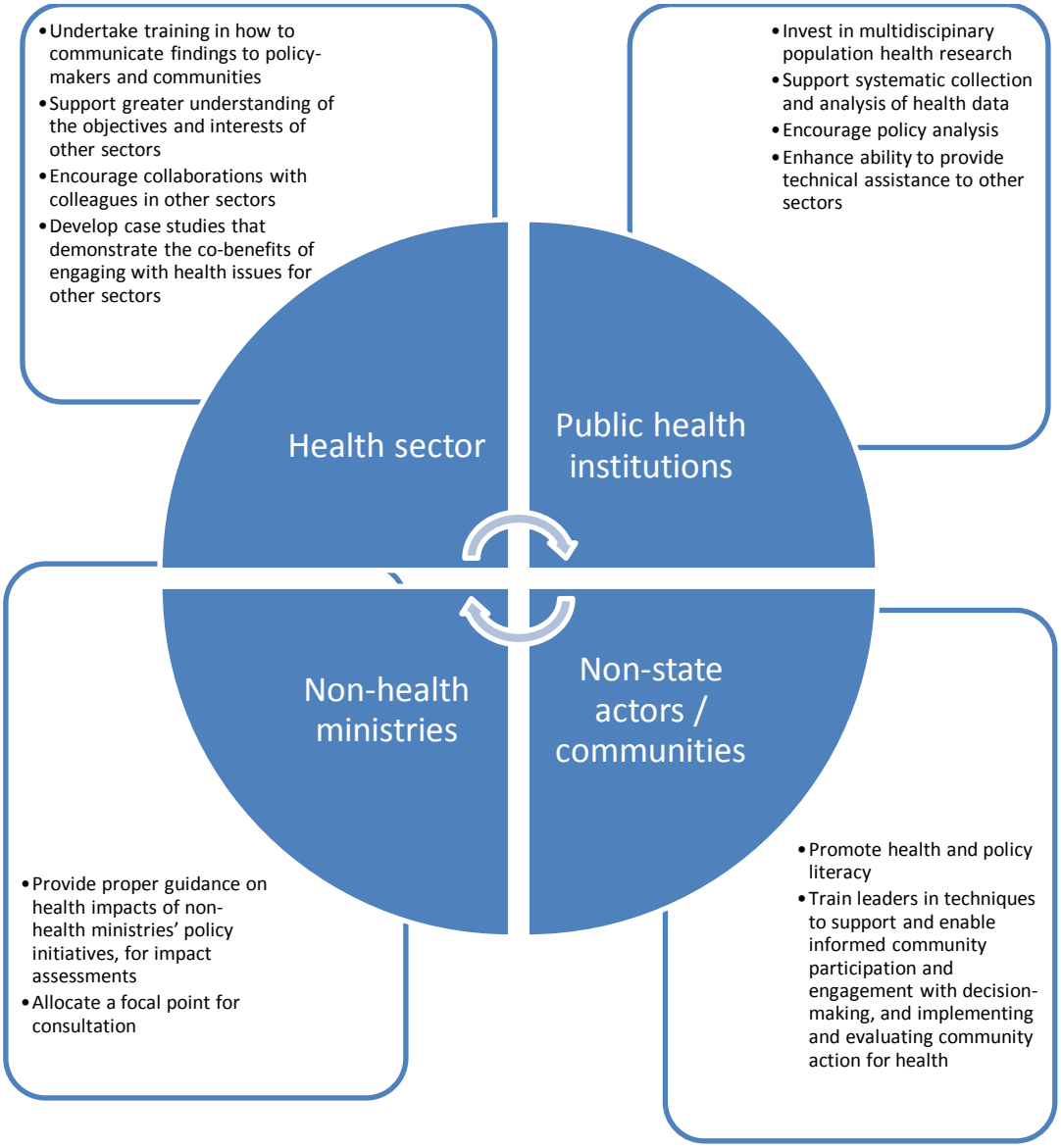
For non-health ministries

- *Provide guidance on the potential health impacts* of non-health ministries' policy initiatives, to ensure realistic impact assessments.
- *Allocate a focal point for consultation*.
- *Identify opportunities to build the capacity of non-health ministries around the health agenda*; for example, by seconding personnel to the health ministry to gain an understanding of health issues and the potential health impact of policies from other ministries.
- *Recognize the expertise of non-health sectors* and invite guidance on health planned projects and policies; this will help to build relationships and a shared understanding of policy agendas.

For non-state actors and communities

- *Support the ability of community members to fully participate in community action for health*; for example, by promoting health and policy literacy; training leaders in techniques to support and enable informed community participation, and engagement with decision-making; and implementing and evaluating community action for health.

- *Build on existing relationships at the local level* – for example, between local government and communities – to engage citizens in action across sectors.
- *Identify opportunities to engage non-state actors*, including the private sector, in regular policy dialogue to facilitate shared understanding of the health agenda.



WHO Health in All Policies Training Manual

The purpose of this manual is to provide a resource for training to increase understanding of Health in all Polies (HiAP) by health professional and professionals from other sectors. The material in this manual will form the basis of two-to- three-day workshops which will: build capacity to promote, implement and evaluate HiAP; encourage engagement and collaboration across sectors; facilitate the exchange of experiences and lessons learnt; promote regional and global collaboration on HiAP; and promote dissemination of skills to develop training courses for trainers. The training is structured to target professionals from middle to senior levels of policy-making and government from all sectors influencing health. It contains 12 modules with suggested timings, learning objectives, key messages, key reading for participants, supporting material for instructors and teaching notes, videos, case studies and other training materials.

2.3 Implementation of actions

The application of action across sectors requires conscientious effort and judicious use of evidence. To maximise the impact of application, theory driven practices are essential and to put theory into practice, tools are necessary.

Listed below are some of the key issues for effective implementation:

- *Strategic application* – the need to address priority public health concerns according to a country's situation when applying the framework. Examples of such concerns include the rapidly growing burden of NCDs and of communicable diseases such as Ebola, HIV/AIDS, malaria and tuberculosis; and the health impacts of environmental changes such as urbanization.
- *Being alert to windows of opportunity* – crises, changes in government and other contextual factors may present opportunities to engage across sectors beyond the scope of planned action.
- *Putting plans into action* – the need to ensure that all the different sectors *understand* their roles and responsibilities (including the amount of resources that need to be invested and the implications of not performing the assigned activities) and also *fulfil* those roles and responsibilities.
- *Developing different strategies* – to increase collaboration with different professional groups (e.g. urban planners) to mobilize their contributions to health and health equity efforts.
- *Providing for contingencies* – the need to manage contingencies that may occur; periodic communication (e.g. virtual meetings, emails and teleconferences) between the sectors will help to encourage progress, identify issues, and share successful experiences and unmet objectives.
- *Creating an organizational culture that supports implementation*.

Salt-reduction campaigns in Bahrain, Kuwait and Qatar

The ministry of health of Kuwait established a national salt-reduction programme in January 2013. The Salt and Fat Intake Reduction task force developed and implemented a national strategy to reduce salt consumption, in consultation with nutrition experts and scientists and officials from Kuwait's Food Standards Office, and in collaboration with the food industry. By the end of 2013, one of the food companies had reduced the salt content of bread – including white pitta bread, burger buns and whole-wheat toast – by 20%.

Kuwait is exploring ways of reducing the salt content of another commonly consumed food item – cheese. The Qatar government is working with one of the country's major bakeries to reduce the use of salt by 20%, and Bahrain is setting up a similar campaign.

Extracted from the Global status report on noncommunicable diseases 2014 p 4
http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf

Multi-sectoral engagement for road safety in Viet Nam

With more than 10,000 people killed on Viet Nam's roads each year, road trauma is a leading cause of death and disability. Since 2010 and under the auspices of the Bloomberg Initiative for Global Road Safety, WHO, as part of an international consortium, formed an ongoing partnership with the National Traffic Safety Committee (NTSC) to support the implementation of evidence based interventions for the promotion of motorcycle helmet wearing and the prevention of drink—driving, contributing to the achievement of national road safety objectives.

As a multi-sectoral committee, the NTSC includes representatives from a range of ministries and agencies, all contributing to various elements of the national response to road traffic injuries based on their jurisdictions and expertise.

Reflecting a safe systems approach to road traffic injury prevention, WHO's engagement included with the NTSC Secretariat producing mass media social marketing campaigns for broadcast on national television, with the Ministry of Transport promulgating comprehensive road safety legislation, with the Ministry of Public Security for enhanced enforcement practices and the use of essential equipment and the Ministry of Health for the development of hospital based guidelines testing and quantifying the role of alcohol in those presenting with road traffic injuries.

Interventions implemented in two provinces, contributed to a 19% and 34% reduction in road traffic mortality between 2010 and 2013.

Tools are required to enable countries to effectively implement the components. These tools include national strategies for action, health sector self-assessments, impact

assessments, disaggregated data (including data on determinants of health), and mapping of government activities and opportunities. Governments may also use legislation including international treaties, presidential orders, establishment of new government units, and memoranda of understanding to improve intersectoral action.

Tools can also be used to incorporate health action across sectors within legislative processes; for example, through oversight by committees with statutory responsibilities for health, public hearings and consultations, issue-based groups and coalitions within the legislature, and public health reports to legislatures.

Other tools can be used to facilitate actions within a sector or between sectors. Such tools include joint budgeting, health impact and health equity impact assessments, health and health equity lens analysis, environmental impact assessment, policy audits and budgetary reviews.

Section 3: Sector roles and responsibilities

3.1 Roles and responsibilities

Lead agency

For health action across sectors to be effective, a lead agency is needed that will actively coordinate and manage the process. In many cases, the health authorities are in a natural position to assume the lead role.

To effectively influence other sectors to undertake action for health, the lead agency must possess the authority to lead, the necessary expertise, and the requisite information about the health issues and their implications for other sectors. The lead agency should also have a good understanding of the priorities and decision-making methods of other sectors.

Whatever agency takes the lead, the terms of reference for all sectors of government must be established at the outset of the planning process, so that all are clear about their roles and responsibilities, and the benefits they may gain. This will avoid duplication of activity, and increase effective collaboration among the various actors.

Health sector

The health sector has the mandate, legitimacy and expertise to initiate partnership with other government sectors to increase cooperation in addressing issues related to the promotion of health and health equity. It has a core advocacy function in promoting action across sectors and in articulating the mutual benefits of such an approach. Its role will shift depending on the form of action across sectors taking place, and the nature of the issue and risk factors.

Possible roles for the health sector are to:

- build knowledge and generate an evidence base for policy development and strategic planning;

- clearly articulate to other sectors the cost of inaction versus investment in action across sectors; for example, as for NCDs, identify opportunities to influence policy to better support health and administrative imperatives of other sectors;
- assess comparative health consequences of options within the policy development process;
- initiate regular and continuous dialogue with other sectors;
- understand the priorities and decision-making methods of other sectors;
- review and assess the effectiveness of action across sectors;
- build capacity through better mechanisms, resources and agency support for skilled and dedicated staff;
- work with other governmental sectors to achieve their goals and, in doing so, advance the health and well-being of the population;
- advocate for health protection and for social determinants of health to be addressed in public discourse and public policies; and
- promote synergy and negotiate trade-offs between sectors and among potential institutional partners.

Other government sectors

Action by sectors other than health can contribute to improved health and health equity; for example, through policies involving social protection, food security, education, poverty reduction, transportation, environment, finance, and trade and commerce. Some sectors work more closely with the health sector than others, depending on two key factors: common interests and co-benefits.

Increasingly, with decentralized governance in countries, the role of mayors (or their equivalents) – and their contributions to promoting and facilitating action across sectors within and beyond the local government – must be examined and documented. The impact of action across sectors at the city level can be substantial through the healthy cities approach, which defines a healthy city as one that is continually creating and improving those physical and social environments, and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.[7]

WHO

In line with its expertise and experience in responding to health issues at the global and regional level, WHO should aim to:

- promote evidence-based practices for action across sectors, synthesize lessons, and develop tools for further adaptation by countries;

[7] *Health Promotion Glossary*, WHO (www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf)

- include health considerations in global and regional policy-making and UN interagency work;
- promote action on universal health coverage and the social determinants of health;
- support policies for global health protection and health promotion;
- promote inclusion of health and determinants of health indicators as benchmarks for development and health outcomes; and
- address emerging global issues that could have harmful health impacts.

At the country level, WHO can provide technical assistance and advocacy to national efforts to implement the framework on health action across sectors; for example, it can:

- compile, analyse and share good practices being used by Member States;
- provide guidance and technical assistance for implementation of policies across sectors at the various levels of governance;
- ensure coherence and collaboration across programmes and initiatives within WHO;
- work with and provide leadership for other UN organizations, to encourage them to consider health objectives when implementing and monitoring major strategic initiatives;
- participate in multisectoral meetings to provide advice on work across sectors to promote health and health equity;
- convene country-level UN interagency task forces – for example, the UN Interagency Task Force on the Prevention and Control of NCDs (UNIATF) – within the UN country team;
- provide technical assistance for action on social determinants of health, and on the development of an evaluation framework; and
- help to build capacity for evaluation methods.

Other UN organizations

Many UN organizations and global forums support action on social determinants for health in fields such as education, environment, refugees, gender and human rights. If health considerations were more explicitly included in these efforts, it would improve their potential impact on health and health equity. The integration of NCDs into roll-out processes of the UN Development Assistance Framework (UNDAF) will support governments in integrating measures for NCD prevention and control into health planning at the country level, as well as national development and policies beyond the health sector.

The UNIATF is a recent example of action across sectors, working at the country level to prevent and control NCDs.

The United Nations Interagency Task Force on the Prevention and Control of NCDs was established in 2013 at the request of the Economic and Social Council (ECOSOC). The Task Force is led by WHO and coordinates the activities of UN organizations and other inter-governmental organizations in support of the 2011 Political Declaration on NCDs and the WHO Global NCD Action Plan 2013–2020. The Task Force's terms of reference were adopted by ECOSOC in 2014. The Task Force has six objectives, which in summary are to enhance and coordinate systematic support to Member States, at the national level; facilitate systematic and timely information exchange across Task Force members on strategies, programmes and activities; facilitate information on resources to support national efforts and undertake resource mobilization; strengthen advocacy efforts; ensure that tobacco control is prioritized; strengthen international cooperation to support national, regional and global NCD plans.

The Task Force undertakes Joint Country Missions to support UN Country Teams (UNCTs) scale up action on NCDs. In 2014, Joint Country Missions took place in Belarus, India and Kenya. The need for UNCTs to respond to NCDs has been highlighted in two joint letters to UNCTs from the Administrator, UNDP and the Director-General, WHO. The 2012 letter proposed UNCTs integrate NCDs into UNDAF design processes and implementation. The 2014 one reiterated the importance of mainstreaming NCDs into UNDAFs and encouraged UNCTs to scale up capacity to support governments in responding to NCDs.

A work plan for 2014-2015 describes actions that the Task Force is working on collectively. A progress report will be issued in December 2015. The Secretary General reports regularly to ECOSOC on the work of the Task Force.

Further details on the Task Force are available at http://www.who.int/nmh/ncd-task-force/en/.

Community engagement

Communities are in a key position to identify health issues and inequities, and to suggest suitable solutions at the local level. Although there is valuable collective local wisdom, it is important to build community capacity by supporting the ability of community members to fully participate in community action for health. This may include promoting health and policy literacy, and training leaders in techniques to support and enable an informed community.

Non-state actor engagement

Non-state actors are individuals and organizations not associated with government; they include members of the private sector (e.g. companies, trade associations), NGOs (both advocacy and service-delivery oriented), academia, faith-based organizations, civil society groups, media and political parties.

NGOs play a critical role in promoting health action across sectors due to their significant influence on affairs of the state. They are usually led by passionate and committed individuals with great advocacy skills and the capacity to influence public

opinion. They can often provide data and evidence on health and equity issues, which is important for identifying vulnerable populations and the need for action. NGOs can provide useful resources and technical expertise in the development of policies and plans. Member States seeking to implement health action across sectors should seek to engage and include potentially relevant NGOs as much as possible.

The private sector is key to achieving specified goals, but can also contribute to negative impacts on health and their risk factors. Thus, understanding potential contributions and impacts on health is a first step to determining appropriate engagement, while managing potential conflicts of interest.

The outcome document of the High-Level Meeting of the UN General Assembly on the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of NCDs (A/RES/68/300) asked WHO to develop an approach to registering and publishing contributions of the non-state actors (including the private sector and civil society) towards achieving the global voluntary NCD targets.

3.2 Managing conflict of interest

Member States' engagement with non-state actors, especially with the private sector, must be regulated in line with national and international law and principles, to safeguard public health interests from undue influence by any form of conflict of interest: real, perceived or potential.

Governments should conduct transparent due diligence and risk assessments before entering into engagement with non-state actors. As far as possible, they should ensure that financial resources for specific local or national coalitions devoted to action for health across sectors, as well as any regulatory or norm-setting functions, are independent. When appropriate, Member States can obtain the support of the international community in the oversight and management of engagement, particularly in regards to international treaty obligations (e.g. Framework Convention on Tobacco Control).

The "Helsinki statement on health in all policies" urges governments to adopt conflict of interest measures to protect policies from distortion by commercial and vested interests and influence.

Using WHO as an example, a framework for non-state actor engagement is being developed to clarify:

- how to capitalize on the beneficial contributions of non-state actors to health action across sectors;
- the distinctions between real and perceived conflicts of interest, and between individual and institutional conflicts of interest;
- how WHO should deal with actors who do not share the interests of WHO, or with situations where secondary interests undermine public health; and
- how WHO should distinguish between direct and indirect interests.

Annex 1: Examples of indicators for monitoring health in all policies and causes of incomplete service coverage using the "EQuAL" framework domains: equity oriented analysis of linkages between health and other sectors (Work in progress)

Monitoring intersectoral influences on access to health services and determinants of health[8] should cover at least three lines of action: ensuring Environmental Quality, Accountability and Livelihoods. As the collection of indicators is still under development, only one area, Environmental Quality will be explored in further depth here. Definitions of the indicators are available through their respective data sources.

Line of action 1: Promote health and health coverage through ensuring a quality environment

Target 1.1 (Amenities): Reduce(by X%) the percentage of people who are prevented from accessing adequate health care and health because of lack of basic services, such as access to water, sanitation, waste removal and transportation.

Potential indicators: (1) Travel time to outpatient and inpatient care in minutes. (2) Access to electricity. (3) Access to improved drinking water. (4) Access to improved sanitation facilities. (5) Access to waste disposal. (6) Infrastructure and services at health facilities.

Track baseline and current trends from existing sources as follows: (1) SAGE[9] questions 5031 and 5009a. (2–5) WHO Global Health Observatory; WHO's household energy database; WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation; additional data is available through surveys such as AIS, DHS, MIS, MICS and SAGE. (6) As no comprehensive indicator was found, a proxy indicator will look at whether health facilities have a separate toilet facilitates for clients and if they experience power outages (SARA and SPA).

Target 1.2 (Housing): Reduce (by X%) the percentage of people whose health is detrimentally affected by sub-standard housing .

Potential indicators: (1) Substandard housing and slums. (2) Access to safe energy for cooking. (3) Crowding.

[8] For a full definition of the social determinants of health, see http://www.who.int/social_determinants/

[9] Abbreviations as follows: Study on Global Aging and Adult Health (SAGE), Multi-Indicator Cluster Surveys (MICS), Demographic and Health Survey (DHS), Labour force surveys (LFS), AIDS Indicator Survey (AIS), Malaria Indicator Survey (MIS), World Values Survey (WVS).

Track baseline and current trends from existing sources as follows: (1) UN Habitat's Monitoring Urban Inequities Programme and Global Urban Indicators Database; additional data is available through MICS Compiler. (2) WHO Global Health Observatory; WHO's household energy database; additional data is available through surveys such as AIS, DHS, MIS, MICS and SAGE. (3) Persons sleeping per room – StatCompiler.

Target 1.3 (Community spaces and products): Reduce (by X%) the percentage of people whose health or access to services is detrimentally affected by unsafe or unhealthy neighbourhoods and inadequate investments in disease prevention in public spaces.

Potential indicators: (1) Investment in disease prevention. (2) Outdoor air pollution. (3) Perceptions of safety. (4) Reported frequency of violence or violence-related events. (5) Number of road traffic deaths.

Track baseline and current trends from existing sources as follows: (1) Possible to estimate through National Health Accounts (NHA) by summing the following: (a) information, education and counselling, (b) immunization, (c) early disease detection, (d) healthy condition monitoring, (e) epidemiological surveillance and risk and disease control, (f) preparing for disaster and emergency. (2) WHO's Ambient Air Pollution database. (3–4) SAGE and WVS. (5) WHO Global Health Observatory.

Annex 2: Objectives, indicators, baselines and targets of the AMRO/PAHO "Plan of action on health in all policies"

The information given in this annex was extracted from the AMRO/PAHO "Plan of action on health in all policies" (CD53/10, Rev.1).[10]

Line of action 1: Establish the need and priorities for HiAP

Objective 1.1: Assess the potential impacts of public policies on people's health, health equity and health systems, ensuring that those responsible for policy-making are aware of and understand these potential policy impacts on health.

Indicator 1.1.1
Number of countries with established national/regional networks of multisectoral working groups and stakeholders to evaluate the impact of government policies on health and health equity.
Baseline (2014): 6. Target (2019): 18.

Indicator 1.1.2
Number of countries and territories implementing the HiAP framework for country action.
Baseline (2014): 6. Target (2019): 18.

Line of action 2: Frame planned action

Objective 2.1: Promote policy dialogue and implement national policies based on data, analysis and evidence required to implement, monitor and evaluate HiAP.

Indicator 2.1.1
Number of countries and territories that have implemented policies to address at least two priority determinants of health among target populations.
Baseline (2014): 6. Target (2019): 27.

Indicator 2.1.2
Number of countries that formally exchange information and best practices at least once every two years on policies addressing health inequities and HiAP.
Baseline (2014): 6. Target (2019): 27.

Objective 2.2: Produce a national health equity profile with an emphasis on the evaluation of the determinants of health.

Indicator 2.2.1
Number of countries and territories producing equity profiles[11] that address at least two

[10] For details, see: http://iris.paho.org/xmlui/handle/123456789/4770
[11] The equity profiles are two-page policy briefs using the methodology established in the WHO Handbook on health inequality monitoring (http://apps.who.int/iris/bitstream/10665/85345/1/9789241548632_eng.pdf, accessed 9 October 2014).

priority determinants of health at the national or subnational level.
Baseline (2014): 1. Target (2019): 18.

Line of action 3: Identify supportive structure and processes

Objective 3.1: Identify a specific mechanism by which the health sector can engage within and beyond the public sector in policy dialogue and in the implementation of HiAP.

Indicator 3.1.1
Number of countries and territories with a specific mechanism, such as intersectoral committees or HIA [health impact assessments], by which the health sector can engage within and beyond the public sector.
Baseline (2014): 6. Target (2019): 18.

Objective 3.2: Identify supportive structures and processes in the implementation of HiAP, as appropriate, at the national and subnational governments through the inclusion of HiAP in development plans.

Indicator 3.2.1
Number of countries that have identified supportive structures and processes in the implementation of HiAP, as appropriate, at the national and subnational government level through the inclusion of HiAP in development plans, as appropriate.
Baseline (2014): 6. Target (2019): 18.

Objective 3.3: Strengthen accountability mechanisms so that they can be applied to different sectors.[12]

Indicator 3.3.1
Number of countries with accountability mechanisms, which support civil society engagement and open access to information.
Baseline (2014): 4. Target (2019): 12.

Line of action 4: Facilitate assessment and engagement

Objective 4.1: Increase participation of civil society and communities in the policy-making and evaluation processes involving HiAP to reduce health inequities.

Indicator 4.1.1
Number of countries and territories with mechanisms to engage communities and civil society in the policy development process across all sectors.
Baseline (2014): 9. Target (2019): 18.

Indicator 4.1.2
Number of countries and territories with specific strategies to engage those

[12] Potential accountability mechanisms include auditing, promotion of open access to information, meaningful public and civil society participation at all levels, and efforts to promote disclosure and transparency.

experiencing inequities in policy discussions at the local, subnational and national levels.
Baseline (2014): 10. Target (2019): 22.

Line of action 5: Ensure monitoring, evaluation and reporting

Objective 5.1: Develop a system for measuring the impact and outcomes of HiAP with respect to health and health equity in order to assess policies and identify and share best practices.

Indicator: 5.1.1
Number of countries and territories that monitor, evaluate, and report on progress towards introducing health and health equity in the development and implementation of government policies.
Baseline (2014): 0. Target (2019): 12.

Line of action 6: Build capacity

Objective 6.1: Build capacity in the workforce in the health sector and other sectors on the HiAP approach, and encourage the implementation of HiAP among these groups.

Indicator: 6.1.1
Number of countries and territories with recognized institutes such as national public health institutes, universities and collaborating centres offering training courses on the implementation and monitoring of HiAP and related concepts.
Baseline (2014): 0. Target (2019): 8.

Annex 3: Examples of HiAP key result areas

The information given in this annex was extracted from the WHO "Health in all policies (HiAP) framework for country action (Annex 1, pg 21).[13]

Examples of HiAP indicators include participation of actors (by type, sectors or level), changes in organizational structures and culture (e.g. interministerial or interdepartmental committees), opportunities for joint actions, and willingness to share information and expertise.

A variety of dimensions of HiAP key result areas should be taken into account, including those that relate to process.

1. Assessing readiness to act and continually improve HiAP – how are professionals and institutions equipped to:

a. Establish needs and priorities for HiAP?

b. Map and understand issues and interests of parties?

c. Use structures to support dialogue?

d. Analyse and communicate health impacts?

e. Negotiate policy changes?

f. Engage community?

g. Reflect on processes, relationships and lessons learnt?

2. Assessing effects of HiAP applications:

a. Are there examples to demonstrate how the HiAP approach has influenced the considerations of health in public policies (such as health protection, address complex health issues, support health equity, sustainable health development and health system strengthening)?

b. Are there examples of policies which could/should have had HiAP applied and did not? Why not?

c. When and why were health interests compromised? Is there a change in willingness to engage over time? Increased institutional support for HiAP? Is there a system process in place to learn from success and failure?

[13] Health in all policies (HiAP) framework for country action. Geneva: WHO; 2014.

3. Assessing effectiveness of the HiAP approach:

a. Measuring longer term outcomes – what are trends in determinants of health, health equity, social determinants over time?

b. Are there measureable changes in attitudes towards understanding of health determinants over time among health sector, other sectors, and individuals and communities?

c. Assessing continued need and cost effectiveness.

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