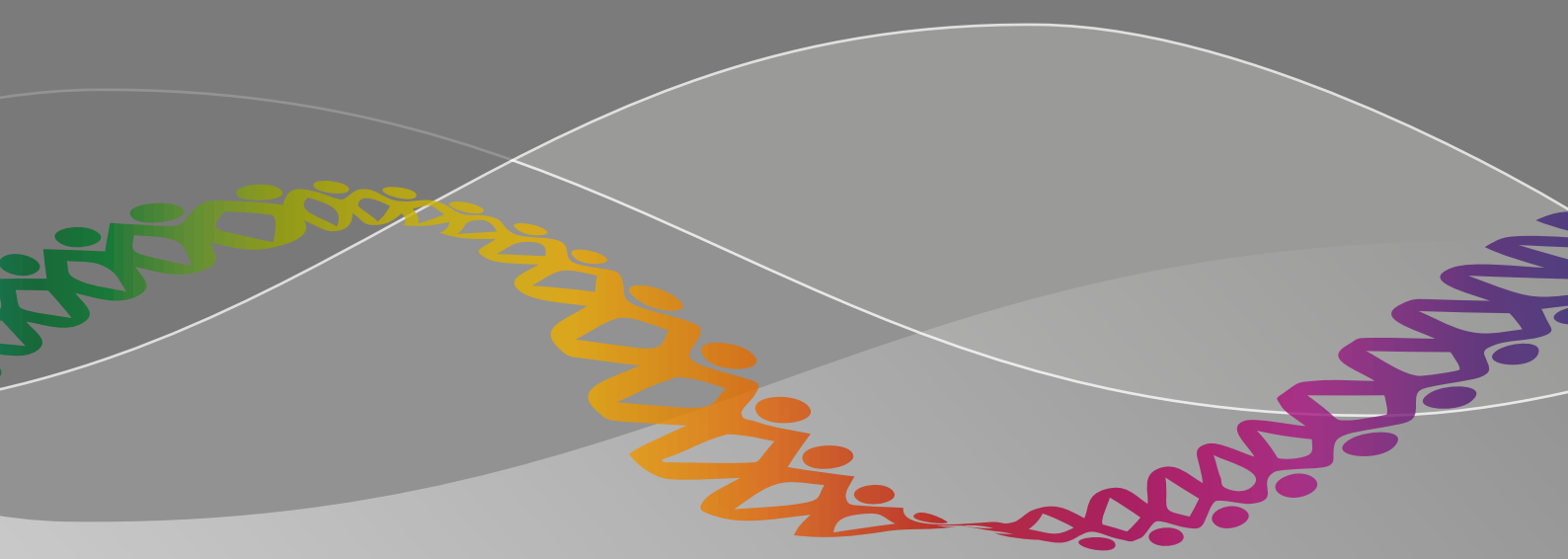

Progressing the Sustainable Development Goals through Health in All Policies:

Case studies from around the world

Government of South Australia

World Health Organization

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Progressing the Sustainable Development Goals through Health in All Policies: Case studies from around the world

Edited by

Dr Vivian Lin
Director, Division of Health Systems,
Regional Office for the Western Pacific,
World Health Organization,
Philippines

Professor Ilona Kickbusch
Director, Global Health Centre,
Graduate Institute of International and Development Studies,
Switzerland

Foreword by the Premier of South Australia

As Premier of a State that has done groundbreaking work in the field of Health in All Policies, I welcome the publication of this outstanding new book of case studies.

It makes clear the imperative to incorporate health concerns into all avenues of public administration and planning – reminding us that human well-being is not a matter for the health sector alone.

We in South Australia have incorporated health into our 10 overarching Economic Priorities, and we have a strong focus on health promotion and prevention.

It has been at the forefront of our efforts in a wide range of areas, including urban planning, transport, maintaining the natural environment and husbanding our precious water resources.

Adelaide was honoured to host, in March 2017, a highly successful international conference on Health in All Policies, in conjunction with the World Health Organization.

That event enhanced our collective understanding of this vital field – helping to bring health into the very centre of policy development and encouraging governments to be more effective, efficient and coordinated.

It also provided further impetus for the entire world to support and work towards the United Nations Sustainable Development Goals.

This collection of case studies complements and builds on the results of the Adelaide conference, and it provides ideas and guidance to policy professionals who are daily addressing complex social, economic and environmental challenges.

I commend this volume to all those seeking to lead, to innovate and, ultimately, to improve people's lives and help communities to thrive.

Hon Jay Weatherill MP
Premier

Foreword by the Director-General of the World Health Organization (WHO)

I believe the global commitment to sustainable development – enshrined in the Sustainable Development Goals – offers a unique opportunity to address the social, economic and political determinants of health and improve the health and well-being of people everywhere.

To achieve this, 'Health beyond the health sector' is one of the flagship initiatives I have launched in my first term of office. This envisages a transformation of the population's health through actions on its determinants. Health in All Policies, as defined in 2013 at WHO's 8th Global Conference on Health Promotion in Helsinki, is 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.

Health in All Policies underscores alignment of interests across policies to serve people's basic needs to live healthy, productive lives, regardless of who they are or where they live. I am therefore pleased to introduce this book with the Premier of the Government of South Australia, whose state leadership in the field is commendable.

Health partners are central in achieving the Sustainable Development Goal, Enhancing policy coherence for sustainable development (SDG target 17.14). The cases in this book show how the Health in All Policies approach is used in policy coherence for sustainable development. Cases from 13 countries come from different jurisdictions, from all parts of the world, covering all regions of WHO.

Public health workers describe how they are dealing with differing levels of resources, political commitment and systems. They innovatively address interlinkages to national development plans, and to strengthening participatory governance, disease prevention and health promotion systems. They confront pressing issues including climate change, natural disasters, urbanisation, the rising non-communicable disease epidemic, rising health inequities and access to basic services and conducive environments for health.

I highly recommend this book. Societies and the global community cannot get value for money for their investments without sharing accountability for health and enhancing partnerships. The experiences it describes are both practical and inspirational to all working for human well-being and the sustainability of our world.

Dr Tedros Adhanom Ghebreyesus
WHO Director-General

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Book editors:

Dr Vivian Lin
Director, Division of Health Systems, Regional Office for the Western Pacific,
World Health Organization, Philippines

Professor Ilona Kickbusch
Director, Global Health Centre,
Graduate Institute of International and Development Studies, Switzerland

Advisory and co-ordinating committee:

Carmel Williams, Manager, Health Determinants and Policy, Prevention and Population Health Branch, Department for Health and Ageing, South Australia

Nicole Valentine, Senior Technical Officer, Department of Public Health, Environmental and Social Determinants of Health, World Health Organization, Switzerland

Claudia Galicki, Senior Project Officer, Health Determinants and Policy, Prevention and Population Health Branch, Department for Health and Ageing, South Australia

Britta Baer, Technical Officer, Division of Health Systems, Regional Office for the Western Pacific, World Health Organization, Philippines

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Editorial and technical advisor:

Michele Herriot, Director, Health Promotion Consulting, South Australia

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Media and Communications Division, Department for Health and Ageing, South Australia
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Cameron Simpson, Graphic Designer, Creative Services, Media and Communications
Karli Borresen, Communications Advisor, Media and Communications

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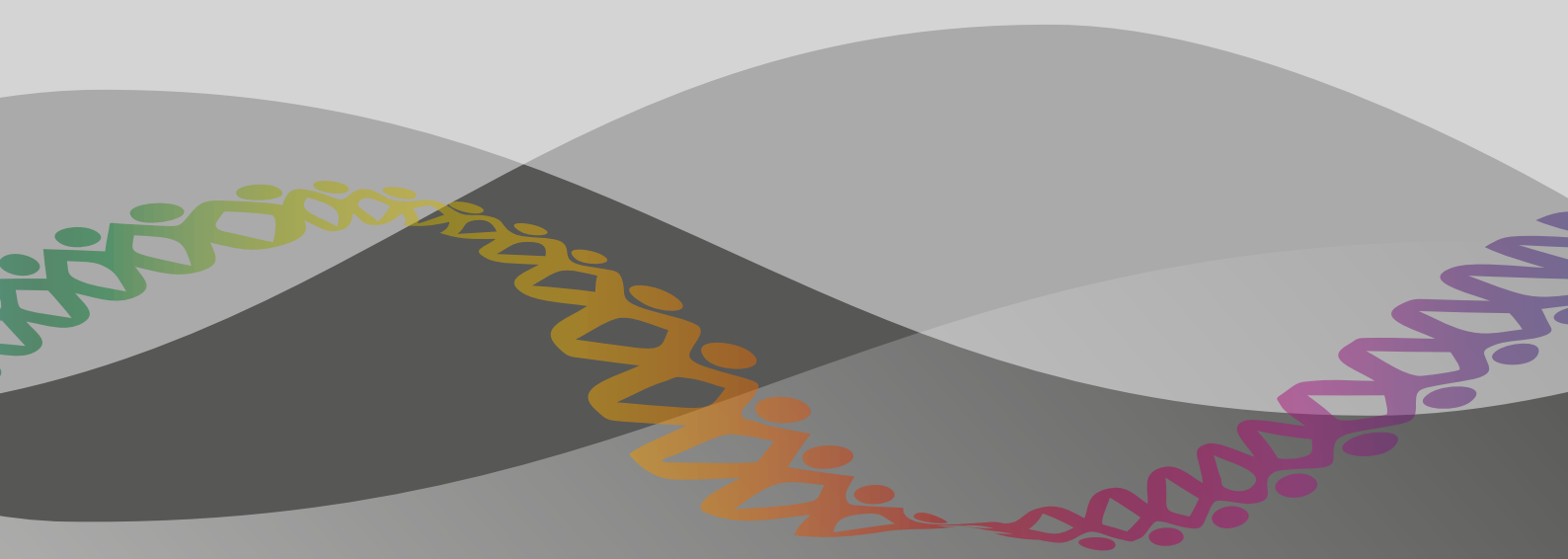

Health in All Policies

Introduction

Authors

Vivian Lin[A], Ilona Kickbusch[B] and Britta Baer[A]

[A]World Health Organization, Regional Office for the Western Pacific, Philippines

[B]Graduate Institute of International and Development Studies, Switzerland

Introduction

Health in All Policies (HiAP) is not a new concept. While the term "HiAP" has received much attention since the 1990s, the concept of working across sectors of government for improved population health and wellbeing is much older than that.[1] Over the last few decades the term has been applied to multiple health topics and challenges – whether implicitly or explicitly. It has been linked to and sometimes interchangeably used in relation to other concepts, including healthy public policy, healthy settings and intersectoral action, whole-of-government and whole-of-society approaches, joined-up and horizontal governance, one health and others.[2,3]

As a recognised approach for governance of health, HiAP is a relatively recent, and an evolving, practice. The evidence base for what factors contribute to good HiAP practice is also evolving. This collection of case examples aims to demonstrate how countries with varying political systems and governance mechanisms are developing and sustaining HiAP, and to examine how HiAP can support the achievement of the Sustainable Development Goals (SDGs), reflecting on discussions at the conference held in Adelaide, South Australia, in March 2017. This is not the first collection of case examples on HiAP.[4] In building on, and being informed by, the growing literature of valuable experiences and learnings on HiAP in recent years, this book aims to contribute to an improved knowledge base as well as to enhanced public health practice in particular by focusing on HiAP examples at different levels of development and maturity.

Understanding HiAP

The World Health Organization (WHO) defined HiAP as 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.[5,6]

A broad understanding of health is core to the WHO Constitution of 1946, which defined health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity". Inherent in this understanding is that population health is influenced by the broader cultural, economic, political and social environment into which people are born, grow, live, work and age, as reiterated by the Ottawa Charter[7] and the WHO Commission on Social Determinants of Health.[8] This recognises the growing complexity of public health, going beyond traditional boundaries and the direct control of the health sector.[9,10] It also takes public health back to important historical lessons which show how sectors other than health contributed to lowering child mortality and increasing overall life expectancy.[11]

What is new is the emphasis on a much more clearly articulated contribution of how a healthy population contributes to the goals of other sectors' and to societal goals overall. Health is an important input for the economy, productivity, socioeconomic development and wellbeing. This makes health a shared goal across different sectors of government and of stakeholders beyond government including the private sector and civil society. A HiAP approach thus focuses attention on the development of partnerships for public policy through identifying 'win-win', co-production and 'co-benefits'.[12]

Evolution of HiAP and governance for health

Kickbusch describes three distinct waves of horizontal health governance, with the first focusing on intersectoral action for health.[13] The 1978 Declaration of Alma Ata stressed the importance of "a comprehensive health strategy that not only provided health services but also addressed the underlying social, economic and political causes of poor health".[14] Primary health care requires action within the health sector but also by the health sector to work collaboratively with others to achieve improved health

outcomes. Kickbusch describes this as a wave of rational policy-making by the health sector – in other words, the health sector demonstrates improved health outcomes through action in another sector, which in turn supports broader development.[13]

The emphasis on collaboration with other sectors for health was also core to WHO's Ottawa Charter for Health Promotion (1986).[7] The Charter stressed the importance of action on public policy and environmental influences as well as of action to support change at community and individual levels.[2] The Charter framed "healthy public policy" as one of five action areas for health promotion, calling for an "explicit concern for health and equity in all areas of policy and by an accountability for health impact".[7] The need for action on the underlying determinants of health, including equity, was further unpacked through later conferences and related discourses, including the 1988 Healthy Public Policy Conference in Adelaide, Australia.[15] Ottawa and beyond make up the second wave of horizontal health governance, characterised by an incremental approach that stresses process, opportunistic entry points and different strategies and tools to respond to the growing complexity of policy-making.[13]

The third wave of horizontal health governance was initiated by the Finnish Presidency of the European Union (EU) in 2006.[13] Finland has a long history of engagement of other sectors for improved health and wellbeing.[16] While early examples of HiAP in Finland and other European countries showed the added value of intersectoral action for health, these examples were often unable to go beyond their specific project limits.[17,18] When placing HiAP on the agenda of its EU presidency, Finland built on lessons learned at home and in Europe and engaged policy-makers, bureaucrats and partners in high-level dialogue on how to achieve more systematic change. The resulting resolution by the Council of the European Union (2006) calls for parliamentary mechanisms and health impact assessments to ensure health and health equity are considered in all government policies and actions.[19] HiAP is framed as "a horizontal, complementary policy-related strategy with a high potential of contributing to population health".[20] Both the Rio Political Declaration[21] and the 2013 Helsinki Statement[5] promote HiAP as a method for facilitating a more integrated and networked approach to policy-making.

HiAP continues to evolve and adjust, as it is being applied to new policy questions and challenges beyond health promotion or beyond national borders, for example in trade. The growing number of actors in health has also created some new opportunities to use HiAP approaches to engage more systematically with stakeholders beyond government, including non-government actors and the private sector. Although most of these fall outside the realm of this book, these trends are important considerations to watch for in future, particularly in the collective attempt to achieve the SDGs.

Kickbusch and Buckett[16] argue that HiAP is critical for addressing 'wicked' problems; that is, policy problems that are complex or intractable, where cause and effect have not been clear, and may require solutions of an interdependent effort. Current examples include chronic diseases, population ageing, climate change, health security and antimicrobial resistance. The emphasis on goals and benefits for both health and the partner sector has been core to the development of South Australia's approach to HiAP.[22] When multiple stakeholders cooperate to address shared interests, there is potential to magnify benefits and advance the goals of all sectors through shared responsibility across sectors.

Advancing HiAP

Despite substantial progress on HiAP globally, regionally and in countries, and a long history to draw on, it has not always been easy to advance HiAP. Although policy-makers are increasingly aware of the need to work across sectors, systematic change has not been easy to achieve and sustain. Understanding and addressing the underlying determinants of health is difficult because they are complex, multi-faceted and dynamic.[16] This is further complicated by a tendency towards market-oriented approaches to policy-making, particularly since the introduction of neo-liberal approaches to public sector management. Mandates, budgets, accountability mechanisms, political climates, timing and organisational culture have created barriers for HiAP.[16,23-25] Moreover, even where HiAP has been successfully initiated, the attention has rarely been on monitoring progress and evaluating impacts, resulting in gaps in the knowledge base for advancing this area of work in future. At the same time, it has often been difficult to explain linkages between steps taken and their impact.[26] The time lag between action and effect has generally been long, conflicting with the sometimes short-term perspective of politicians and policy-makers, and related requests for evidence.

Despite these challenges, there are many examples of HiAP globally[27] and more countries and regions are looking at embarking on this path, especially in view of SDG implementation. While there is no single or simple model for HiAP that can easily be exported to other countries or settings, there is a growing evidence base of conditions for HiAP that we can learn from. For example, Kickbusch and Buckett outline the existence of shared goals and objectives, organisational capacity, opportunities for collaboration and relationships as important success factors.[16] Lin et al add to this list and discuss the influence of leadership and mandates, human and financial resources, research and tools, and partnership and stakeholder management in fostering HiAP.[28] Arrangements for governance, participation, health sector engagement and monitoring and evaluation were further emphasised by the Rio Political Declaration as well as a collection of Australian case studies.[4]

This draws attention to community and civil society engagement as a driver for change, as well as the potential value of the law and the legislative environment in fostering HiAP.[29,30] Corbin et al unpack core elements for fostering partnerships, including trust and informal/formal relationships and roles.[31] Wismar et al (2012) provide an overview of different governance structures with each having its own profile in terms of intersectoral actions. They argue that the choice of the exact process or structure for HiAP should align with the desired purpose and action, often working in parallel with other intersectoral mechanisms.[32] There is less comparative analysis of how different political systems apply HiAP.

At a local level, the healthy cities model has resulted in numerous successes of holistic and multi-stakeholder action for better health and wellbeing.[33] In the Western Pacific Region, Healthy Islands have provided an opportunity to make practical inroads into HiAP, facilitating whole-of-government and whole-of-system approaches to health and wellbeing that stress community participation, partnership, and empowerment. The healthy cities movement has also inspired complementary approaches targeted at villages, schools, or hospitals, often referred to as the settings approach. More recently, the central place of cities and communities was recognised in the Shanghai Consensus on Healthy Cities[34], adopted by more than 100 mayors at the 9th Global Conference on Health Promotion. The Shanghai Consensus affirms commitments to "prioritize the political choice for health in all domains of city governance and to measure the health impact of all our policies and activities". Bringing together multiple sectors and community stakeholders in a comprehensive approach, it advocates efforts to "create co-benefits between health and other city policies" and identifies 10 action areas, including: delivering the basic needs of all residents; eliminating air, water and soil pollution in our cities and tackling climate change; investing in children;

making environments safe for women and girls; improving the health and quality of life of the urban poor, slum and informal settlement dwellers, and migrants and refugees; addressing multiple forms of discrimination; making cities safe from infectious disease; promoting sustainable urban mobility; implementing sustainable and safe food policies; and making environments smoke free.[34]

A key question has been how to elevate these local examples and commitments successfully beyond a specific place or issue to a higher, more systematic level. To guide progress and learning, Lin et al[2] encourage reflection on the process of policy development in an effort to fill knowledge gaps on HiAP processes and their effectiveness. De Leeuw and Peters[35] suggest nine core questions from a political and policy science perspective that aim to guide action on HiAP: "How has the problem been framed and by whom? Within the problem definition and tentative policy logic, which policies are already in force or in development; [a]re there any measures of success? What information is there about the problem, its magnitude and consequences, and relevant stakeholder positions, now and in the future? What facts, ideas and assumptions constitute the policy logic in relation to the problem? What evidence, experience and opportunity exist to develop winning alternative approaches? What social, economic and institutional 'win–wins' can be established; [w]hat gains can be identified? What are the power, priority and support positions of all stakeholders in particular policy proposals? What politics are involved in the initiation and final stages of policy development and adoption? Have policy implementation barriers and facilitators been considered and integrated in policy formulation?"

HiAP as a tool for advancing the Sustainable Development Goals (SDGs)

Attention to HiAP has never been more timely or relevant. For 15 years, the Millennium Development Goals (MDGs) were a driving force behind many issues affecting the health of people all over the world. Despite significant strides towards achievement of the specific goals, progress was uneven and the MDG approach lacked a concern with governance.[36] The SDGs, adopted by world leaders in September 2015, built upon the lessons learned from the MDGs and called for an integrated approach to "just, rights-based, equitable and inclusive" action to address today's challenges and promote growth, social development and environmental protection for all.[37] While SDG 3 aims to "ensure healthy lives and promote well-being for all at all ages", core health targets are also embedded in other goals.[37] More broadly, health is influenced by and contributes to all other goals and targets as well. These positive and negative links between health and other social, economic, cultural and political factors operate both at the individual and the societal level. They lie at the heart of health inequities – the unfair and avoidable differences in health status seen within and between countries. This places equity at the centre, with particular focus on disadvantaged groups that are typically excluded from social benefits such as a good education, health care and economic participation while facing higher burdens of disease and disability. The social determinants of health interact with each other, leading to compounded inequities for marginalised population groups.

Achieving health in the SDGs so that no one is left behind, a central tenet of the SDGs, requires new ways of working by bringing together various government sectors, civil society, academia, development partners and communities.[38] The ambitious and transformative agenda of the SDGs challenges governments and partners to be more political, systemic and holistic in their thinking, recognising linkages across health

programs and sectors of policy-making. The 9th Global Conference on Health Promotion, co-organised by WHO and the National Health and Family Planning Commission in November 2016 in Shanghai, China, reiterated the interconnectedness of health and all the SDGs, calling for a political choice for health to move beyond fragmentation to strengthened policy coherence and efficiencies for improved health, health equity and development. Action is needed at global, regional, national and local levels to "apply fully the mechanisms available to government to protect health and promote wellbeing through public policies".[39] The 2016 Shanghai Declaration stresses the role of legislation, regulation, and taxation to address unhealthy commodities, fiscal policies to enable new investments in health and wellbeing, universal health coverage to achieve health and financial protection as well as strengthened global governance to respond to cross-border health issues. Partnerships and shared responsibility across sectors and stakeholders, with civil society, the private sector, and communities, are at the heart of good governance for health and sustainable development. This positions HiAP as an essential tool for acting on the SDGs.[40]

Adelaide Conference on "Health in All Policies: Progressing the Sustainable Development Goals"

In March 2017, the Government of South Australia in collaboration with WHO, held an international conference, marking the ten-year commitment to implementing HiAP in South Australia. The conference brought together approximately 150 experts from government, academia, civil society and international partners to share experiences and to celebrate the significant progress in implementing HiAP approaches in different regions and countries. More specifically, the conference aimed to:

- Reflect upon the South Australian experience of HiAP and factors critical to its success.
- Explore how different regions and countries with varying governance settings are sustaining HiAP, and how these approaches can be adapted or strengthened to support action on the social determinants of health.
- Examine the role of HiAP as a strategy in the implementation of the United Nations 2030 Agenda for Sustainable Development and its Sustainable Development Goals.
- Support and promote action for a strengthened health and environment agenda.

The conference also provided the first major opportunity to discuss the outcomes of the 9th Global Conference on Health Promotion and its recommendations in greater depth.[39] It resulted in an outcome statement – the Adelaide Statement II - which frames HiAP as a practical strategy for achieving the transformation that lies at the heart of the SDGs (see Appendix 1).[41] The statement recognises the many examples of HiAP – including at all levels of government and in different contexts – and stresses the importance of political choices and good governance; strong partnerships and shared leadership; dedicated capacity and resources and accountability and evidence as central to HiAP.

Brief overview of this book

This book, arising from the Adelaide conference, is intended for the international HiAP community – including people who are already practising HiAP and aim to sustain it, helping those who are thinking about doing HiAP to progress, and helping others to start planning HiAP.

The case studies in this book highlight the diversity of applications of HiAP and its multiple processes, dimensions and outcomes in different countries and regions and political systems. It includes experiences of HiAP at the city level, such as in Quito, Ecuador, at the regional/state level such as in California and the national level, for example in China. While there are many different versions of and contexts for HiAP, there are also some shared lessons across countries and regions. A common challenge has been how

to elevate HiAP to a higher level of government and maintain momentum. The book aims to respond to this concern and help to improve our understanding of how to initiate, implement and progress HiAP. It thus goes beyond intersectoral action on specific topics or for specific projects and explores actions for achieving and sustaining HiAP more systematically and long term.

Case studies in this book were selected across different levels of maturity of HiAP. The case examples underline that the journey to and success of HiAP are influenced by history, politics and culture. The book includes more mature and well-known examples of HiAP, including lessons from Finland, New Zealand, Thailand and South Australia. Authors for these case studies were asked to reflect on the journey towards HiAP, providing a sense of evolution and dynamism, and the different phases that HiAP approaches may have gone through. Agility is a key theme coming through, including being able to adapt to changing circumstances to sustain momentum and prevent implementation failure. The book also captures newer, emerging practice on HiAP across the globe, including Namibia, Sudan and Suriname. Authors discuss the incentives and drivers of initiating and maintaining HiAP, including champions and triggers for action. The role of champions of HiAP is highlighted, including how the engagement of communities and civil society, elected leaders and parliamentarians, as well as government bureaucrats at multiple levels can set the tone for change. Authors reflect on strategic approaches and entry points for HiAP across different systems, stages of development and income level, illustrating governance and policy level work and mechanisms that facilitate moving forward, in a sustained way rather than one-off pieces of work. While the case studies do not provide an evaluation of where HiAP makes a difference to narrowly defined health outcomes, taken together they provide an overview of how HiAP can help to create an enabling environment for advancing health and health equity and for strengthening policy coherence.

Conclusion

Although focused on the SDGs more broadly, the United Nations Development Group's model for Mainstreaming, Acceleration and Policy Support (MAPS) may provide a useful frame for exploring maturity and sustainability, and related inputs required at different stages of HiAP.[42] Mainstreaming may provide a starting point for the integration of HiAP into international, national, subnational and local development plans and budget allocations. Once established, the focus of HiAP will be on acceleration, i.e. targeting resources to areas identified as priorities in the mainstreaming process and expanding their scope and reach. Policy support to maintain momentum relies on the availability of skills and resources to address the underlying determinants of health and health equity. To strengthen and sustain momentum, the elements of partnership, that is development (engaging additional partners, including, for example, parliamentarians, nongovernmental organisations or the media), accountability (strengthening monitoring and review frameworks) and data (strengthening the capacity to collect and analyse information), cut across all three components.

The SDGs challenge all of us to move towards whole-of-government and whole-of-society approaches that leave no-one behind. HiAP is core to this agenda. It is hoped that this collection of case studies will improve understanding among relevant policy-makers and partners in existing approaches on HiAP. It also highlights learning on how to initiate, implement and sustain progress on HiAP. Acting on these lessons will be essential for accelerating action to achieve the SDGs.

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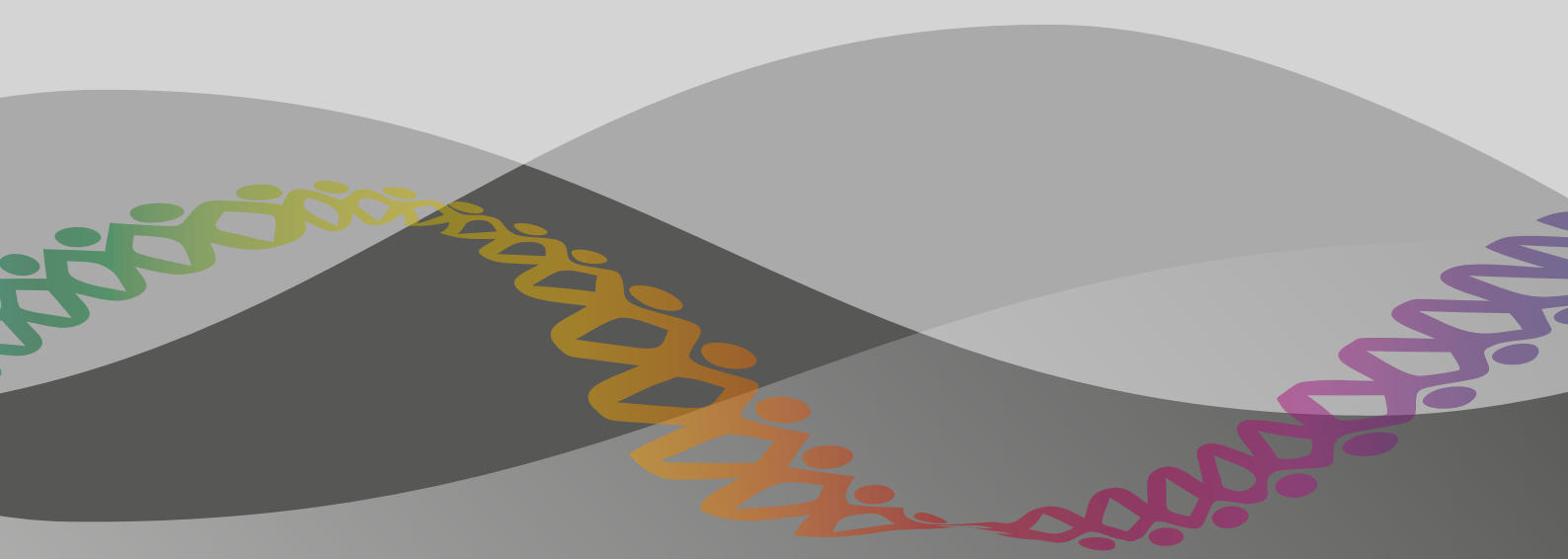

Health in All Policies

Using the Health in All Policies approach for progressing the SDGs: perspectives from WHO

Authors

Nicole B Valentine[A], Faten Ben Abdelaziz[A], Dheepa Rajan[A], Eugenio Villar[A], Gerard Schmets[A], Marina Maiero[A]

[A]World Health Organization, Switzerland

Introduction

The World Health Organization (WHO) is in a unique position to support implementation of the 2030 Sustainable Development Agenda.[1] Health is an input to, or impacted by, most, if not all, of the 2030 Sustainable Development Goal (SDG) targets.[2] Thus, health actors at global, national and sub-national levels are uniquely positioned to contribute to the SDG target 17.14, "Enhance policy coherence for sustainable development", which is essential for aligning interventions for development.

The Health in All Policies approach (HiAP), as defined in Helsinki[3] (Box 1), provides a way to implement policy coherence for sustainable development. Several major WHO areas of work are advocating for action on health determinants, each with varying degrees of explicit reference to HiAP. In this chapter, the latest global declarations for addressing determinants from each of these major WHO areas is viewed through the lens of the implementation of HiAP, as characterised in the Adelaide II Statement (Appendix 1).[4] The analysis aims to demonstrate both the validity of HiAP when viewed from the perspective of different communities of public health actors, and to describe specific examples for HiAP implementation that enrich the scope for action. By so doing it shows that HiAP, while still evolutionary, provides a common point of reference for a set of practices that are needed to achieve policy coherence in sustainable development.

Core global health determinants action declarations

Four major areas of WHO's general program of work are reviewed in this chapter. Common qualities they share are that they all promote intersectoral work and social participation in public policy-making to address a broad range of determinants. The four areas are the 'social determinants of health' (SDH); health promotion; health systems; and the environment, health and climate change. Five key global WHO action frameworks are linked to these four areas. Each framework advocates for action across multiple types of health determinants (i.e. political, social, behavioural, cultural, environmental (physical), ecological, commercial etc.). Each framework reflects the breadth of the Sustainable Development Agenda[1], and each adopts a country target audience (although having specific recommendations for global actors or sub-national actors) with the exception of one framework for mayors, which is linked to a national framework as explained below.

The first framework for the SDH relates to the Rio Political Declaration on SDH[5] ('Rio Declaration') that has recently been shaped into the Framework for Monitoring Action on the SDH globally and aligned with the 2030 Sustainable Development Agenda ('the SDH Action Framework').[6] The Rio Declaration action pledges, drawing on the Commission on Social Determinants of Health recommendations[7], were originally formulated in 2011 at the World Conference on Social Determinants of Health in Brazil by delegates from over 120 United Nations Member States and representatives from the United Nations system, civil society, and technical experts.

Box 1. WHO's definition of the HiAP approach as endorsed at the 8th Global Conference on Health Promotion in Helsinki in 2013

"Health in All Policies is 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. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being."

The Shanghai Declaration on Promoting Health in the 2030 Agenda for Sustainable Development was developed in 2016 along with the Shanghai Consensus on Healthy Cities ('Mayors' Consensus') formulated by mayors from over 100 cities at the Ninth Global Conference on Health Promotion. The latter mayor-focused action framework illustrates the specific application of the more general national framework for Promoting Health in the 2030 Agenda for Sustainable Development.

The framework provided by "Health Systems for Universal Health Coverage - a joint vision for healthy lives" ('UHC 2030 Vision'), co-published by the WHO and the World Bank, describes how health systems reach Universal Health Coverage (UHC). It is one of the key publications from the International Health Partnership for UHC 2030.[8] The UHC 2030 Vision highlights three interrelated health systems policy areas needed for enabling health system performance: governance, financing and service delivery.

Finally, WHO and the Government of France, holding the Presidency of the 21st Conference of Parties to the UN Framework Convention on Climate Change (UNFCCC COP21), jointly hosted the Second Global Conference on Health and Climate in cooperation with the Government of Morocco. The report, "Building Healthier Societies Through Implementation of the Paris Agreement: conference conclusions and action agenda" ('Health and Climate Action Agenda')[9] describes actions around two broad themes: adapting to climate change and contributing to the reduction of global emissions of climate pollutants (including with co-benefits for health through mitigation).

Essential HiAP implementation characteristics

As summarised in Adelaide II, a combination of four HiAP implementation characteristics are emerging as important ingredients for success: i) good governance; (ii) development of strong and sound partnerships based on co-design, co-delivery and co-benefits; (iii) dedicated capacity and resources; and (iv) the use of evidence and evaluation.

Two of these four implementation characteristics are further elaborated in Adelaide II, namely aspects of good governance and partnerships for HiAP. Adelaide II characterises HiAP governance as: "providing an authorising environment from the highest levels of government; political and executive leadership as well as leadership at all levels of the hierarchy and horizontal leadership; leveraging decision-making structures; creating an environment for cultural change in practices and ways of working; leadership that looks outwards, encourages dialogue, supports experimentation and innovation; developing a clearly articulated and shared vision."

Adelaide II also characterises the following ways of working across government and society in strong and sound partnership, through: "co-design, co-production and collaboration to achieve shared goals and realise co-benefits; dialogue and systematic consultation; diplomacy to build constituencies to support change; shared measures, reporting and public accountability; basing action on evidence (jointly constructed or valued, or with cross-sectoral relevance); learning-by-doing; reflecting on practice and responding to changing contexts."

Two other characteristics in the Adelaide II Statement warrant further elaboration. Dedicated capacity and resources which have been extensively covered elsewhere in HiAP literature, typically refers to human, technical and financial resources with systematic functions, across the policy cycle, to address health determinants (see also the Helsinki Declaration[3,10]). HiAP evidence and evaluation refers to specific ways in which knowledge can be generated by, and with relevance for, multiple disciplines, and how knowledge can support intervention solutions, including evaluation of processes, that do not rely purely on the application of medical technology.[11,12]

Comparing WHO determinants action frameworks with respect to HiAP

The key WHO action frameworks are summarised in Table 1 according to the Adelaide II HiAP implementation characteristics (listed in column 1). One observes that all frameworks clearly call for using HiAP and all make some reference to each of the four essential implementation characteristics of HiAP. The different frameworks have overlaps and are hence reinforcing, but they are also complementary with respect to their particular emphases and examples. These different emphases will be drawn out in the analysis of each HiAP implementation characteristic below.

In the area of HiAP governance, the SDH Action Framework centres an entire action area around development strategies, viewing the national development planning processes as a key leverage point for improved governance for health. The Shanghai Declaration places great emphasis on the authorising environment for health, calling for "bold political action". In particular, the Shanghai Mayors' Consensus recognises the important role of mayors, and the authority of mayors in decentralised political and bureaucratic systems to take greater leadership. The UHC 2030 vision emphasises the health policy and strategy planning process and the involvement of multiple stakeholders, in particular focussing on social dialogue and the role of participatory governance (e.g. as conducted in Thailand). The Health and Climate Action Agenda emphasises a coherent approach to climate, health and economics, leveraging decision structures for the Nationally Determined Contributions to UN Framework Convention on Climate Change (FCCC) and for cities' and communities' climate integrated mitigation plans (the latter also referenced in the Shanghai Declaration). The significance of the last observation is that these are new processes designed in large by non-health sector actors to address the extremely complex global challenge of climate change.

In the area of HiAP partnerships, the SDH Action Framework emphasises co-design and partnership across government and society, referring to participatory approaches, empowerment of vulnerable groups, communities and civil society through access to information and improved accountability (linking back to governance). It calls for openness across government agencies and constituencies in policy-making. The Shanghai Declaration and Mayors' Consensus stress the prioritisation of policies with co-benefits, the role of urban planning and city and community settings, supportive national frameworks for cities, increasing citizen's control of their own health and the use of innovative, interactive technology and public involvement to build constituencies for change. They emphasise the role of the information environment in empowering citizens' health literacy. The UHC 2030 Vision emphasises public dialogue and systematic consultation with communities and other stakeholders. The Health and Climate Action Agenda stresses the need for articulating a shared vision through evidence-based best buys, formulated on the basis of the inclusion of health impacts, which links to the concepts of national capital and externalities.

In the area of HiAP dedicated capacities and resources, the SDH Framework emphasises the need for dedicated public capacity on intersectoral action, equity, determinants, and public health. The Shanghai Declaration and Mayors' Consensus highlight investing in developing health literacy and an enabling informational environment for citizens. The UHC 2030 Vision stresses governance platforms for dialogue and citizens' forums. This requires investing in population and community capacities to participate meaningfully in policy-making. It also makes reference to 'balancing' funding for curative and prevention services – which could increase dedicated financing for HiAP. General references to health workforce alignment and the alignment of development assistance to go beyond communicable disease to include social issues are also references to human resources capacities for HiAP. In the spirit of this last theme, the Health and Climate Action Agenda

Table 1. Comparison of key public health action frameworks addressing health determinants and their reference to essential characteristics of HiAP

WHO Area:	*Social Determinants of Health*	*Health Promotion*	*Health Promotion*	*Health Systems*	*Environment, Health and Climate Change*
Action framework	SDH Action Framework[i] (original Rio Political Declaration 2011)	Shanghai Declaration on Promoting Health[ii] (2016)	Shanghai Mayors' Consensus (2016)[iii]	Universal Health Coverage 2030 Vision[iv] (2017)	Health and Climate Action Agenda (2016)[v]
Words	1700	1356 (total) 899 (national)	457 (cities)[9]	4142	1383

Structure of main action areas	• Adopt better governance for health and development
	• Promote participation across the policy cycle
	• Reorient the health sector to reduce health inequities
	• Strengthen global governance and collaboration
	• Monitor progress and increase accountability
		• Promote action on all SDGs
		• Make bold political choices for health
		• Promote good governance as crucial for health
		• Enhance the role of cities and communities as critical settings for health
		• Promote health literacy to empower and drive equity
			• Mayors commit to five Healthy Cities governance principles
			• Mayors commit to ten Healthy Cities action areas to be integrated in implementation of the 2030 sustainable development agenda
				• Strengthen health systems to achieve health security and Universal Health Coverage
				• Improve health system performance for better equity, quality, responsiveness, efficiency, resilience through actions on:
				  • Service delivery
				  • Governance
				  • Financing
				  • Success depends on stakeholders, beneficiaries, and providers
					• Adapt to climate change by strengthening the health and related systems for essential services (water, sanitation, food)
					• Contribute to the reduction of climate pollutants to protect environmental and social determinants of health:
					  • Address health risks and opportunities
					  • Support health and climate action
					  • Measure country progress

Good governance	• Commit to equity, human rights-based approach • Work across different sectors, levels of government (horizontal) • Use national development plans or strategies • Reach out and promote mechanisms for dialogue and problem-solving with an equity focus • Ensure accountability through participation, transparency	• Commit to equity, human rights-based approach • Apply mechanisms to protect health and promote wellbeing • Legislate and tax unhealthy commodities • Implement fiscal policies as a powerful tool	• Use high-level position of mayors • Use urban development planning and policies to reduce poverty and inequity • Use integrated approaches to settings • Harness social innovation and interactive technology	• Commit to equity, human rights-based approach • Commit to transparency and accountability for results • Develop national health strategies and leadership • Make health systems everybody's business • Promote international cooperation based on mutual learning and development effectiveness principles	• Provide health leadership in multi-sectoral decision-making processes related to climate mitigation • Articulate a coherent approach to climate change, health, and economics (shared vision) • Use integrated health and climate mitigation policies in cities and communities

i Global monitoring of action on the social determinants of health: a proposed framework and basket of core indicators (WHO 2016). Available from: http://www.who.int/social_determinants/monitoring-consultation/en/

ii Shanghai Declaration on Promoting Health in the 2030 Agenda for Sustainable Development. Available from: http://www.who.int/healthpromotion/conferences/9gchp/shanghai-declaration/en/

iii Shanghai Consensus on Healthy Cities. Available from: http://www.who.int/healthpromotion/conferences/9gchp/healthy-city-pledge/en/

iv Health systems for universal health coverage - a joint vision for healthy lives (WHO, World Bank 2017). Available from: https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/mgt_arrangemts___docs/UHC2030_Official_documents/UHC2030_vision_paper_WEB2.pdf

v Second Global Conference on Health and Climate. Conference conclusions and action agenda. Available from: http://www.who.int/globalchange/conferences/second-global/conclusions/en/

WHO Area:	*Social Determinants of Health*	*Health Promotion*	*Health Promotion*	*Health Systems*	*Environment, Health and Climate Change*
Action framework	SDH Action Framework (original Rio Political Declaration 2011)	Shanghai Declaration on Promoting Health (2016)	Shanghai Mayors' Consensus (2016)	Universal Health Coverage 2030 Vision (2017)	Health and Climate Action Agenda (2016)
Strong and sound partnerships	• Promote inclusive and transparent decision-making, implementation and accountability for health and health governance at all levels • Enhance access to information, justice, public participation, safe-guarding public interest, and empower communities • Develop partnerships that identify individual and joint roles for health improvements	• Increase citizens' control of their own health and its determinants • Harness the potential of digital technology • Support cities to promote equity and social inclusion	• Prioritise policies with co-benefits between health and other city policies, and engage in partnership-based urban planning • Harness knowledge, skills and priorities of diverse populations through community engagement	• Develop a bottom-up participatory system design between the citizen/beneficiaries, the state and the service providers • Use policy dialogue mechanisms to 'join up' different parts of government, and mechanisms of voice and community empowerment • Convey collective preferences of citizens • Build capacity across sectors in emergency preparedness, response, recovery and addressing the SDH	• Provide authoritative and evidence-based guidance on health risks and benefits • Become advocates, community leaders, scientific educators and champions of the rights of individuals and populations to be protected from health risks posed by climate change • Raise public awareness of opportunities for simultaneous promotion (co-benefits) of health and mitigation of climate change
Dedicated capacity and resources	• Dedicate resources and public health capacity for disaggregating data, intersectoral work, sharing • Support all sectors in the development of tools and capacities to address SDH • Strengthen public health capacities to address social, economic, environmental, behavioural determinants	• Recognise health literacy as a critical determinant of health and invest in its development • Invest in the information environment in order to facilitate citizen's control	• Recognise health literacy as a critical determinant of health and invest in its development • Invest in the information environment in order to facilitate citizen's control	• Invest in platforms for dialogue • Balance finances of prevention vs. curative; consider fiscal space • Align training to local needs with curricula and affirmative action • Align development assistance to address social issues	• Strengthen core public health capacities on climate change • Invest in training courses and mainstreaming into medical and public health training • Draw on climate funds • Mobilise and guide investment in climate change and health
Evidence and evaluation	• Disaggregate data • Measure societal well-being • Share evidence • Enhance research and surveys • Ensure access to research	• Bring together existing measures of well-being, disease burden, and determinants with a focus on inequity	• Bring together existing measures of well-being, disease burden, and determinants with a focus on inequity	• UHC progress core indicators • Health systems strengthening indicators • All sectors involved in design, monitoring, evaluation and follow-up (enforcement)	• Assess health gains potential through NDCs to the UNFCCC • Articulate health–climate linkages

emphasises capacities in health diplomacy. But it also refers to scaling-up dedicated climate change-health funding sources.

Finally, in the area of HiAP evidence and evaluation, the SDH Action Framework stresses monitoring with disaggregated data, comprehensive surveys, and sharing research in all sectors of society (alluding to health literacy). The Shanghai Declaration clearly refers to measures of well-being, disease burden, and determinants with a core focus on equity. By so doing, it highlights the need for traditional burden of disease and impact to encompass more complex causal analyses. The UHC 2030 Vision refers to multi-sectoral mechanisms being crucial for monitoring, evaluating and enforcement. The Health and Climate Action Agenda emphasises predictive modelling and information on the additional health gains from policies across sectors for reports on 'National Determinants Contributions', a specific Climate Change policy mechanism.

Implications for action

Reviewing these four action frameworks brings into sharper focus the opportunities for scaling up HiAP at the global level. The analysis shows reinforcing calls for HiAP to address complex problems emanating from different public health areas (SDH, health promotion, health systems and the environment, health and climate change).

Given the many commonalities in the approaches, bold action can be taken by WHO at the global level to convene key target constituencies to discuss matters of policy coherence important for several different WHO work areas. This may imply convening specific sectors e.g. finance or trade, for example, to discuss policy coherence for multiple health outcomes, across multiple determinants (e.g. child obesity, maternal health, palm oil in exports, agriculture, rural infrastructure investments). A regional HiAP initiative organised by WHO/Europe, and hosted by the Ministry of Social Affairs and Health of France (7–8 December 2016, Paris, France) provides a leading example. WHO convened Member States, representatives of international organisations and civil society and experts to a conference on "Working together for better health and well-being; Promoting intersectoral and interagency action for health and wellbeing in the WHO European Region". The conference aimed to strengthen intersectoral cooperation between the health, education and social sectors in the WHO European Region, for better, more equal health and social outcomes for children and adolescents and their families.[i]

It is equally interesting to observe from the analysis, the nature of, and slightly limited reference to, the role of health services. In the SDH Action Framework, there is reference to national health plans placing a greater emphasis on social and environmental policies. In the Shanghai Declaration, the notion of aligning both health and social services to optimise fair access and place people and communities at the centre offers another perspective. In the UHC 2030 Vision, a similar notion to that articulated in Shanghai is represented but the notion of health systems as everyone's business alludes to the social institutional role of health services and leaders. In addition there is an emphasis on health emergency readiness (as required by the International Health Regulations). In the Health and Climate Action Agenda, health facilities should embrace the climate change mitigation and resilience agenda, demonstrating leadership and aligning with a common vision of sustainable development. One conclusion to draw from all of these references is that there is a need for greater determinants literacy in health services and in the health workforce worldwide. Global standards on HiAP and determinants capacities in the health workforce will therefore be needed as part of the upcoming WHO National Health Workforce Accounts.

Finally, the specificities offered by the different frameworks present a rich scope for action. The essential broad scope of approaches described in the original SDH Action Framework

i See more: http://www.euro.who.int/en/media-centre/events/events/2016/12/paris-high-level-conference/about-the-conference

is enhanced and in several cases made more robust by the specific emphases of these other action frameworks. The Shanghai and Health and Climate Change Action Agenda make the strongest explicit link to sustainable development. The specific rich set of action themes that can form the basis of concerted global action by WHO are: health literacy supported by capacity building and participatory governance instruments; the authorising environment, including fiscal (economic) policies; urban development planning processes; multi-sectoral evaluation and accountability processes (including reporting on the SDGs); linkages with emergency readiness; and health diplomacy in contributions to climate change planning, evidence and reporting (as well as the specific funding opportunities offered under Climate Change).

These important observations for global action notwithstanding, at the same time it is noted that not all relevant WHO cross-cutting determinants frameworks are represented here. We focused on those linked to WHO work areas convened in a relatively short time-frame to sponsor the Adelaide II Conference. That process excluded several potentially relevant work areas such as animal and human health, antimicrobial resistance, food safety, and the International Health Regulations for health emergency preparedness.[i] Nonetheless, it is unlikely that their inclusion in this analysis would have contradicted any of the principal findings, rather they would have enriched it.

Conclusions

This modest analysis illustrates that there is powerful potential for WHO to make a greater impact in supporting the implementation of HiAP nationally and globally. This can be done through acting globally to convene particular actors and build capacity on the health determinants across different health (and non-health) constituents. There is also greater potential for enhancing impact and efficiency gains from WHO having a strategic, holistic picture of the areas of work promoting HiAP. Building essential HiAP characteristics into the Organization's next high-level strategic General Programme of Work could be a feasible approach. It can then identify key areas for acting jointly on the different mechanisms and themes offered by the different frameworks.

The different jurisdictions working to implement the Health in All Policies approach that are described in this book are working adaptively to apply HiAP in their settings. The approach of WHO to HiAP at the global level can have many implications for the way country actors implement HiAP. In closing, a quote from Adelaide II is an apt remark: "Many of the determinants we need to address are at the global level. It is essential that we build international alliances between countries, cities, civil society organisations and citizens to address these determinants (p 2)."[4]

i For further information on the global initiative of One Health see: https://www.onehealthcommission.org/en/why_one_health/what_is_one_health/ and for WHO's related work on human and animal health see: http://www.who.int/zoonoses/en/; http://www.who.int/zoonoses/activities/en/. See also the International Health Regulation: http://www.who.int/topics/international_health_regulations/en/; and for Food safety see: http://www.who.int/foodsafety/en/

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Case studies from around the world

The case studies featured in this book are described in the table below, highlighting the different stages of HiAP maturity across regions.

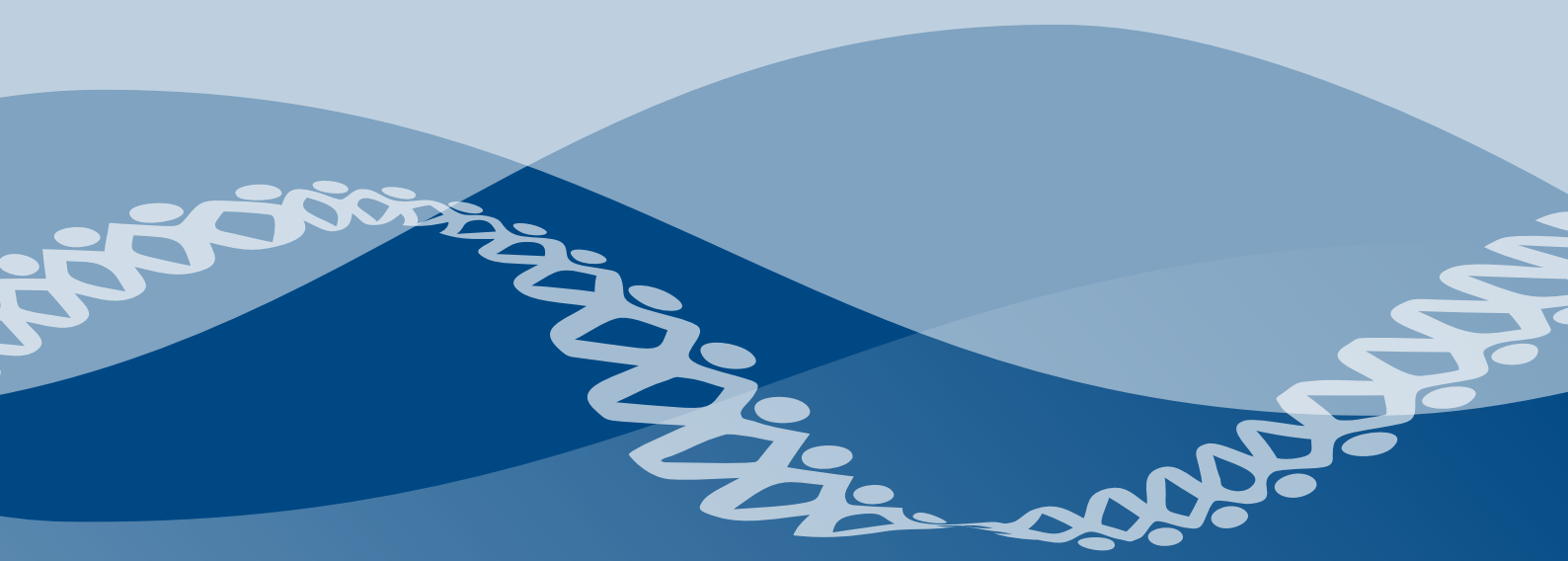
Region	Stage of maturity	Case study title	Description
1 South Australia	Mature	Health in All Policies in South Australia: lessons from 10 years of practice	The South Australian Health in All Policies initiative is an approach to working across government to better achieve public policy outcomes and simultaneously improve population health and well-being. Established in 2007, the successful implementation of Health in All Policies in South Australia has been supported by a high level mandate from central government, an overarching framework which is supportive of a diverse program of work, a commitment to work collaboratively and in partnership across agencies, and a strong evaluation process.
2 Finland	Mature	How to take into account health, wellbeing and equity in all sectors in Finland	Finland has a strong history of Health in All Policies implementation. The current Finnish Government Programme has five strategic priorities, one being promoting health and well-being. Its implementation consists of 26 key projects to support these high-level objectives. A critical health and well-being project is focussing on the development of a new model for cross-sectoral work which expands action to strengthen well-being considerations into decision-making, as Finland moves to a Health and Well-being in All Policies (HWiAP) approach. The new model provides a more robust framework for how all sectors of government can take into account the impact of their decisions and actions on health and well-being, and further promote equity issues.
3 Thailand	Mature	Thailand's National Health Assembly – a means to Health in All Policies	Thailand's National Health Act 2007 offered a new form of governance through the National Health Commission (NHC) to be established as an advisory body to the Cabinet on health policies and strategies. The NHC is mandated to coordinate with sectors across government to strengthen healthy public policy. Health in All Policies practice has provided a useful mechanism and process to engage with other sectors to promote better policy integration for health and well-being. The National Health Assembly (NHA) is one of the processes which the NHC uses to enable HiAP action. The NHA brings together people from government agencies, academia, civil society, health professionals and the private sector to discuss key health issues and produce resolutions to guide policy-making. It provides an innovative model of how governments may be able to increase public participation, citizen engagement and intersectoral collaboration to support evidence-based and inclusive policy-making.

Region	Stage of maturity	Case study title	Description
4 **California USA**	Mature	California Health in All Policies Task Force	The State of California created a Health in All Policies Task Force in 2010 in order to build inter-agency partnerships across State government to address issues of health, equity and environmental sustainability. The Task Force was established by an Executive Order and has maintained high-level government leadership support since its inception. The Task Force has broad representation across sectors from 22 state agencies working together to improve health and promote equity through changes to state policies, programs and practices.
5 **Canterbury New Zealand**	Mature	Applying a Health in All Policies approach to the Greater Christchurch Urban Development Strategy: the experience to date in Canterbury, New Zealand	In 2005/06 the Canterbury District Health Board (CDHB), in partnership with the Christchurch City Council, led the Canterbury region's first policy-level health impact assessment, which focussed on the Greater Christchurch Urban Development Strategy (GCUDS). Subsequently, the two agencies created a public health specialist role to strengthen the relationship between local government and health and well-being outcomes. The Health in All Policies approach was formalised as the Canterbury HiAP Partnership in 2010. An update of the GCUDS, with a public health specialist as a project team member, explicitly focussed on community well-being and led CDHB representation at governance, management and implementation levels. The case study demonstrates the importance of ongoing collaborative efforts at many levels over a sustained period.
6 **China**	Emerging	Action plan for promoting healthy China – outline of the Healthy China 2030 Plan	The State Council issued the Outline of the Healthy China 2030 Plan in October 2016 as an action plan for promoting the development of a 'Healthy China' over the next 15 years. It is the first time that China has developed a medium to long term national strategy for health, which takes a "one health" approach. The development of a 'Healthy China' is central to the Chinese Government's agenda for health and development. The Outline puts health at the centre of the country's policy-making machinery, making the need to include Health in All Policies an official government mandate. It indicates the commitment of China to participate in global health governance and supports the goals of the 2030 Agenda for Sustainable Development. Multisectoral collaboration and innovation play a key role in Healthy China.

Region	Stage of maturity	Case study title	Description
7 **Quebec Canada**	Emerging	Government policy of prevention in health: A HiAP approach in Quebec, Canada	In 2016, the Government of Quebec launched its Government Policy of Prevention in Health, a policy that mobilises a range of partners to further enhance the population's health, with a view to ensuring health equity. The Policy of Prevention in Health is a first for the province, and also for Canada. It is supported by the highest government authorities in Quebec. Conceived as a whole-of-government approach to health, it calls upon 15 ministries and government agencies specialising in different fields of intervention to work together to achieve the goals of population health. The Policy is structured around 28 measures (ministerial commitments) and five areas of research jointly identified with the ministerial partners.
8 **Wales UK**	Emerging	Legislating for sustainable development and embedding a Health in All Policies approach in Wales	The Well-being of Future Generations (Wales) Act 2015 provides an enabling framework for thinking and working differently, and embeds a Health in All Policies approach through the aspiration and architecture of the legislation. Its seven well-being goals aim to make Wales a healthier place, where the social, economic, environmental and cultural well-being of Wales is improved. The Act requires public bodies, including local authorities, to make sure that when making their decisions they take into account the impact they could have on people's well-being, and expects them to work together better, involve citizens, and look to the future as well as focusing on the now. This places sustainable development at the centre of decision-making, and upholds Wales' long-standing commitment to ensuring a sustainable future for all.

Region	Stage of maturity	Case study title	Description
9 Sudan	New	Sudan's Health in All Policies experience	Health in All Policies initially emerged as a potential enabler to the National Health Policy (2007), which highlighted the important role of intersectoral collaboration to address the determinants of health and to improve population health. It was the HiAP Roadmap developed in 2015 through a series of stakeholder meetings and workshops, however that provided the impetus to begin to unpack and discuss how HiAP action could be used as a tool to support cross-sectoral policy-making. As the framework and structures for HiAP practice continue to be built in Sudan, early support is demonstrated through 12 ministries signing commitments to work together with the Sudanese Ministry of Health for joined-up policy, with another 12 under development. A continuing engagement process is supporting the early implementation of HiAP, including the development of mechanisms for better governance for health and capacity building for effective policy, planning and evaluation.
10 Suriname	Emerging	Reducing the burden of disease and health inequity through HiAP – the case of Suriname	Health in All Policies was initiated through the WHO sub-regional training workshop in 2015. This was followed by a National Consensus Workshop (NCW) to determine policy priorities and how to move forward with HiAP implementation. A recommendation out of the NCW saw the establishment of eight intersectoral policy working groups (PWGs), and a monitoring steering and strategy group (MSS) in early 2016. High-level commitment through the engagement of the Speaker of Parliament, Vice President and Ministers has been present from the outset and this support continues to shape the HiAP approach in Suriname. In addition, the advocacy and support of HiAP 'champions' has been critical to getting HiAP started in Suriname and creating a network of engaged policy actors. The PWGs have developed policy proposals on a range of issues, and the selected policy priorities are now progressing to the implementation phase, which will complete Suriname's first HiAP cycle.

Region	Stage of maturity	Case study title	Description
11 **Quito Ecuador**	Emerging	Healthy Neighbourhoods – closing the gap in health inequality, City of Quito, Ecuador	This case study reports on work of the municipality and communities in the Metropolitan District of Quito and the Municipality of Quito Health Department through the Healthy Neighbourhoods project. The case study provides an example of HiAP action at the local level and features a strong community engagement and participation element that has supported cross-sectoral collaboration around community priorities in the District. The Healthy Neighbourhoods project, through the application of HiAP, promotes community led initiatives, supports healthy public policy and integrates health in urban planning and local investment decisions. The project highlights the work to address the non-communicable diseases epidemic in Quito, and how health inequities are being considered across sectors of local government.
12 **Namibia**	New	Namibia: Developing a National Strategy on Health in All Policies	Namibia, like many other regions, has struggled to achieve significant health gains in the past two decades due to the challenges of working across sectors. Previous attempts to engage across sectors through the Healthy Cities initiative and road safety and injury prevention strategies have proven useful, however, a targeted government-wide approach to consider how other sectors' policies impact on health has been missing. The endorsement of the United Nations Sustainable Development Goals provides Namibia with an opportunity to more closely link health with other sectors' work given the interconnected nature of all the goals and their interaction with the health goal. The development of the National Health in All Policies Implementation Strategy aims to provide the necessary framework for multi-sectoral action, and the support of central government is enabling a joined-up process, and helping to take forward the governance aspects needed for HiAP implementation to be successful.
13 **Zambia**	New	Zambia's experience in national policy formulation and how it informs the HiAP process	The Government's vision for health is outlined in the revised National Development Plan, which recognises that the determinants of health lie outside the control of the health sector. Although Zambia has only recently begun to take steps to institutionalise a Health in All Policies approach, Zambia's policy formulation process provides a sound basis for mainstreaming HiAP into the policy-making mechanisms across government. The critical role of the Policy Analysis and Coordination Division in Cabinet Office, in the Office of the President, is pivotal to facilitating buy-in and coordinating actions across sectors. A growing economy and the United Nations Sustainable Development Agenda provide further opportunities for Zambia to embed HiAP as a recognised way of working together to improve health and promote sustainability.



Health in All Policies

Health in All Policies in South Australia: lessons from 10 years of practice

Authors

Carmel Williams[A] and Claudia Galicki[A]

[A]South Australian Department for Health and Ageing, Australia

1

Introduction

Health in All Policies is about promoting healthy public policy and is based on the understanding that health is not merely the product of health care activities, but is influenced by a wide range of social, economic, political, cultural and environmental determinants of health. The concept of Health in All Policies (HiAP) originated in Europe and has been applied, in various forms, in a number of countries. In South Australia (SA)[i], Health in All Policies has been adopted as an approach to working across government to better achieve public policy outcomes and simultaneously improve population health and well-being through 'joined-up' policy development. The South Australian Health in All Policies approach utilises a model specific to the Government's organisational structure to address the overarching strategic objectives. By incorporating a focus on population health into the policy development process of different agencies, the Government is better able to address the social determinants of health.

Health in All Policies was first introduced to South Australia by Professor Ilona Kickbusch, in her role as the 2007 Adelaide Thinker in Residence, when she proposed that South Australia adopt a Health in All Policies approach and that this approach be applied to the Government's strategic priorities and policy imperatives.[1]

Since that time HiAP practice in South Australia has undergone a number of transitional phases. However, from the beginning, the implementation of HiAP has been supported by a high-level mandate from central government, an overarching framework supportive of a diverse program of work, a commitment to work collaboratively and in partnership across agencies, and a strong evaluation process. The adaptive nature of HiAP practice in South Australia has enabled it to survive changing political and bureaucratic circumstances and it remains part of the State's strategic approach to improving the health and well-being of South Australians.

South Australia's HiAP approach has now been underway for 10 years. This achievement is largely due to the commitment of senior decision-makers and policy officers across government in supporting collaboration for policy-making and delivery in ways where mutually beneficial outcomes are achieved.

The South Australian HiAP model is built upon two foundational pillars: strong governance and flexible partnership practices and processes, including Health Lens Analysis. The two pillars provide scope for the approach to apply new methods and tools in response to particular policy issues or changing contexts. The methodology used is matched to the needs of the policy environment. It provides robust assessment and analysis, exploring the links between the policy area and the health and well-being of the population. While the key elements of the two pillars have remained constant, there have been changes in the way they are achieved.

Importantly, the South Australian Health in All Policies model focuses on improving population health and well-being outcomes through action on the policies of other sectors that impact on the social determinants of health, rather than starting from a health policy focus. To date, the Health in All Policies approach has been applied to a diverse range of policy areas of importance to South Australia, many of which are beyond the usual purview of the health sector.

i South Australia is the southern, central state of mainland Australia. It has a total land area of 983,482 square kilometres (379,725 square miles), which is similar in size to Egypt, or the combined areas of France and Germany. Adelaide is the capital city of South Australia. The state has a population of more than 1.7 million people, 77% of whom live in Adelaide and surrounding metropolitan areas.

Vision

Public policy creates the social, economic and environmental conditions to promote population health, well-being and equity.

Aim

Improve the health and well-being of South Australians by strengthening cross-government action on the social determinants of health through a Health in All Policies approach to government priorities and public policy.

Governance and Reporting Structures

The South Australian HiAP initiative is jointly overseen by the Department of the Premier and Cabinet (DPC) and the Department for Health and Ageing (DHA), with DPC providing the central authority and mandate for the initiative across government.[2] This partnership has been a key feature of the South Australian approach and while the relationship between the departments has remained strong, the mechanisms that underpin the partnership have changed and evolved over time. When Health in All Policies first started, the initiative reported to the formal governance structure established to oversee the implementation of South Australia's Strategic Plan (SASP), a whole of government plan to guide the action of government.[3] As government priorities changed so did the governance and reporting structures for HiAP.

The history of SA HiAP governance and accountability mechanisms are listed below:

- *Premier's endorsement:* As Thinker in Residence, Professor Kickbusch's recommendation to apply a HiAP approach to Strategic Plan targets was endorsed by the then Premier of South Australia Hon Mike Rann.
- *Executive Committee of Cabinet (ExComm):* Following the Premier's endorsement, Health in All Policies operated under the same governance and accountability mechanisms established to oversee the implementation of South Australia's Strategic Plan targets. Each agency Chief Executive is required to report to the Cabinet on the achievement of targets allocated to their department, and HiAP offered a framework through which activities to assist in achieving the targets could be progressed.
- *First Health in All Policies Memorandum of Understanding (MOU):* In 2009, a formal agreement was developed between the DHA and the DPC to acknowledge the collaborative partnership and shared responsibility for HiAP.
- *Seven Strategic Priorities Cabinet Taskforce:* The Seven Strategic Priorities[4] became the policy focus of the new Premier, Hon Jay Weatherill and he established a Cabinet Taskforce and a Senior Officers Group for each of the seven priorities. In line with the MOU, Cabinet Office supported the inclusion of HiAP as part of these new governance arrangements.
- *The South Australian Public Health Act 2011:* The Public Health Act provided an additional governance mechanism and a legislative basis for HiAP, through its principles and powers within the Act that provided additional levers to address the determinants of health and to formalise cross-sector partnerships.[5]
- *Second Health in All Policies Memorandum of Understanding:* The Second MOU, endorsed in 2014, reinforced the strong partnership between DPC and DHA, acknowledged the important role of the Public Health Act and extended its focus to systematising HiAP across government.
- *Public Sector Reform and Public Value:* Health in All Policies principles and practices are now shaping the across-government approach to strengthen joined-up policy, which has been endorsed by all government departments' Chief Executives and forms part of the Government's public sector reform agenda.
- *Performance Agreement of Chief Executive of the Health Department:* To further embed the commitment to HiAP within the Department for Health and Ageing, the Chief Executive has added HiAP as one of the measures

of accountability within the performance agreement, providing another layer of governance and accountability.

Central government leadership has been essential to the success of HiAP in South Australia and provides a clear statement of the Government's commitment to the initiative. It also provides a mandate to work across government, and has provided partner agencies such as other departments, with the impetus and motivation to engage with Health in All Policies. In addition to the horizontal governance structure, the South Australian HiAP model utilises the traditional vertical decision-making structures of individual government agencies in project approval processes. These vertical governance structures are important as they maintain the authority and policy responsibility of individual department Chief Executives and executive leadership teams. The structures have ensured that when policy recommendations are made, there is high-level understanding and commitment to their implementation. Figure 1 shows how the vertical and horizontal structures intersect in HiAP processes and outlines how the HiAP team navigates the recommendations through these multiple decision-making processes. At every adaptation of the HiAP approach, consideration has always been given to how to maintain or re-form the horizontal and vertical governance structures – be they across the whole HiAP approach, individual programs of work, or on a project-by-project basis.

At the present time the central mandate and governance for HiAP is provided through the implementation of the MOU between DPC and DHA, with further legitimacy and accountability provided through the legislative framework of the *South Australian Public Health Act 2011* (the Act).[5] Importantly, these mechanisms are not time bound and so provide enduring, overarching governance and reporting structures for HiAP, and contribute to HiAP being systematised within the South Australian government. Ten years of HiAP implementation has contributed to the changing culture within the public sector, where cross-sector collaboration is valued and the benefits of working together as 'One Government' are recognised throughout the public service.

Figure 1. Health in All Policies Horizontal and Vertical Governance

Staffing and Funding

A dedicated HiAP function within the Department for Health and Ageing was established to support the implementation of the HiAP initiative. The position for a HiAP program manager was drawn from the existing public health and health promotion budgets and positions to support the work also came from existing resources within the Health Department.

Implementation of HiAP has used limited resources, including a small and varying number of staff, which at full complement included six full-time staff. To illustrate the scale of investment, the SA Health budget for 2015-16 was $5.8 billion. HiAP totalled 0.00948% of that budget.[6] The initiative relies on HiAP project partners providing in-kind support and contributing limited additional resources where possible and adapting their normal business to accommodate the needs of the HiAP work.

Mechanisms for the South Australian HiAP approach

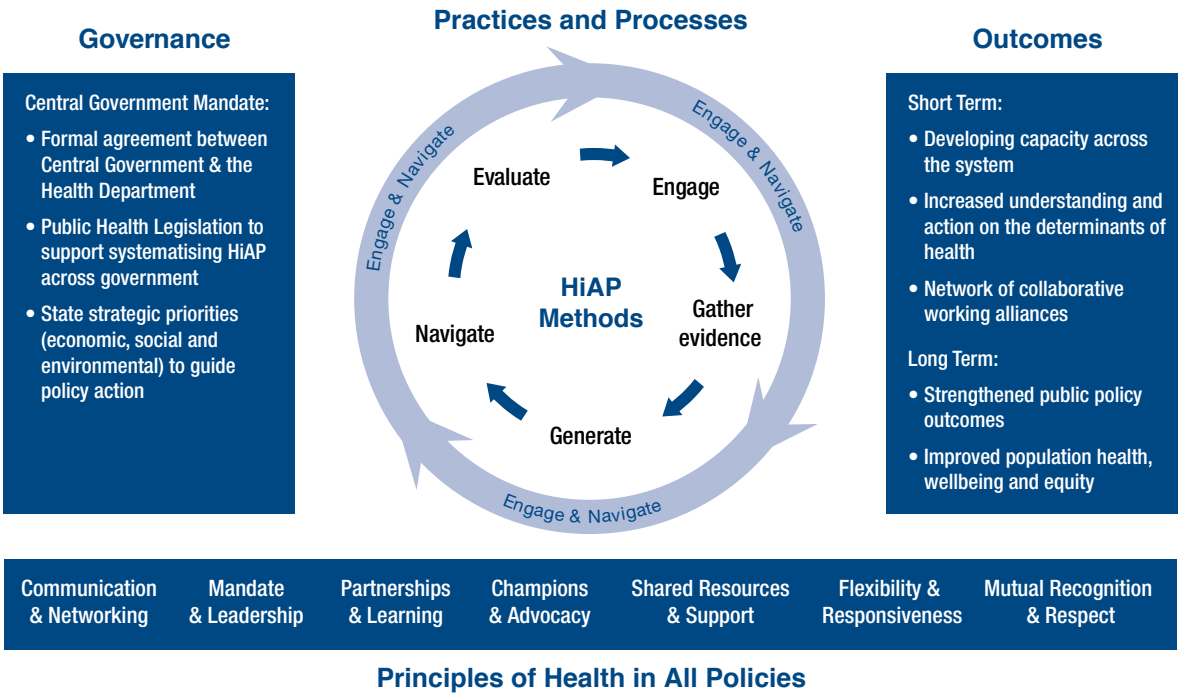
The South Australian HiAP methods aim to provide a robust assessment and analysis to explore the links between the policy area and health and well-being of the population. Figure 2 shows the current South Australian HiAP model.

Practices and Processes

The practices and processes that underpin the HiAP approach have a strong focus on building and sustaining relationships in line with the collaborative approach. Co-design and co-benefit direct effort towards establishing trust, a shared understanding and common purpose amongst partners. Five stages guide the co-design process and form the cornerstone of practice helping deliver shared outcomes or co-benefits:

The Engage stage begins the process and continues throughout the life of the partnership. This stage develops relationships, clarifies contextual issues, and establishes a shared work plan and processes.

Figure 2. South Australian Health in All Policies model



Gather evidence is the next stage and is an essential feature of the approach. It includes review of both quantitative and qualitative data and literature helping to ensure the evidence is inclusive of all perspectives, while maintaining rigour.

Identifying solutions and developing shared recommendations for action forms the basis of the **Generate** stage. This stage includes documenting both the processes used to gather the evidence and the findings arising from the evidence. In most situations the co-design process used during the two previous stages results in the partners comfortably arriving at agreed solutions.

Guiding the recommended solutions through the decision-making processes of partner agencies forms the **Navigate** stage. This stage needs to account for any strategic and/or political imperatives that may compromise or confirm the decision to endorse and act on the solutions. The navigate stage influences the collaboration throughout the life of the partnership, in much the same manner as the engage stage.

Accountability and recognition are important drivers of long term initiatives and the **Evaluate** stage enables the South Australian HiAP approach to demonstrate its impact and ultimately its value to the public sector and the wider South Australian community.

Methods

These practices and processes are applied to policy issues using a range of key methods. The methods have expanded in response to feedback, legislative and strategic opportunities and direct requests for evidence from partner agencies. The four primary methods are briefly summarised below.

Tight timeframes can dictate the policy process, and in these circumstances **Desktop Analysis** can provide a rapid response, reviewing and analysing existing evidence and sharing with partners. This approach is only applied when time constraints do not permit more robust methods.

90-Day Projects bring a sharper focus to the policy issue under investigation as the dedicated timeframe focusses effort and resources. The 90-day project concept was initiated by the Office for the Public Sector (OPS) and is strongly based on the Health Lens Analysis methodology. These projects are usually run by the OPS, however, specific HiAP 90-day projects follow a more co-facilitated approach between the HiAP team and the OPS. The 90-day project cross-agency teams (partners) work though a co-design process, explore the policy issue from multiple perspectives and identify solutions that deliver co-benefits to the public sector and the community.[7]

The establishment of **Public Health Partner Authorities** (PHPAs) is a mechanism under the the Act that provides for formalised partnerships between the Department for Health and Ageing and partnering agencies to enable joint action across sectors, levels of government and community.[8] These partnerships are formalised through an agreement that documents a long-term shared work agenda (up to five years), ways of working and expected outcomes of the partnership. HiAP has negotiated PHPAs with several state government departments, universities, the non-government and community sector and also has potential to partner with the private sector. PHPAs have expanded the reach of the HiAP approach beyond the government sector.

The **Health Lens Analysis** (HLA) has been the primary method of South Australia's HiAP approach and continues to be applied to issues requiring more intensive analysis and when time permits a greater level of exploration.[9] Usually a mix of tools is used, which are fit for purpose, including: literature reviews/scans, pathway analysis, stakeholder mapping, qualitative and quantitative research, and economic modelling. It is an iterative process and uses flexible methodologies to ensure that the approach fits with the policy issues in question, the resources available and the local populations affected. Importantly, HLA provides the opportunity to identify knowledge and evidence gaps for a particular issue and then work systematically with partners to resolve these gaps, creating new evidence where required.

Evolution of Health in All Policies practice in South Australia

There were a number of factors which coincided to create the political environment and will within the Government of South Australia to adopt the Health in All Policies approach which has continued to evolve in response to a variety of challenges and opportunities.[10] These changes have occurred in five distinct phases or transitions:

1 Proof of concept and practice (2007-2008)

The concept of Health in All Policies was introduced to South Australian government decision-makers as an innovative approach to addressing health system pressures, the escalating incidence of chronic disease, and the growing burden of an ageing population. The growth of the health budget was a major concern to the Government of South Australia and leaders realised that new approaches were required. The political environment was receptive to adopting a HiAP approach, and South Australia's Strategic Plan provided the necessary framework to establish Health in All Policies as a whole of government concern.

Since South Australia's Strategic Plan was first introduced in 2004, the Government has maintained a strong commitment to achieving the targets outlined in the Plan. In 2007, the plan was updated, coinciding with the timing of the establishment of Health in All Policies.[1] The targets included in the plan mirrored the social determinants of health covering issues related to employment, education, housing, food, transport, early life and social support, and it recognised that concerted and cooperative action across multiple sectors of South Australian society is required to achieve them.

It was within this context that Professor Ilona Kickbusch, in her role as the 2007 Adelaide Thinker in Residence, proposed that South Australia adopt a HiAP approach and that this approach be applied to the government's strategic priorities and policy imperatives. Further, Professor Kickbusch proposed that South Australia could develop and implement a Health in All Policies approach that would complement the government's organisational structure, so that HiAP worked within the policy development process of different agencies.[11] Linking Health in All Policies with the Plan provided the opportunity to establish HiAP as a whole of government response, a missing link in previous attempts at joined-up approaches.

A preliminary mapping process was undertaken to document the evidence linking health with other government policy priorities, and identify interested policy officers across government to test ideas and potential processes for HiAP. These early adopters were critical for helping to shape HiAP from the concept phase to a practical approach.

2 Establish and apply method (2008-2009)

The South Australian HiAP model sought to build strong intersectoral relationships across government and help to develop policy that delivered co-benefits to the health sector and the partnering sector. The focus on co-benefits was established as a critical feature of the HiAP model, as the aim was to deliver a win-win outcome, not just a win for the health sector. This has remained integral to South Australian HiAP practice.

A strong feature of South Australia's HiAP is the clarity of description regarding implementation. During the *establish and apply method* phase, a model of HiAP implementation was developed, and has been updated throughout the life of the initiative to reflect changes in governance and the different methods applied to HiAP. The model was designed to capture the two key elements underpinning the approach at the time: governance and the Health Lens Analysis (HLA) methodology. To trial and test the method, a small number of policy issues (e.g. water security and regional migrant settlement) were explored using the HLA methodology. This enabled an iterative process to begin to shape and strengthen the model.

In addition, a dedicated HiAP function was created within the Department for Health and Ageing and was resourced with a HiAP program manager and intermittent policy staff to provide support to the first set of HLA projects.

3 Consolidate and grow (2009-2013)

This phase saw the HiAP Unit grow to a small sustainable team. The HLA process was applied to multiple policy issues and the methods expanded to provide increased flexibility. The policy areas were selected based on a number of priority setting processes which occurred as part of the governance arrangements for HiAP, including considerations of where HiAP could best support the targets under South Australia's Strategic Plan. These policy issues included: broadband access and use; active transport; urban planning; determinants of obesity[12]; education; overseas students' health and wellbeing; sustainable regional development; and mobility (drivers' licensing). In each case the relationship between the policy (a social determinant of health) and health outcomes was mapped to detail interactions and synergies. This pathway analysis helped to explain to decision-makers, including within the health sector, why partner agencies were working together, and helped to maintain a focus on the co-benefits.

In 2012, the Government of South Australia released the *Seven Strategic Priorities*[i], which identified new areas of focus for the state; these complemented the targets contained in the SA Strategic Plan. As a consequence, governance for HiAP shifted to operate through the Seven Strategic Priorities mechanisms for relevant matters or through the Senior Management Council (SMC), a group comprised of the Chief Executives of all government departments, and finally Cabinet itself. The HiAP Unit undertook a Health Lens Analysis across the seven strategic priorities to identify the health and well-being connections to each of the priority areas.[13] Through this process, opportunities for new collaborations were identified, and relationships between the HiAP team and senior government decision-makers were expanded.

To reflect the changing context in which HiAP was operating and the growing recognition that the process was very interactive, the HiAP model was updated in 2011 and then again in 2012, to better capture the dynamic and fluid nature of the approach.

The early success of South Australia's HiAP approach was shared through the Adelaide International Meeting in 2010[14] and the first HiAP Summer School in 2011.[15] Both these occasions highlighted the supportive relationship with the World Health Organization (WHO). This phase also saw the development of the first Adelaide Statement on Health in All Policies – an outcome of the 2010 International Meeting.[16]

The monitoring and evaluation of Health Lens Analysis projects was built into the South Australian model in the early stages of the HiAP initiative. Each Health Lens Analysis project included an evaluation component. Process and impact evaluations were undertaken by the Southgate Institute, Flinders University of South Australia, and demonstrated the early policy impact and the value of the approach to partners.[17]

4 Adapt and renew (2014)

Significant political and organisational changes during the *adapt and renew* phase presented both challenges and opportunities for South Australia's HiAP approach. This phase tested the flexibility of HiAP processes and demonstrated the adaptable nature of the approach within a changing political and policy environment. Within the Health Department, the HiAP Unit merged into the newly established Public Health Partnerships Branch as the Strategic Partnerships team, and the HiAP work shifted to incorporate a stronger focus on supporting the implementation of the *South Australian Public Health Act 2011*.[5]

i When released in 2012, the priorities were: creating a vibrant city; an affordable place to live; every chance for every child; growing advanced manufacturing; safe communities, healthy neighbourhoods; realising the benefits of the mining boom; premium food and wine from our clean environment.[4]

The Act provided an opportunity to strengthen HiAP as it had an expanded focus – on illness prevention and health promotion. Importantly, the Act recognises the determinants of health as the underlying causes of health and well-being and includes principles and mechanisms designed to increase partnerships and strengthen action on the determinants.

A State Public Health Plan 'South Australia: A better place to live' was developed to guide the implementation of the Act.[18] The Plan identifies HiAP as an important driver in the development of systems that build partnerships across and between state and local government. The Act provides (among many other functions) two important mechanisms:

1. Section 17, which involves the Minister for Health's role in providing expert advice to the South Australian Government on matters which may impact on public health. This is being planned through the design of instruments and mechanisms so the Minister for Health can provide health advice and consider health impacts of government policy.
2. Section 51, which involves the establishment of Public Health Partner Authorities. Agreements are negotiated between the DHA and the partnering agency. The voluntary agreements are developed with the intention of improving population health and well-being through action on the social determinants of health, whilst achieving the goals of the partnering organisation.

While the Public Health Act provided a good opportunity for HiAP to adapt and renew, changes underway within the prevention and health promotion functions across South Australia presented significant challenges. At this time, South Australia was in the midst of an economic transition, with health care costs continuing to escalate creating pressure for the health system to deliver major budget savings. This fiscal pressure led to a number of organisational re-alignments designed to ensure prevention efforts were optimised through the new mechanisms provided by the Act.

The HiAP Unit, renamed the Strategic Partnerships Team, worked through the implications of all these changes on HiAP action. The Department of the Premier and Cabinet reconfirmed the commitment of the Cabinet Office by renewing the 2009 DPC – DHA MOU. The updated MOU sets out how DPC will play an on-going role in supporting the DHA to establish across government partnerships and governance arrangements to further support HiAP and action on the determinants of health.

5 Strengthen and systematise (2015-2017)

The *strengthen and systematise* phase saw the governance mechanism underpinning the HiAP approach diversify and consolidate. Public Sector Reform and Public Value provides a new authorising environment for strengthening joined-up approaches, drawing on HiAP principles and practices. The Premier's priorities have offered expanded policy opportunities in areas such as:

- A focus on 'One Government'
- Planning reform (urban built environment)
- Economic priorities
- Reinvigoration of the Safe Communities, Healthy Neighbourhoods Strategic Priority and Taskforce (one of the Seven Strategic Priorities) with a related focus on the urban built environment and health.

There has been continued effort to implement Section 17 of the Act through the principles and practices that underpin the HiAP approach, to support across government health advice.

The health system is not the only government agency that struggles to address complex multi-faceted problems and policy imperatives that require collaborative approaches and processes. The structural and cultural barriers to cross agency collaboration are a significant challenge. Given the positive disposition towards HiAP among many executive and senior officers across government, the HiAP team was supported to explore mechanisms and processes that would strengthen cross government collaboration and joined-up policy processes for the whole public sector through the Working Together Strategy, which is led by Cabinet Office.

In August 2016, the Government of South Australia released the *Working Together for Joined-Up Policy Delivery Report*.[19] It summarises the barriers and outlines the strategies that will be required to influence and shape the policy development culture within the public sector. These changes include governance and structural supports; new processes and tools; and identification and support for Joined-up Policy Champions.

The Report recognises HiAP as an existing practical example of how to achieve joined-up policy development. The lessons of governance and a focus on people and relationships, including co-design and co-benefits that are explicit in South Australia's HiAP approach have been embedded in the Working Together Strategy. The implementation of the Working Together Strategy is now attempting to change the culture and hence deliver greater public value.

During the *strengthening and systematising* phase, 10 years of HiAP practice in South Australia was also celebrated through the International Conference *Health in All Polices: Progressing the Sustainable Development Goals* held in Adelaide in March 2017 in partnership with the WHO. This meeting resulted in the development of the Second Adelaide Statement on HiAP, which positions HiAP for the first time in the context of the 2030 Sustainable Development Agenda.[20] South Australia has also signed on as one of the foundational members of the Global Network for Health in All Policies (GNHiAP), which aims to strengthen capacity for HiAP implementation.[21]

Each new phase has been informed by the lessons of the previous transitional stages, and a more detailed understanding of the needs for HiAP practice applied as a result. These transitions have been 'fluid' to optimise the strategic opportunities, whilst navigating the challenges. In this context, changing structures and processes have emerged as part of a continuous development cycle – never static, responding to the political and policy-making environments, and changing windows of opportunity.

Monitoring and Evaluation

Monitoring and evaluation is built into the South Australian HiAP model.[22,23] As the HiAP model has expanded to include new methods, different approaches to evaluation have been required in order to demonstrate the impact of newer practices, for example Public Health Partner Authorities. Building on the successful process and impact evaluations of the Health Lens Analysis projects, the HiAP team is considering how best to progress individual project-based evaluation, to capture the outcomes of more recent HiAP activities.

In 2011, the Southgate Institute for Health, Society and Equity, Flinders University of South Australia was awarded a National Health and Medical Research Council (NHMRC) grant to conduct an overall evaluation of the South Australian HiAP initiative. The research aimed to determine the effectiveness of the initiative in motivating action across sectors in order to improve population health and health equity.[6] The evaluation of the initiative is expected to be finalised at the end of 2017.

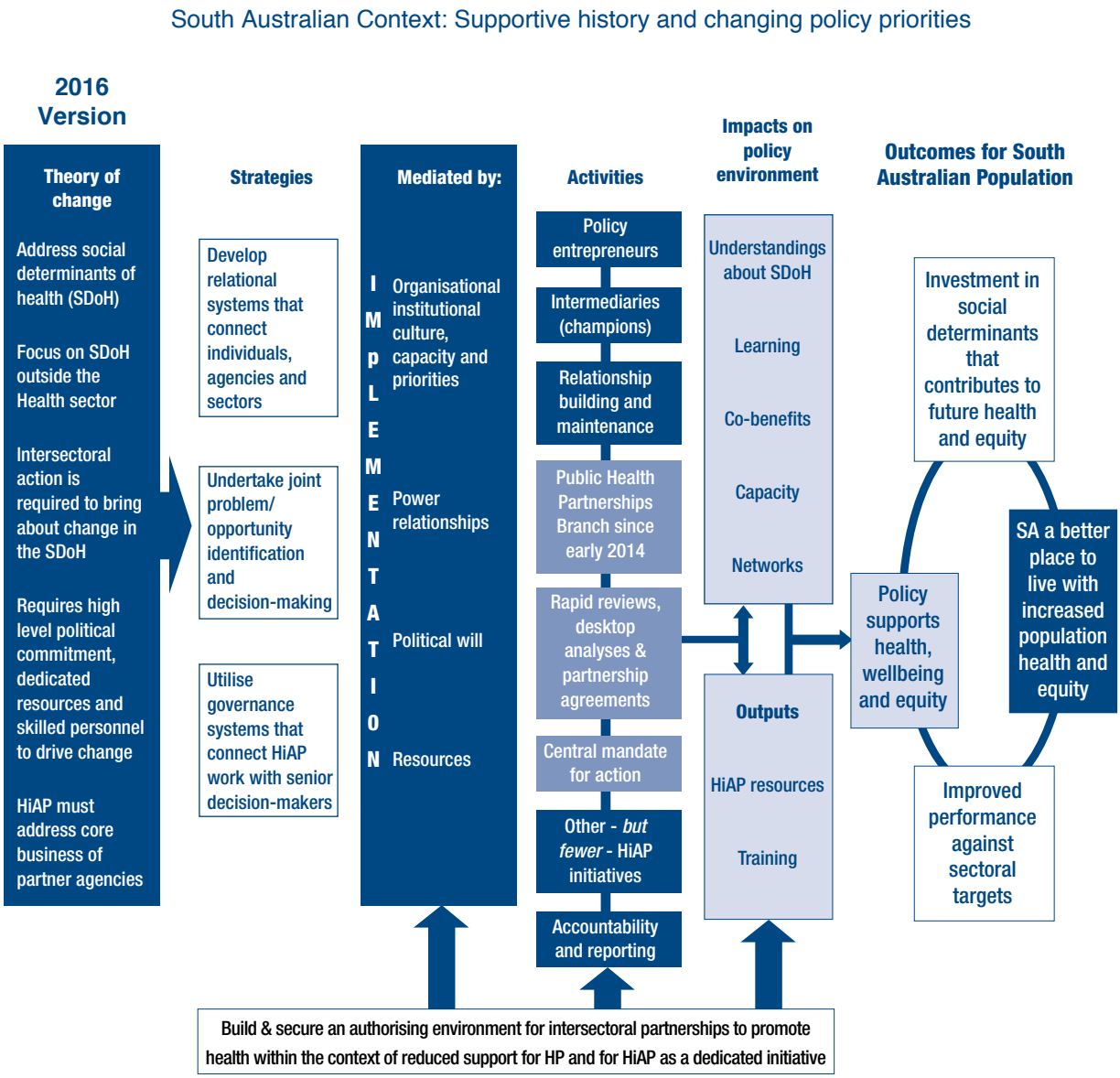
Outcomes

The evaluation of the Health Lens Analysis projects and the broader evaluation of South Australia's HiAP initiative have identified key messages and themes. These often refer to less tangible outcomes, which are more difficult to measure and track over time; for example, relationship building and knowledge transfer between HiAP partners. The program logic model (Figure 3) presents a sound framework to examine HiAP processes and policy impacts. It is through this evidence-based logic that the evaluation demonstrated that HiAP has encouraged policies and interventions that will, in the long-term, improve health and well-being in South Australia.

Common messages and themes identified in the evaluation included:

- Greater understanding and stronger partnerships between health and partner agencies with a focus on co-benefits has

Figure 3. Program logic model (2016 version)



Adapted from: Baum F., Lawless A., Delany T., MacDougall C., Williams C., Broderick D., Wildgoose D., Harris E., McDermott D., Kickbusch I, Popay J. and Marmot M. (2014) Evaluation of Health in All Policies: concept, theory and application, Health Promotion International, vol.29, S1, pp. i130-i142

built trust, recognition of shared interests and goals, and respect. The partnerships have provided the HiAP Unit with the opportunity to 'hook' onto emerging policy agendas, which may not have been possible without these partnerships. They have also been important for the continuity of HiAP and maintaining it on the government agenda.

- Enhanced capacities for intersectoral collaboration – the HiAP experience has informed new ways of thinking, built understanding of differing policy perspectives, and created alliances across sectors, allowing traditional organisational processes to open-up to more collaborative practices. HiAP partners are able to speak about the benefits of the approach and apply HiAP principles and intersectoral collaboration to their work beyond that of the original HiAP project focus.
- Increased understanding by policy-makers of the impact of their work on population health and well-being and the importance of social determinants.
- Limited understanding of partners of the role of health equity and the need for intersectoral policy to address the social gradient that creates health inequities. It is acknowledged that the South Australian HiAP model did not always place equity at the centre of the approach. However, equity issues were regularly raised with partners and wherever possible these were included in the evidence gathering and generate stage of the model. It is recognised that equity needs to become a greater focus of the South Australian HiAP approach moving forward.
- Development and dissemination of policy relevant research – interpreting and applying qualitative and quantitative research to policy problems to find evidence-based solutions is at the core of South Australian HiAP practice. At times new research has needed to be generated as part of the evidence gathering process, where significant gaps have been identified. Staff in other agencies often approach the HiAP team, as they are recognised as a resource with content expertise and experience in policy research and translation.
- Strengthened policy-research partnership – the focus on evidence-based policy-making and a strong evaluation component has enabled policy actors and academic researchers to share knowledge and facilitate an improved policy-research translation interface.
- Conceptual learning (redefining goals, problem definitions and strategies) and social learning (dialogue and interaction between stakeholders) have been beneficial for all involved.

Community of Practice

A significant outcome of the South Australian HiAP initiative has been the development of an informal Community of Practice (CoP), which continues to grow as new partners are exposed to and undertake HiAP related activities. This network of engaged policy actors has contributed to the government's recent public sector reform agenda, which is founded on a co-design methodology to improve public policy-making and delivery and enhance public value. By translating and 'championing' HiAP principles into new contexts, the CoP is able to infiltrate new policy landscapes – at times without the involvement of the HiAP Unit – further contributing to and supporting the systematisation of HiAP across government.

Policy impacts

Reflecting on the less tangible outcomes has supported the evolution of the HiAP initiative, and through a constant 'learning by doing' approach strengthened the methodologies used to ensure outcomes in a changing policy environment. Box 1 shows a sample of policy impacts that have been achieved throughout the ten years of HiAP in South Australia, drawing on the different methodologies that have been applied to particular policy issues.

Box 1. Practical examples of the impact of HiAP in South Australia

1. Health Lens Analysis (HLA)

1.1 Method/policy focus: Healthy Sustainable Regional Communities (2012-2014)

Determinant/policy issue: Sustainable regional development, including employment

Partner agency: Department of State Development (DSD)

During a period of mining-led economic development it was important to examine the overall health and well-being of regional communities, their sustainability, and ability to capitalise on the expansion of the resources sector in South Australia.

Policy impact: The development of the 'Regional Atlas of Community Health and Wellbeing' in the Upper Spencer Gulf (Far North Region of South Australia) was developed to inform evidence-based planning, policies and service delivery in the region using a triple-bottom line approach (environment, social, economic).[24] The analysis found the existing economic focus needed to be complemented by greater attention to the social and environmental aspects of regional development. The development of the Atlas enabled a broad assessment of needs in regional development and planning, and demonstrated a new approach to engagement, data collection and analysis, and planning for often remote and sparse communities with complex needs. The Atlas continues to inform emerging challenges for regional areas, including optimising community assets and strengths.

1.2 Method/policy focus: Aboriginal drivers' licensing (2009 - 2014)

Determinant/policy issue: Mobility and road safety

A HiAP priority setting process identified a focus on addressing fatal vehicle accidents, given their significant contribution to Aboriginal mortality and morbidity. Aboriginal people have lower drivers' licensing rates and face a range of barriers in the licensing system. Evidence demonstrates the strong correlation between unlicensed driving and being involved in fatal motor vehicle crashes. In addition, having a driver's licence is important for mobility and access to services, education, employment and family/community activities, which ultimately supports health and well-being.

Partner agencies: Department of Planning, Transport and Infrastructure (DPTI), Attorney-General's Department, SA Police, Department for Correctional Services and Department of State Development

Policy impact: The most significant outcome of this collaborative project was the introduction of legislative change to assist Aboriginal people in remote communities to obtain their licence. This provided an exemption for Aboriginal people in remote areas, enabling them to progress from a 'learner' to 'provisional' licence more quickly and in doing so obtain their licence sooner. This change has maintained standards within the licensing system, whilst providing greater flexibility to enable more Aboriginal people to obtain a licence. Bringing about such systemic change in the licensing process was a goal of the Health Lens project from the outset. The HiAP approach allowed for a breadth of evidence and perspectives to inform a robust process and the development of policy recommendations.

The work also informed a 90-Day project, which built on the recommendations of the Health Lens Analysis to further explore Aboriginal road safety issues in remote communities and potential solutions.

2. Public Health Partner Authorities (PHPAs)

2.1 Method/policy focus: Healthy Parks Healthy People South Australia (2015 – current)

Determinant/policy issue: The environment - increasing access to parks and supporting the health and well-being benefits of contact with nature

Exposure to natural green spaces, such as parks and reserves, has the potential to provide significant benefits for physical and mental health, particularly places that are easy to access, have multiple uses and have little or no cost. The presence of a diverse natural environment in South Australia, supported by a newly formalised partnership with the environment sector, provided an opportunity to strengthen the connections of nature to health. There was an emerging policy window to explore how health promotion and prevention approaches could be used to deliver nature-based strategies and help tackle policy challenges on issues such as chronic disease, climate change, child development, social exclusion and disadvantage and land degradation.

Partner agency: Department of Environment, Water, and Natural Resources (DEWNR)

Policy impact: The Healthy Parks Healthy People South Australia (HPHPSA) approach was launched in 2015 as a partnership between the health and environment sectors. It is guided by the vision of ensuring all South Australians experience the health and well-being benefits of being connected to nature.

A HPHPSA Framework[25] was developed in 2016 to guide policy action in seven key focus areas, and a Leadership Team consisting of the Health and Environment Departmental Chief Executives, distinguished academics and public health experts provides high-level governance oversight.

Policy work to date has mainly focused on two key focus areas: mental health benefits of contact with nature; and green infrastructure in urban settings. The work under the mental health focus area has informed a strengthened focus on nature-based health promotion as part of the consultation process on the SA Mental Health Strategic Plan, and the HPHPSA approach has been included in the SA Suicide Prevention Plan. The work being undertaken under the green infrastructure focus area is intending to influence the urban planning and design policy space to ensure that 'quality' dimensions of green public open space are incorporated into the planning system, especially as densification becomes more pronounced in Adelaide and its inner suburbs.

3. Other Government Priorities – using a mix of HiAP methods

3.1 Method/policy focus: Planning Reform (2016 – current)

Determinant/policy issue: The urban built environment

There is a long standing relationship between the Health and Planning sectors in South Australia underpinned by a mutual commitment to building healthy environments. This partnership contributed to the Department of Planning, Transport and Infrastructure (DPTI) becoming the first government agency to be recognised as a PHPA.

The Planning Reform provides a unique opportunity for health and well-being considerations to be built into the mechanisms, processes, and policies that will form the new planning system. The reform agenda is the biggest overhaul to South Australia's planning system in over 20 years and provides the foundation and triggers for delivering healthier communities given the impacts of the built environment on health and well-being.

Partner agency: Department of Planning, Transport and Infrastructure (DPTI)

Policy impact: Through the Public Health Partnership with DPTI, the Health Department is providing health and well-being advice and feedback into the development of policies that will guide the implementation of the new planning system. For example:

- State Planning Policies on healthy and liveable neighbourhoods
- The Planning and Design Code
- Planning tools for the provision of 'quality' green public open space.

In addition, a recent update of the 30-Year Plan for Greater Adelaide included a strengthened focus on healthy neighbourhoods, which resulted from the close collaboration with planning sector policy officers.

3.2 Method/policy focus: Premier's Healthy Kids Menu Initiative (2015 – current)

Determinant/policy issue: Access to healthy and nutritious food

Childhood obesity continues to be a challenge worldwide and in South Australia approximately one in four children are overweight or obese. Evidence suggests that food retailers play a key role in creating a supportive environment for individuals to make healthier food choices.

In 2015, the Premier commissioned the Healthy Kids Menu Initiative[26] to ensure access to healthier meal options for children when dining out, and requested the Health Department lead and facilitate the program. The initiative aims to have more Healthy Kids Menus available in food venues for purchase by families and children. Using a co-design process, the initiative has unfolded in a number of stages, following an evidence-based approach.

Partner Agencies: Cabinet Office (Department of the Premier and Cabinet), and non-government stakeholders; the hotel, restaurant, catering and club industries. A Taskforce comprising of industry representatives, parents and nutritional experts, chaired initially by the Parliamentary Secretary to the Minister for Health and then the Assistant Minister to the Premier, was established to provide oversight to the initiative.

Policy impact: The Healthy Kids Menu Taskforce provided a set of recommendations which resulted in the development of an industry code of practice, a guide for business, and the establishment of a pilot program to begin to grow demand and build a critical mass to support healthy menu options for children. The pilot phase has seen the recruitment of 20 early adopter venues, with the ultimate goal of moving to a sustainable model.

The impact of the initiative to date has been recognised through the establishment of an ongoing category and award for Healthy Kids Menus through the annual South Australian Restaurant and Catering Industry Awards for Excellence, and the Australian Hotels Association's (SA) Awards for Excellence.

Reflections on South Australia's HiAP initiative

Relationships are critical to the success of any collaboration and this is particularly true in the case of South Australia's Health in All Policies approach. The formation of trusting relationships has been an important feature and significant time has been taken to build and sustain relationships with decision-makers and policy officers across government, the non-government sector and within the health department. When required, the HiAP Unit has been able to draw upon these relationships to pursue a 'tricky' policy issue, lobby and advocate for HiAP, and to connect the HiAP team to strategic networks. It has been possible to leverage relationships and connections to ensure the approach is relevant, useful and sustained. It has been noted that, at times, the length of time taken to complete HiAP work, for example the Health Lens Analysis projects, has been an impeding factor. This highlights that the less tangible benefits of building respectful and trusting relationships takes time and is critical to the HiAP approach. While the HiAP processes undertaken can take a reasonable period of time, they provide the best opportunity to create sustainable change as it increases knowledge and strengthens capacity for change across the system. It requires partners to commit to hearing and understanding people's differing perspectives and being prepared to change viewpoints and accommodate new ideas.

The governance underpinning current Health in All Policies practice is still a relatively new concept and when HiAP first began in South Australia, Finland was the only place where the approach was being actively implemented. The Finnish model did not fit the South Australian context, which meant that the SA approach had to be innovative and 'learn by doing'. As there was no formula, framework or toolkits to guide the work, partners had to trust that the process was valuable and commit to working with ambiguity, enabling everyone to learn and develop together. As the approach has matured, SA specific frameworks, toolkits and models have been developed. However, innovation has remained an important feature of the approach, as it adapts to new contexts and opportunities. HiAP partners (and the HiAP team itself) also need to be adaptable, comfortable with ambiguity and open to new ideas, opportunities and horizons. HiAP sets the scene for policy officers to be exposed to multiple and diverse fields of knowledge and offers a rich and exciting foundation for ongoing learning.

The importance of continuity of staff should not be underestimated in the success story of HiAP over the past decade. Within the HiAP team itself, at a management and officer level, this has been critical, but it's equally important at the senior executive levels within the Department for Health and Ageing and in other government agencies. Continuity of connection with advisors and key individuals with expertise from within and outside South Australia, including Professor Ilona Kickbusch, has allowed the HiAP work to be showcased at an international level, while also contributing to reflection and change of HiAP practice in South Australia.

Conclusion

The South Australian Health in All Policies initiative has demonstrated its value as an approach to collaborative policy development. Health in All Policies also provides a framework for meeting the needs of sectors outside of health as well as long term population health and well-being goals, reflecting one of the key underpinning philosophies of the initiative, reciprocity. Cross-sector collaboration and partnerships have been recognised as important system building strategies, and mechanisms to support and systematise these practices across state and local government will help to ensure the ongoing action on the determinants of health and improvements to the health and well-being of the South Australian population.

Finally it is useful to think of HiAP as both an art and a science. Successful implementation of the SA HiAP approach requires balancing the science and technical skills with political intuition, emotional intelligence and creative

insights. HiAP is not a linear straight-forward process; rather it adapts and strengthens, creating a web of HiAP actors across the South Australian Public Sector to improve population health and well-being.

The authors would like to acknowledge the valuable contribution of all the members of the South Australian HiAP team over the past 10 years. We also greatly appreciate the support, expertise and investment of all the HiAP partners and their respective organisations.

Key Contact/s and Further Information

Carmel Williams, Manager, Health Determinants and Policy, Department for Health and Ageing, South Australia

Email: HealthHiAP@sa.gov.au
Web: www.sahealth.sa.gov.au/healthinallpolicies

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Health in All Policies

How to take into account health, wellbeing and equity in all sectors in Finland

Authors

Tuulia Rotko[A], Timo Ståhl[A], Meri Larivaara[B] and Tapani Kauppinen[A]

[A]National Institute for Health and Welfare (THL), Finland

[B]Ministry of Social Affairs and Health, Finland

2

How to take into account health, wellbeing and equity in all sectors in Finland

Introduction

Finland has a long track record in health in all policies type work in public policy making. As far back as 1972 the Economic Council of Finland (chaired by the Prime Minister), responsible for exploring social policy goals and their measurement, published a "Report of the working group exploring the goals of health".[1] Since then systematic work across sectors for health and health equity has been progressed as part of Finnish health policy.

The search for an effective way of working across sectors within the government was further boosted when Finland joined the European Union (EU) in 1995. At that time it was considered important to build effective coordination of EU-affairs for the preparation of Finland's EU positions. Ten years later when Finland prepared for the 2006 presidency of the European Union, the concept of 'Health in All Policies' (HiAP) was launched for the first time and promoted at the EU level.[2] Since then, it has gained a strong foothold globally. The most recent prominent international activity by Finland was the hosting of the World Health Organization (WHO) 8th Global Conference on Health Promotion in Helsinki in 2013, with Health in All Policies as the main theme of the conference.[3]

HiAP continues to be a priority in Finnish health policy[4] and action on the social determinants of health as well as equity is included.[5] It is also formulated broadly as HWiAP (Health and Wellbeing in All Policies). The current Finnish Government program (2015) states a limited number of ten year objectives, including "Health promotion and early support have strengthened in decision making across sectors, services, and working life due to better legislation and better implementation."[6]

Implementation of this statement will be realised through a Government key project "Health and wellbeing will be fostered and inequalities reduced" and its sub-project "Confirming cross-sectoral structures for taking into account health, wellbeing and equity in all sectors of the government early enough".

In Finland there have been several structures and mechanisms for intersectoral collaboration over the years e.g. intersectoral committees and working groups. One of the key structures has been the cross-sectoral Advisory Board for Public Health which is not currently operating although it has a legislative base. Currently, there are no long-term public health objectives formulated (the latest national public health program finished in 2015[7]) other than those in the Government Program. Further there is no regular reporting of health and social policy to the Parliament. Only 3-5% of the draft legislation contains some level of Human Impact Assessment.[8]

The Government Key Project is a new form of offering support and expert assistance to different ministries. It is a natural continuation of the work conducted with all sectors of the government in the preparation of the current Government Program which included a network of representatives of all ministries, a series of working seminars with all ministries involved, and a joint writing process also involving a number of ministries. Ideally, the new model would be a good addition to the established HiAP structures however, it seems that the Government is currently exploring whether this new way of working could deem the previous structures unnecessary.

Vision, aims, objectives

Vision

Equity and human impacts (including health impacts) will be considered in decision-making in every policy sector.

Aims

To find new, concrete solutions for action in cross-sectoral collaboration to promote health, wellbeing and equity.

Objectives

- Keep up HiAP work in Finland at the national level. Maintain collaboration between ministries and increase health, wellbeing and equity issues on the political agenda.
- Recognise good practices for cross-sectoral collaboration together with opportunities and address barriers to collaboration.
- Build a new model for cross-sectoral work and recommendations for action. The core of the new model consists of descriptions on how all sectors of government can take into account the impact of their decisions and actions on health, wellbeing and inequity, and how they can promote health, wellbeing and equity in their work.

Governance and reporting

This case study describes HiAP work at the national level including cross-sectoral collaboration on health, wellbeing and equity issues between ministries in Finland. The Ministry of Social Affairs and Health (MSAH) (with the help of the National Institute for Health and Welfare - THL) is the leader of the process and authorised under the Government Program. Participation of other ministries is voluntary. The collaboration targets a limited number of Government Key Projects ('burning questions') that are being progressed by different ministries as part of the implementation of the Government Program.

Each Key Project will be documented and the learnings and recommendations shared with all ministries. Documentation will focus on the process and its evaluation. Recommendations will be given to improve the structures and to define the course of action. The work will be reported and presented to the Government and ministers. Evaluation will report on progress in collaboration, changed attitudes, increased understanding and hopefully also changes in the course of action.

Mechanisms and processes

This intervention has an intensive short-term collaboration approach with selected projects in contrast to earlier HIAP work in Finland. The work is being performed by four people (two in MSAH and two in THL) as well as extra 'subject experts', who are collectively working on seven pilot projects over three and a half years. The total extra funding for this intervention is 0.3 M€. Action on the social determinants of health is embedded in Government Key Projects led by other ministries. Themes of this collaboration include digitalisation of public services, energy and climate strategy, reform of vocational upper secondary education, so called 'youth guarantee' to tackle unemployment of young people and national food production.

Although socioeconomic inequities are still wide in Finland[9], health and wellbeing in all policies is the main point in this project rather than equity. However, often it is easier to talk about equity issues with ministries other than health.[10] Health is often perceived to be the responsibility of the Ministry of Social Affairs and Health alone, while equity (and wellbeing) is shared with others. As a civil servant in the Ministry of Finance put it, "We are all in the wellbeing business." Equity viewpoints are raised whenever possible, and they have been addressed in at least four pilots.

Timeline

In the summer of 2015 the new Government began the Key Projects and by autumn 2015 the contents of all projects were formulated and voluntary participation notices were received resulting in seven Key Projects selected as pilots. In spring 2016 the pilots were divided into two thematically interrelated groups and an orientation meeting was held with each thematic group.

Twelve months later follow-up bilateral meetings with the participating pilots focused on developing a shared understanding of the themes of the pilot. Based on these discussions each ministry's civil servants selected one or two specific topics for further work. It was decided that THL would prepare brief information papers analysing health, wellbeing and equity perspectives for each topic. The first drafts were prepared in autumn 2016 and some were being used in the various working processes of ministries at this time. During the winter and spring 2017 all brief information papers were discussed and completed with civil servants of the participating ministries, and a delivery plan agreed.

At the same time information on the experience of collaboration has been collected, the process evaluation (observation) conducted, and building blocks described to inform the generic model for cross-sectoral structures, as well as the recommendations on how to better take into account health, wellbeing and equity issues in the decision-making at the ministerial level in all sectors in Finland.

Initially the model and recommendations will be presented to the Ministerial Group for Wellbeing and Health and subsequently they will be presented and discussed in each ministry in order to engage a broader audience and to underline the benefits of cross-sectoral work. By the end of the Government's term of office early in 2019 the evaluation of the results of this intervention will be published.

This process is quite similar to Health Lens Analysis (Engage, gather Evidence, Generate, Navigate, Evaluate).[11]

Establishing and maintaining partnerships

This project is mostly about testing new methods of collaboration and looking for co-benefits by navigating and building relationships and partnerships across sectors. The process has been led by MSAH with strong support from THL. A lack of shared leadership with other ministries may diminish the commitment and, thus, also the results of the project. Taking the concrete actions, i.e. the Key Projects of other ministries as the target of the work helped in building partnerships, as collaboration was based on offering support and creating mutual understanding of different sectors' viewpoints, objectives, intentions and interests. In this project non-governmental actors are not involved due to limited resources and the need to improve collaboration within the government. Box 1 presents a practical example of one pilot.

Box 1. Pilot project Youth Guarantee – specific topic: Ohjaamo (One-Stop Guidance Centre) model

One of the Government's Key Projects, the 'Youth Guarantee', led by Ministry of Education and Culture volunteered to serve as a pilot project. In June 2016 civil servants from three ministries (Ministries of Education and Culture, Economic Affairs and Employment, and Social Affairs and Health) and experts from research institutes met.

The first meeting discussed what the Youth Guarantee is all about and built shared understanding. The position of the Ohjaamo (One-Stop Guidance Centre) model in the changing structures of local and regional government was chosen as a specific topic for further work. THL drafted a brief information paper setting out the options for organising this kind of centre in the future by compiling data from different sources and undertaking key interviews. The paper was prepared in collaboration with several experts from different organisations.

Ohjaamo – One-Stop Guidance Centre

One-stop guidance centres create new, low-threshold guidance services for young people. The increasing youth unemployment and the decreasing resources for guidance have created a need for new forms of co-operation. There are about 40 multidisciplinary Ohjaamo centres established in Finland. They are meant for people below the age of 30 and are operated by agencies from several different administrative fields as well as businesses and third sector parties working together.

Finland is currently preparing a fundamental reform of health and social services, and regional government. The aim is to transfer the organisation of healthcare and social services and other regional services to counties as of 1 January 2019. This reform impacts on the organisation of multisectoral services and professional networks.

The Government published a draft of the legislation detailing health, social services and regional government reform and circulated for comments. The Ohjaamo (One-Stop Guidance Centre) draft paper was provided to municipalities to assist them in formulating their comments to the draft legislation, because different options to organise these kind of centres in the future were described. In March 2017 MSAH officers met again with the civil servants working with the Youth Guarantee to complete the Ohjaamo paper and to discuss further collaboration.

In this case, the paper raised points of youth wellbeing and how to reduce inequities, good health as a prerequisite for education and employment, structures, responsibilities and collaboration in public services and the need for comprehensive support.

Experience has shown that having a specific topic to focus on as well as a brief information paper, was a good way to promote the cross-sectoral collaboration. It defined a concrete topic from which to find data from different sources and allowed discussion of practical issues. It was also easier to show benefits to different parties and increase the level of shared understanding.

Outcomes

Building partnerships, maintaining collaborations and creating trust between partners is a time consuming and continuous task. Collaboration can be maintained only by keeping up dialogue with partners. However, through this process new ideas and insights were found concerning potential policy impacts on people, vulnerable groups, wellbeing and social inequalities. Mutual trust was also strengthened in this project.

Brief information papers were necessary to gain deeper insight into the themes and to facilitate discussion of concrete business. The function of these brief papers was to 1) authorise participation (MSAH & THL), 2) facilitate the identification of a new perspective (HIAP) and 3) collate information.

During the process we observed a phenomenon called the 'happiness wall'.[12] In one ministry, we were told that all the human impacts had been taken into account, and they thought the collaboration was unnecessary. However, when two brief information papers were drafted and discussed together, new ideas arose and the benefit of collaboration was recognised. Similar observations were made in other pilots. This kind of process, which is more intensive and has the starting base in a sector other than health, has not been used in the past in Finland. Previously the discussions have mostly been at a general and high level. Similar dialogues have mainly been held in relation to public health reporting.[13]

The best results of the process (in achieving better understanding and perceiving the process beneficial) can be seen in those pilots that reached a significant level of collaboration. In the beginning some of the pilot partners were doubtful and wondered how health and equity issues would be linked to their work, but as the process moved forward they could also see the shared benefits and noticed new, shared viewpoints that could help them to achieve their own aims.

Recommendations for better cross-sectoral work can already be given. They are based on the experiences of this project and on other similar cross-sectoral processes e.g. regular cross-sectoral informal meetings on gender equity. These should be scaled up and adopted as good practice in all ministries. A certain amount of human resources should be allocated for support, expertise and facilitation of collaboration, in order to maintain a focus on health, wellbeing and equity issues in the core work of other sectors. More commitment is still needed from these sectors to allow this to advance.

Challenges and opportunities

The partnership building did not work in all pilots. In one of the pilots only the contact person was committed to the project. Since the benefits of the collaboration were not noticed more broadly in the ministry, the process had to stop after the first general meeting. In another pilot process the contact person changed during the process and the pilot Key Project was delayed meaning the collaboration process was not possible in the given timeframe. After the first meeting in this ministry, a broader group of civil servants from different units was keen to continue collaboration and could see the potential benefits from the project. However, as the project was only focused on Government Key Projects it was not possible to broaden the scope and the process was stopped.

The success of this kind of a process depends on human resources (working time) allocated to the work and gaining commitment from high-level civil servants. One civil servant cannot make much difference, if the leadership in his/her ministry or department does not provide support. The idea of good governance alone is not sufficient to bring out the importance of universal well-being and health; significant discussion and information is required. Benefits for all the partners need to be shown as early as possible; even ideas of potential benefit can be valuable.

Three tips:

- Focus on concrete and high priority issues in other ministries, as the starting point for HiAP work. (Government Key Projects in this case).
- Present new viewpoints, produce evidence (data from different sources), and formulate core messages in collaboration. Plan together how and when these messages can be used/ delivered.
- Set a well-defined target for collaboration in order to promote your cross-sectoral work. It helps:
  - to make health, wellbeing and equity issues visible (data)
  - to discuss at a sufficiently concrete level
  - to present benefits to different parties and increase shared understanding.

Reflections and conclusion

Using a more commonly shared umbrella concept than HiAP could be a good way to approach different sectors. For example, Sustainable Development might be useful however so far HiAP is not closely linked to Sustainable Development Goals in Finland.

Human impacts (including health and social impacts to people) are hardly ever a core part of the preparation of decisions/programs/strategies in other sectors. Nevertheless, long-term HiAP work among civil servants shows that they are committed to work across sectors and recognise the benefits of the cross-sectoral work.

A mandate from the Government program is a necessity. MSAH officers knew some of the pilot partners before the pilots, which made it easier and quicker to build trust between each other (mutual trust is essential for effective collaboration). But high-level political commitment was essential. This is even more crucial now when many important structures and mechanisms that used to be in place in Finland have been discontinued as described in the Introduction. This last point has taught us that we need to be prepared to defend any gain that has been achieved.

Key contact/s and further information

Dr Tuulia Rotko, National Institute for Health and Welfare THL

Email: tuulia.rotko@thl.fi

Web: https://www.thl.fi/fi/web/thlfi-en

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Health in All Policies

Thailand's National Health Assembly – a means to Health in All Policies

Authors

Nanoot Mathurapote[A], Tipicha Posayanonda[A], Somkiat Pitakkamonporn[A], Wanvisa Saengtim[A], Khanitta Sae-iew[A], Weerasak Putthasri[A]

[A]National Health Commission Office, Thailand

3

Introduction

Since the global community announced the Alma-Ata Declaration on Primary Health Care in 1978[1] with the goal of Health for All, global development's direction has gradually turned from economic-led growth to development which has health as an integral part. This paradigm of health was reiterated in 1986 with the Ottawa Charter on Health Promotion.[2] Since then, the health paradigm, which emphasises the social determinants of health perspective, has been multiplied in various concepts, approaches and activities such as healthy public policy, multisectoral action for health and Health in All Policies. The launch of the Sustainable Development Goals requires collaboration across sectors and participatory governance to achieve all goals, especially Goal 3.[3] Thailand takes this opportunity to review our past implementation and plans to move forward by improving the existing governance body, processes and tools.

Thailand initiated health system reform around the late 1990s driven by the fact that despite low child mortality rates and high life expectancy, the population still faced high levels of preventable death and relied heavily on health care services, contributing in turn to increasing levels of national health expenditure. A National Health System Report 2000, conducted by the Senate Committee on Public Health, recommended that Thailand required new laws and governance arrangements to tackle the structural problems impacting on health. Participation of the government sector, academia and civil society in decision-making and a whole-society approach has underpinned subsequent health systems reform.

One of the major legacies of the health systems reforms is the National Health Act 2007 that enabled the establishment of a new form of governance, the National Health Commission, to be an advisory body to the Cabinet on health policies and strategies. The National Health Commission is expected to coordinate with multiple sectors across government and the community to come up with healthy public policies. This puts the Health in All Policies (HiAP) approach on centre stage in policy decision-making.

The National Health Assembly (NHA) is one of several tools that the National Health Commission applies to attain Health in All Policies. The National Health Commission Office (NHCO) is responsible for coordinating and facilitating the work of the National Health Assembly from developing policy proposals to implementation, evaluation, and policy revision. Apart from laws, governance bodies and HiAP processes, success cannot be achieved without changing people's mind-set. The National Health Act incorporates an expanded definition of health to include the broader term of well-being in which the physical, mental, spiritual and social dimensions of health are in balance. This broader definition allows the non-health sector, especially civil society, to join the National Health Assembly.

Vision, aims, objectives

Vision

Health and well-being in Thailand is improved through participatory public policies which are developed from evidence-based information with the active participation of multiple sectors (government, academia and community).

Objectives

1. Development, formulation, progression and implementation of participatory public policies.
2. Providing platforms and coordination of various sectors in society to join in exchanging knowledge and evidence-based information through a systematically organised and participatory forum called the NHA in order to develop and move forward participatory public policies.
3. Development and capacity building of NHA constituencies in deliberative participation and participatory democracy which are considered key interactive processes for the development of public spirit and involvement of people in policy issues.

Governance, reporting and monitoring

To enable implementation of HiAP in Thailand, the National Health Commission is established under the chairmanship of the Prime Minister. Its composition involves three key sectors namely the government sector, knowledge sector and civil society sector resulting in effective interactions and joint decision-making. Each sector plays a different role, supplementing others. There are six ministries in the government sector of the Commission: the Ministry of Agriculture, Ministry of Public Health, Ministry of Industry, Ministry of Interior, Ministry of Natural Resources and Environment and the Ministry of Social Development and Human Security. Each of these has the authority and the budget to push the policies into action. The knowledge sector, meaning academia and professionals, provides evidence to inform consideration of policies, while the civil society sector raises the voice of the people and helps transform national policies into action at the local level. The results of this joint decision-making between the three sectors are submitted to either the Cabinet or directly to key agencies and local governments, as appropriate.

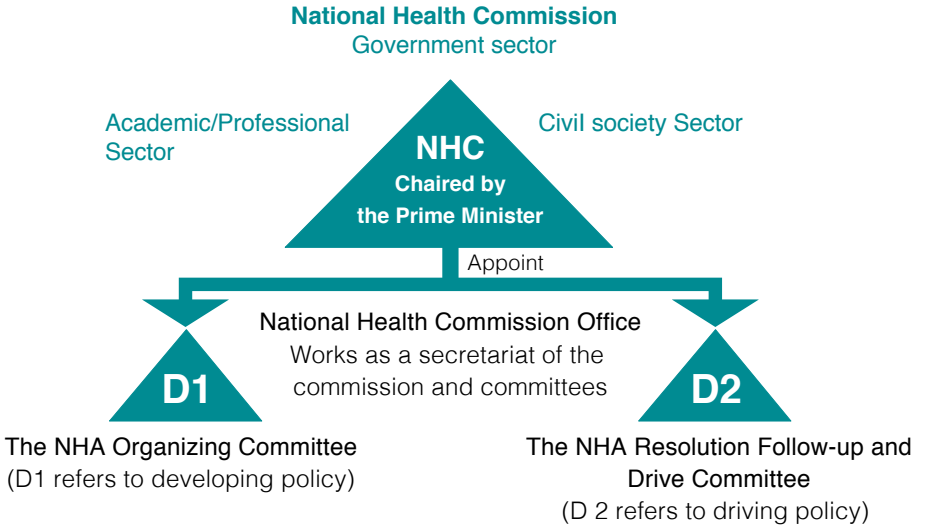
To ensure effective policies, the National Health Commission set up two committees to carry on the cyclical process of the NHA:

- The NHA Organizing Committee is in charge of developing the policy proposals including drawing up the rules and guidelines of the NHA process, classifying and defining constituencies, setting agendas, drafting resolutions and convening the NHA.
- The NHA Resolution Follow-up and Drive Committee is in charge of strategizing and facilitating implementation of NHA resolutions, monitoring and evaluating the implementation, reporting on the progress or outcomes at the NHA and revising the past resolutions (if needed).

The committees are referred to as D1 and D2. D 1 stands for developing policy proposals or so called resolutions and D 2 means driving policy of adopted resolutions in action (see Figure 1).

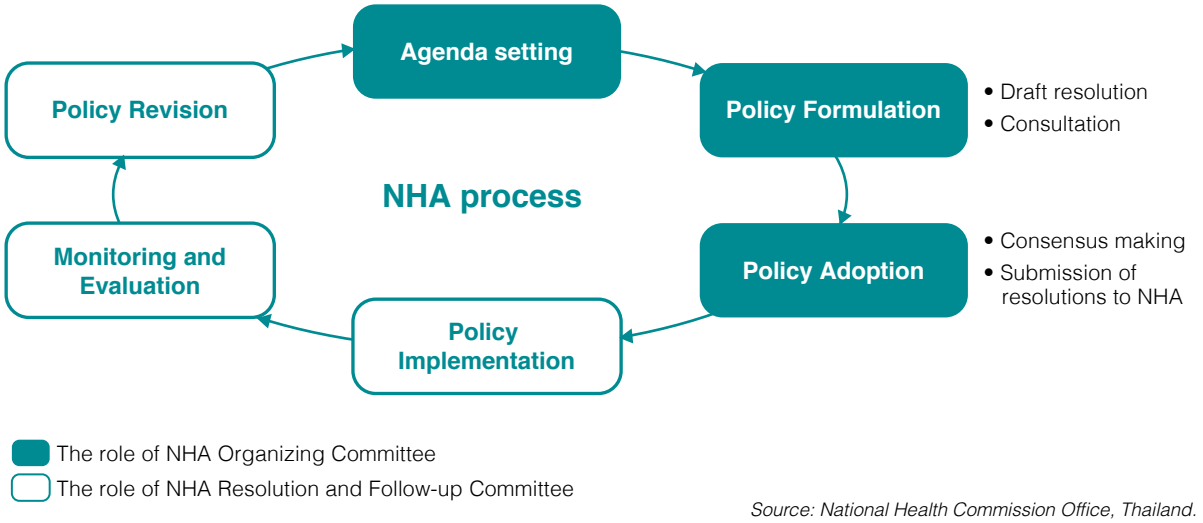
The composition of both committees is also strictly comprised of representatives of the three sectors, the same as the National Health Commission. Both committees operate through multisectoral working groups. The chairperson of each committee is rotated, which is not the

Figure 1. Thailand National Health Commission Governance



Source: National Health Commission Office, Thailand.

Figure 2. National Health Assembly processes



Source: National Health Commission Office, Thailand.

case with the National Health Commission. Since 2008, the NHA Organizing Committee chairperson has had representatives from the health professions, academia, private sector, civil society and currently a government official from the Ministry of Public Health is the chairperson. The chairperson of the NHA Resolution Follow-up and Drive Committee is rotated from civil society to a public health minister most recently.

Mechanisms and processes

'Health Assembly' is defined in the National Health Act 2007 as a process in which the public and related state agencies exchange their knowledge and learn from each other through an organised systematic forum with public participation, leading to recommendations on healthy public policy and good health for the public. In practice Thailand has three types of health assemblies: (a) a national health assembly (b) provincial health assemblies, and (c) issue-based health assemblies. The purpose of this is to strengthen multisectoral action for health and/or Health in All Policies at all levels. Furthermore, it nurtures the culture of public consultation and participation from the grassroots level to the national level.

The National Health Act stipulates that the NHA is convened annually, normally in December. As of the ninth NHA held in 2016, seventy-three resolutions have been discussed and adopted. Drawing from this experience, the NHA process can be explained in the following six steps (see Figure 2):

1. Agenda setting

The NHA process starts from issues of concern or proposals submitted by (1) constituencies from all sectors and (2) the National Health Commission and other commissions under the National Health Commission, to the NHA Organizing Committee for consideration. The selection criteria used include: urgency, nationwide impacts, public interest, and the potential for issues to be progressed to implementation. In addition, unsuccessful previously submitted proposals can be brought up by the NHA Organizing Committee for reconsideration. Similarly, the NHA Resolution Follow-up and Drive Committee can submit revisions to adopted resolutions for consideration. All agenda items must comply with the National Health System Charter. Complex issues requiring multisectoral actions have a high tendency to be selected as NHA agenda items.

2. Policy Formulation

2.1 Drafting documents: background documents and draft resolutions

After the agenda setting, each item requires wide multisectoral participation to document current conditions, problems and potential solutions as inputs for drafting evidence-based resolutions. The process starts from a multi-stakeholder technical working group on each agenda item appointed by the NHA Organizing Committee. The members of working groups are drawn from persons/agencies who propose the issues, key stakeholders from the government, knowledge, and community sectors.

2.2 Consultation

Public hearing forums for stakeholders are held to consult on all agenda items, with background documents and draft resolutions. Afterwards, the revised draft resolutions (if any) are sent out to all constituencies for their consideration and preparation prior to the NHA. The National Health Commission Office also distributes media materials such as brochures and animations to help constituencies easily understand the key messages of resolutions.

Seventy-seven constituencies from all the provinces organise their public hearing forums to determine their provinces' positions and decide who will be their provincial delegates to attend the NHA.

3. Policy Adoption

3.1 Consensus making

During the three-day NHA, all constituencies dialogue and adopt each drafted resolution by consensus. In the case of no agreement on certain contents in a draft resolution, a drafting group is set up for discussions and to seek agreement. If there is no agreement on such a draft resolution, that agenda item will be reconsidered in the next NHA.

3.2 Submission of resolutions to National Health Commission

After adoption, resolutions are sent through two channels. The first channel is to submit to the National Health Commission for approval and then to the Cabinet for noting and/or approval for further action. The second channel is to submit to all constituencies directly. The constituencies are encouraged to implement resolutions without waiting for Cabinet resolutions because resolutions are made based on their consensus and commitment.

4. Policy Implementation

After adopting resolutions at the NHA, the NHA Resolution Follow-up and Drive Committee analyses and manages each resolution into the implementation plan because each resolution involves many activities with various players. The entry point and key driver of a resolution requires clarification. The key driver may not be the key responsible agency. This Committee facilitates implementation of each resolution by setting up a multi-stakeholder working group; the memberships may be the same or different from the working group that drafted the resolution. The members of the latter working group are responsible for different aspects of the resolution but all have the common goal.

5. Policy Monitoring and Evaluation

The NHA Resolution Follow-up and Drive Committee monitors, evaluates and categorises the past resolutions into three categories by considering progress of the performance and commitment of the key drivers and/or key responsible agencies. The implementation of each category is then strategically facilitated in different approaches.

Category 1: Well Performing

A well-performing resolution falls in to at least one of three criteria: 1) all activities are implemented completely or, 2) significant progress has been made and there is potential to complete all activities or, 3) a key responsible player is committed to having a policy or a plan in response to a resolution. Sometimes, a well performing solution is revised or combined with other resolutions and has become a new resolution. Out of the eight NHA sessions from 2007 – 2015, 16 out of 69 resolutions[i] (23%) are considered high performing. The NHA Resolution Follow-up and Drive Committee monitor their progress from a distance.

i An additional four resolutions have not yet been categorised.

Category 2: In progress

Forty-eight resolutions are classified into the in progress category. The NHA Resolution Follow-up and Drive Committee not only monitors their progress, but also facilitates their implementation in different ways.

Category 3: Performance with challenge

Five resolutions face challenges in implementation for many reasons e.g. a resolution is considered irrelevant to the current situation or unrelated to an agency's role as specified in resolutions. Some problems are too complicated and complex to tackle by the agencies specified in resolutions. These resolutions are reviewed and revised becoming a new resolution for consideration at the NHA.

In addition, the NHA Resolution Follow-up and Drive Committee places importance on knowledge management as another way to monitor, evaluate and motivate implementation of resolutions. The committee often organises workshops or forums for knowledge exchange, as well as supporting studies to draw lessons learnt from resolutions where there has been tangible progress.

6. Policy Revision

As stated above, those resolutions with lower performance will be reviewed and revised, then proposed to the NHA again.

In summary, the NHA Organizing Committee (D1) is responsible for steps 1 - 3 which relate to policy development. The NHA Resolution Follow-up and Drive Committee (D2) is responsible for step 4 - 6, which involves driving policy. Both committees communicate to NHA constituencies and the public on draft resolutions, adopted resolutions and the progress of resolutions. The National Health Commission Office is a secretariat of these Committees facilitating the NHA process and the work of all committees, subcommittees and working groups.

Establishing and maintaining partnerships

Establishing and maintaining partnerships needs both a 'head and heart' approach. The National Health Commission Office, as the secretariat of the National Health Commission, NHA Organizing Committee and the NHA Resolution Follow-up and Drive Committee, applies the following strategies:

- Understand partners and stakeholders

  Stakeholder analysis for each NHA agenda or policy is compulsory in order to understand the role, expertise and number of key stakeholders. Moreover, it is important to analyse and think strategically about who is a key driver, who is a key responsible agency and who is a key supporter. For example, in the case of agriculture and food safety related resolutions, the key driver is BIO Thai (NGO); the key responsible agency is the Ministry of Agriculture and Cooperative; and the key supporter is the Ministry of Public Health (see Box 1 for an example). In other resolutions such as children and youth related resolutions, the key driver and key responsible agency is the same agency, i.e. the Ministry of Public Health but the key supporters are NGOs and the Ministry of Education.

- Provision of a neutral platform for all

  Partnerships should be built based on a common interest, despite people having different views. To maintain the partnership, each partner should have a role to play. As a result, the NHA process is driven by committees and working groups providing platforms for our partners and stakeholders to update on progress, exchange information and consult on solutions. NHCO must play a neutral role among partners and stakeholders since we provide the platform and the process.

Box 1. Resolutions on agriculture and food safety

From the first NHA to ninth NHA, there were three resolutions related to agriculture and food safety namely NHA1.5[4] on agriculture and food in the era of economic and environmental crisis; NHA5.5[5] on food safety: solving problems from agricultural chemicals and NHA5.8[6] on coping with health impacts from entering the ASEAN community: a case of food and agriculture products. These resolutions reflect long-term unsolved problems on this matter. Although the resolutions were made with consultation with stakeholders and the public, implementation of the resolutions has made slow progress.

The NHA Resolution Follow-up and Drive Committee set up the working group on agriculture and food safety to drive these resolutions all together instead of driving each resolution separately. The working group consists of Ministry of Agriculture and Cooperatives, Ministry of Industry, Ministry of Public Health, Thai Health Promotion Foundation, Thai Chamber of Commerce, Thai Federation of Industries, Thai Fresh Market Association, National Farmer Council, Foundation for Consumers and BIO Thai to name but a few. Apart from updating who is doing what according to their organisations' mandates, the working group made a joint decision to close a legal loophole on control of agricultural chemicals, a leverage point in this agenda.

All chemical substances are under the control of the Ministry of Industry which is responsible for the Hazardous Substances Act. The measures to manage chemical substances in the Act are designed for a closed environment like a factory. Therefore, it does not apply easily to an open environment such as a paddy field. BIO Thai, an NGO working on organic agriculture, food safety and fair trade, became a key driver who ran a participatory process of drafting the Bill on Chemical Pesticides. However, this endeavour had been progressed at the technical and implementation level. NHCO therefore raised this issue with the Permanent Secretary for Agriculture and Cooperatives. Finally, the Ministry of Agriculture and Cooperatives agreed to take on responsibility from the working group and co-organise a public hearing on the Bill and potentially submit this Bill to the Cabinet.

- **Build understanding and networking among partners through capacity building**

  NHCO organises a series of capacity building activities for partners, NHA constituencies and the stakeholders of each NHA resolution to ensure that they understand the philosophy, principle and process of the NHA including the content and context of NHA resolutions. Typically the participants of these capacity building activities are from mixed sectors, with both health and non-health backgrounds.

- **Inclusiveness**

  The principle of inclusiveness for NHA constituencies is applied. It is permissible for any organisation or network to be NHA constituent.

Outcomes

The work of the NHA leads to a number of important outcomes. It creates:

A culture of horizontal multi-sectoral collaboration

Throughout the NHA process, across-sector and across-government agencies work together to reach each milestone, both drafting the resolutions for adoption and progressing the resolutions' implementation. The year-long process of the annually convened NHA helps create a culture of working across sectors in a horizontal manner.

New champions for health

Following the new working culture, as explained above, new champions for health are created. The Ministry of Agriculture and Cooperatives is an example. In relation to the issue of agriculture and food safety, the health of the population is affected by agriculture policies and practices. The NHA process opened a neutral platform for the Ministry of Public Health, the Ministry of Agriculture and BIO Thai among other stakeholders to discuss issues and find solutions that may not be the role of any one organisation but require joint stewardship.

Changes in policies

Often there are several agencies working on the same issue with no guiding or consistent policy framework. As a result of the NHA process there can be changes in policies to meet multiple needs and have flow on effects. For example, recently the Ministry of Public Health has issued a policy to pilot the use of organic agricultural products as cooking materials in selected hospitals. The Bill on Safety from Chemical Pesticides was used as a leverage point to achieve this change.

A mechanism to achieve Sustainable Development Goals (SDGs)

Despite most NHA resolutions responding to Goal 3 of the SDGs, some resolutions are beyond health because NHA constituencies come from both health and non-health backgrounds. Of the 73 resolutions, examples of resolutions beyond health are shown in Table 1.

Table 1. Relationship between Sustainable Development Goals and National Health Assembly resolutions

Sustainable Development Goals	Related National Health Assembly Resolutions
SDG 5 on Gender equality	NHA Resolution 1.10[7] on Sexual Health: sexual violence, unplanned pregnancy and sex issues relating to AIDS/ sexually transmitted diseases
SDG 6 on Clean water and sanitation	NHA Resolution 9.1[8] on Safe drinking water for the people
SDG 7 on Affordable and clean energy	NHA Resolution 5.6[9] on Prevention and mitigation of health impact from biomass power plant
SDG 11 on Sustainable cities and communities	NHA Resolution 9.2[10] on Managing and developing healthy community and urban housing

Therefore, the NHA is a potential tool and mechanism towards achieving the SDGs.

Challenges and opportunities

Critical Success Factors

The critical success factors for implementing HiAP are summarised as follows:

- A neutral role of policy facilitator

  The best working environment for HiAP is based on trust. NHCO, as the secretariat of the National Health Commission and the other two committees, plays a neutral role in gaining trust among partners and stakeholders, so that NHCO can successfully facilitate the participatory policy process.

- **Building a sense of ownership by stakeholders**

  Throughout the NHA process, key stakeholders of each resolution are invited to draft the resolution and wider stakeholders are invited to participate in consultations. After the adoption of resolutions in the NHA, formal and informal monitoring either by a government agency, NGO or civil society organisation is arranged to continue the progression of resolutions. Best cases are highlighted and acknowledged and promoted in meetings. It is important to help stakeholders realise that if they participate in the NHA, everyone can gain from what they propose though not necessarily achieve all they hope. The government sector has supported the public and driven their work, while problems raised by the community sector get solved. Academia and professionals use their knowledge to serve the society.

- **Clear and measurable NHA resolutions**

  Well-written resolutions help implementation and monitoring. A 'road map' for each resolution is created to ensure all stakeholders easily understand their roles and the milestones of success.

Challenges

There are challenges in the process:

- **A sense of representation**

  Each constituency is expected to consult on resolutions among their organisations and networks and even organise a public hearing. Doing so requires a budget to support this which can be a barrier. It is not easy to ensure that NHA constituencies speak on behalf of their constituency.

- **Political commitment**

  Despite the fact the NHA can call for multisectoral participation in the policy process, political commitment on each resolution is a necessity for successful implementation. NHCO has recently issued a door-knocking strategy to meet ministries whose policies impact on health such as the Ministry of Natural Resources and Environment, Ministry of Industry and Ministry of Agriculture and Cooperatives, in order to unlock bottleneck situations.

- **Indicators for success**

  Some resolutions involve a policy change or a structural change that may not quickly translate into improvements in outcomes. Without intermediate indicators this could lead to a wasted effort.

Reflections and conclusion

Based on the NHA experience of implementing HiAP, the three key messages for other countries, regions and Ministries of Health wishing to implement HiAP are:

1. Ensure a broad definition of health

Health in Thailand was redefined as wellbeing covering physical, mental, spiritual and social dimensions according to the National Health Act in 2007. This broader definition opens a door for non-health sectors, and especially civil society, to collaborate with the health sector on an equal basis. This is why Thailand can apply the whole of society approach to achieve Health in All Policies.

2. Make an organisation responsible for HiAP

The driving force that makes HiAP possible is the National Health Commission and NHCO both of which are required in the National Health Act to be accountable for this mission. Apart from the NHA, Thailand also organises provincial health assemblies, issue based health assemblies and health impact assessments.

3. Seize opportunities

The political climate around health threats and challenges that require multisectoral collaboration to solve can be an opportunity to start HiAP. Thailand used these threats and challenges to health as an opportunity to rethink and reform the health system and introduce the concept of HiAP to the health system, despite the fact that it was not named HiAP at that time.

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National Health Commission Office, Thailand
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Health in All Policies

California Health in All Policies Task Force

Authors

Julia Caplan[A], Karen Ben-Moshe[A], Lianne Dillon[A], Solange Gould[B], Meredith Lee[B], Kelsey Lyles[A], Dahir Nasser[B], Linda Rudolph[A]

[A]Public Health Institute, California, USA

[B]California Department of Public Health, USA

4

Introduction

California context

California is the largest and most diverse state in the United States, with almost 40 million people[1] and no racial or ethnic majority. Chronic disease[i] accounts for over 75 percent of deaths in the state and is associated with tremendous health care costs.[2] In addition, California's residents face persistent inequities in social, economic, and environmental conditions, which lead to significant health inequities.[3] Climate change is exacerbating the health challenges that Californians already face, with the greatest impacts affecting communities that are already vulnerable to health inequities.

California has 58 counties and more than 7,000 local, regional, and county governmental agencies (e.g. school districts, cities etc.), many with overlapping and sometimes conflicting duties and responsibilities.[4] Local and regional government agencies hold significant decision-making power over topics that affect community health such as land use, transportation, education, and community safety. Federal and state government play an important role by providing funding, developing guidance, setting regulations, and administering grants and social services programs that support these local decisions.

California's geography includes densely populated coastal areas, such as the Los Angeles region with 10 million people[1], as well as large agricultural areas and sparsely populated desert and mountain regions. Each region is different and the solutions to creating healthy communities vary significantly.

Establishment of California Health in All Policies Task Force

The California Health in All Policies (HiAP) Task Force (Task Force) grew out of an understanding that multi-agency collaboration could help California address its high rates of chronic disease, while simultaneously tackling growing inequities and mitigating climate change. Staff and leadership at the California Department of Public Health (CDPH) and Health and Human Services Agency (HHS) recognised that many of the solutions to chronic disease and climate change are the same, such as promoting active transportation, walkable communities, access to parks and greening, and that these solutions require intersectoral collaboration. Climate change and childhood obesity were top priorities for then-Governor Arnold Schwarzenegger and CDPH and HHS leadership introduced him to the Health in All Policies (HiAP) approach as a possible way to help California simultaneously tackle both of these issues. Near the end of his term, while co-hosting the 2010 National Summit on Health, Nutrition and Obesity with former President Bill Clinton, Schwarzenegger signed an Executive Order establishing the California Health in All Policies Task Force as a collaborative, multi-agency body charged with promoting health, equity and environmental sustainability.[5,6]

Governance and accountability

Executive Order S-04-10 placed the Task Force under the auspices of the Strategic Growth Council (SGC), a cabinet-level body that enhances collaboration between state agencies to advance the goal of creating sustainable communities.[7] The Executive Order required the Task Force to submit a report of priority actions and strategies for state agencies to improve health, environmental sustainability and equity. Although the Task Force's initial mandate was short-term, the initiative has grown since then and the Task Force carries out collaborative work in a variety of topic areas, building capacity across state government to promote health, equity and environmental sustainability.

The Task Force has representatives from 22 agencies, meets quarterly as a full body, and completes its work through actions by individual departments and through inter-agency teams. HiAP staff monitor progress and present updates at public SGC meetings four to six times per year. This includes development of action reports which summarise outcomes and lessons learned on specific areas of work. All materials are available online and SGC meetings provide an opportunity for public comment.

External stakeholders (e.g. local and regional governments, advocacy organisations, funders,

i Also referred to as non-communicable diseases or NCDs.

policy think-tanks) play a key role in the Task Force, and provide input through workshops, individual consultation and public comment. Although not part of the formal governance structure, HiAP staff meets quarterly with an external stakeholder group of health equity policy experts to ensure integrity of the public health focus, align the state-level work with local community priorities and solicit guidance. External stakeholders also exert pressure on government to take action on issues that may not be politically easy to pursue.

Vision and purpose

The Task Force is guided by shared principles which it has updated over time.

In 2010, the Task Force developed the Healthy Community Framework[8], based upon input from government and non-government stakeholders around the state.

California Healthy Community Framework (adapted)

A healthy community provides for the following through all stages of life:

- meets basic needs of all (e.g. food, housing, health care, education)
- quality and sustainability of environment (e.g. clean air, sustainable energy use)
- adequate levels of economic and social development (e.g. living wage, safe job opportunities)
- health and social equity (e.g. fair access to resources and opportunities)
- social relationships that are supportive and respectful (e.g. civic engagement, community safety).

In 2012 CDPH launched a "Healthy Communities Data and Indicators Project" and has created a standardised set of measures and data linked to the social determinants of health[9], as defined in the Healthy Community Framework.

In 2015, the Task Force developed a shared vision and purpose statement, to further articulate the unique role that the Task Force plays.

Vision: California government advances health, equity, and sustainability in all policies.

Purpose:

- promote a government culture that prioritises the health and equity of all Californians across policy areas
- incorporate health and equity into state agency practices
- provide a forum for agencies to identify shared goals and opportunities to enhance performance through collaboration.

The Task Force is currently (2017) exploring opportunities to further link the Healthy Community Indicators to the work of the Task Force, and identify accompanying quantifiable targets.

Staffing and funding

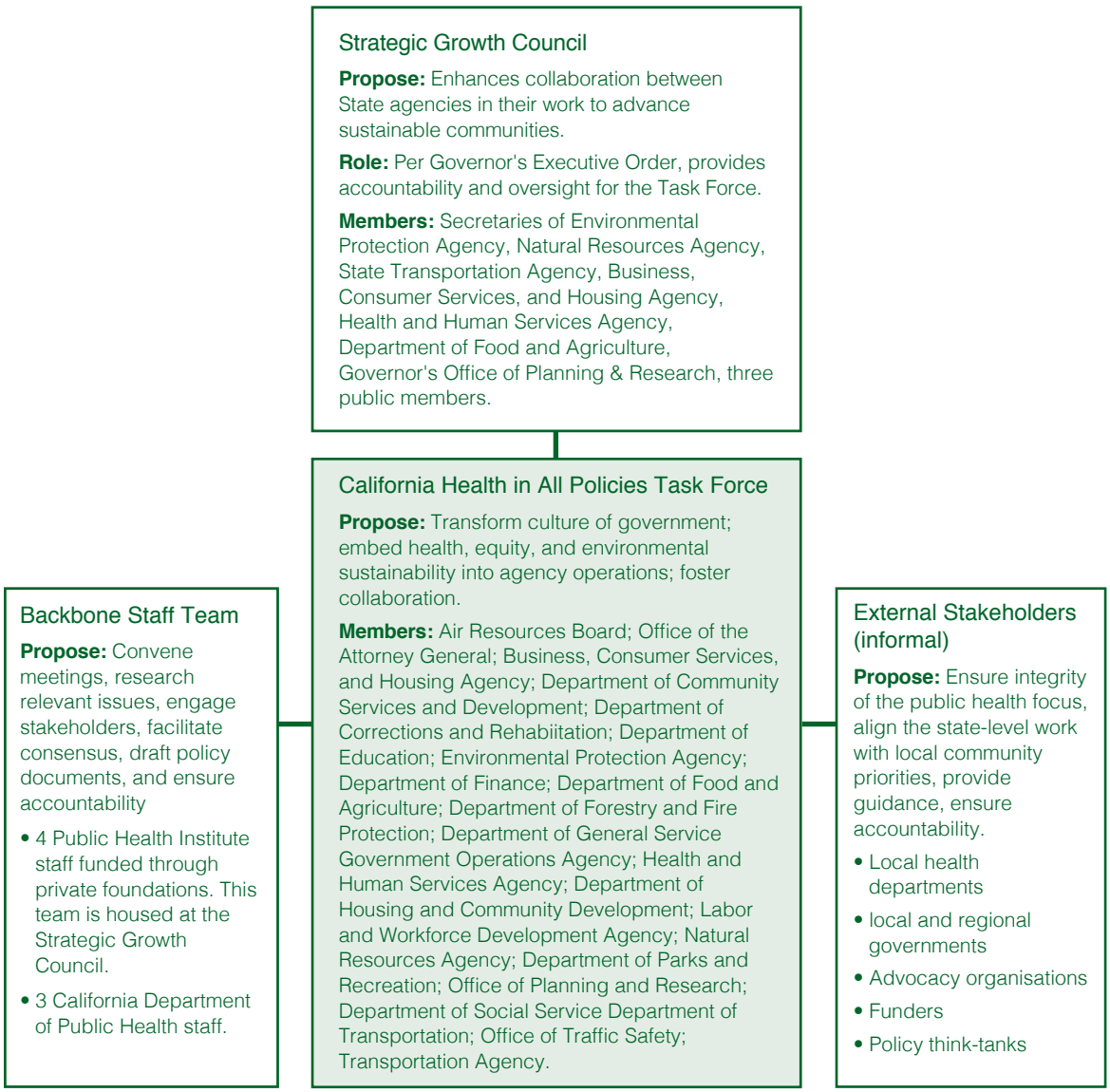
The Executive Order directed CDPH to staff the Task Force, but did not allocate funding or new positions to support this work. CDPH assigned one existing full-time staff person to support the Task Force and approached The California Endowment (a private foundation) and other organisations for additional funding. Using philanthropic funding, four additional staff were hired through the Public Health Institute (PHI) (a not-for-profit organisation) to act as the backbone staff for the Task Force, in partnership with CDPH.

In 2012, the California legislature conveyed its support of HiAP through Senate Concurrent Resolution 47[10], and in a separate piece of legislation established California's Office of Health Equity (OHE) within CDPH, calling for OHE to work collaboratively with the Task Force.[11] The CDPH and PHI HiAP staff moved to OHE from their previous placement in the chronic disease division, and CDPH subsequently created two additional government-funded positions to support HiAP, bringing the total number of government-funded positions to three. From 2010-2016 all HiAP staff were located at CDPH. However, in August 2016, the four PHI HiAP staff were moved to the SGC with the goals of providing greater access to executive leadership across government, increasing cabinet-level

involvement in the Task Force, and strengthening efforts to incorporate health and equity into initiatives and programs led by the SGC and the Governor's Office of Planning and Research. The state-funded staff remain at CDPH to ensure a strong connection to HiAP's health and health equity roots and subject matter experts. The team continues to function as one unit.

The total cost of the HiAP Task Force is approximately 1 million USD per year, including governmental funding, private foundation funding and in-kind support from state agencies. The primary cost is staffing the seven-person backbone team, as described above. Additional expenses include professional development, conferences and meeting supplies. Government provides in-kind support to the PHI staff including office space, technology/telecommunications needs, some administrative support and limited travel funds. Finally, Task Force members provide in-kind support through their staff time and resources. This varies significantly depending upon the level of involvement of the partner agencies, but can be quite significant for those agencies that have incorporated health and equity into major organisational projects. The mix of public and private funds allows the Task Force to have

Figure 1. Health in All Policies Task Force governance and staffing structure



greater flexibility than many other state initiatives (e.g. not-for-profit staff have more flexibility to try innovative approaches and not-for-profit funds can be used for food at meetings, which has significant impact on building relationships). The governance structure is shown in Figure 1.

Mechanisms and processes

In December 2010, the Task Force submitted a report to the SGC with 39 recommendations for state government action to promote health, equity and environmental sustainability. These recommendations align with the Healthy Community Framework and form the basis of the work of the Task Force.

Task Force activities are largely administered through voluntary multi-agency Action Plans that promote goals and support policies related to active transportation;[i] parks and community greening; land use, schools and health; violence-free and resilient communities; access to healthy food; economic development; and healthy and affordable housing. The Task Force develops Action Plans through an iterative process and identifies priorities using criteria including:

- feasibility
- promotes health and equity
- supports community priorities
- alignment with gubernatorial goals
- provides co-benefits for agencies
- requires the coordination and collaboration of more than one agency.

The Task Force employs a modified consensus decision-making process (i.e. any member agency can veto an action).

Implementation activities vary widely, including providing forums for coordination on topics of mutual interest, offering capacity building workshops and presentations, and directly embedding health and equity into government grant programs and guidance documents.

Example: Through the 2011 Active Transportation Action Plan the Task Force hosted a convening on the links between active transportation, walking and biking to school and school facilities decision-making. Over 200 leaders and stakeholders discussed policy agendas and how to ensure high-quality, opportunity-rich schools in healthy, sustainable communities. As a result of the convening, the Task Force formed a six-agency Land Use, Schools, and Health Work Group to identify and work on related issues. That group has engaged in stakeholder mapping, increased collaboration to promote greening school campuses with vegetation and trees and developed its own Action Plan with a focus on collaboratively enhancing data collection and analysis.

Equity in government practices

Task Force members have expressed commitment to promoting fair and inclusionary policies and practices. In January 2017, staff conducted a questionnaire to learn about agencies' equity work and found that many agencies are pursuing equity goals and practices and would like opportunities for capacity building and sharing of best practices. HiAP staff regularly facilitate learning opportunities for state agencies to enhance their understanding of the relationship between the social determinants of health, equity, and their sector. Several agencies, including land use planning, social services, and natural resources, have applied an equity lens to grant guideline development or planning guidelines, to ensure that resources and programs benefit the highest-need communities. As of May 2017, the Task Force is developing an Action Plan on equity in government practices, with a focus on building capacity to incorporate equity metrics, criteria, tools, and strategies in agency guidance, planning, grants and institutional practices.

i Active transportation refers to walking, biking, rolling, or public transportation.

History and evolution of the HiAP Task Force

The activities of the Task Force have changed over time, as a result of political will, partner readiness, and adaptive response to emerging opportunities. The text below describes the evolution of the Task Force over the course of seven years.

Stage 1 – Establishing Mandate and Structure (2009-2010)
In 2009 government and non-government leaders developed a proposal for a Health in All Policies initiative and secured political support to create a mandate. This resulted in a Governor's Executive Order in 2010, establishing the Task Force and charging it with initial tasks. CDPH assigned one temporary staff person to this project and the Task Force received a funding commitment from The California Endowment which allowed for the development of a dedicated short-term staff team in partnership with the Public Health Institute. By the end of this period the Task force had a mandate, membership list and staff structure in place.

Stage 2 – Engaging Stakeholders (2010-2011)
Staff engaged partners inside and outside of government to establish relationships, build trust, develop a shared vision and identify opportunities for action. The Task Force convened as a plenary group and held public input workshops throughout the state. This work culminated with the Task Force developing the Healthy Community Framework and aspirational goals, and identifying 39 recommendations for government action. Staff also engaged the SGC, which accepted the recommendations report and directed the Task Force to select priorities from among the recommendations and develop multi-agency action plans to begin implementation. California inaugurated a new Governor in January 2011, and staff briefed representatives of the new administration on the HiAP Task Force's vision and work to date.

Stage 3 – Securing Commitments (2011-2012)
The Task Force shifted from identifying opportunities to securing commitments to implement activities and policies that promote health and equity. The Task Force developed nine action plans with individual agency commitments, many of which involved collaboration between three or more agencies on a single issue, and formed multi-agency working groups to support deeper collaboration. Task Force members were cautious about commitments and early action plans largely focused on light commitments such as information sharing. Staff focused on achieving early wins and largely followed the lead of agency partners regarding their needs and priorities. A few agencies began engaging HiAP staff to provide health and equity consultation on grant-making and other programmatic work. The legislature affirmed its commitment to HiAP through Senate Concurrent Resolution 47 (2012) and the creation of the Office of Health Equity.

Stage 4 – Implementation (2012-2015)
Staff and Task Force members deepened trust and partnerships across government, strengthened their commitments and settled into a period of ongoing implementation. During this period agencies took steps such as creating health and equity stakeholder groups and embedding health and equity criteria into decision-making processes for allocation of funds. Agency leaders began to see the value of the HiAP approach as a mechanism for achieving their own goals, and several agencies began including HiAP concepts in their programmatic goals, strategic plans and communications materials. Task Force members' interest in addressing equity grew and staff saw a significant increase in requests for health equity consultation on policies, programs, and guidance. Staff also worked to increase accountability by developing frequent public reports and increasing stakeholder communications. Staffing continued through the Public Health Institute, while CDPH added two full-time staff positions for the Task Force.

Stage 5: Systematise (2016 – present)
The SGC has indicated interest in formalising the HiAP approach as an ongoing initiative within state government. A combination of recent legislative mandates, bold gubernatorial leadership, and public interest has led agencies to place a stronger focus on health and equity across programs. The Task Force has served as a venue for normalising conversations about seemingly controversial topics, and agency partners see the HiAP approach as a vehicle for helping them achieve their goals. This period has seen a sharp increase in requests for health equity consultation, which has led staff to shift toward a more targeted approach, including building the capacity of government partners to apply a health and equity lens themselves. The Task Force is developing a new multi-agency action plan focused specifically on equity in government practices and is launching a racial equity capacity building training for government partners. Staff have greater access to agency leadership, increasing opportunities to embed health and equity into existing decision-making structures within government. As California prepares for a gubernatorial election next year, administration leaders are also considering opportunities for ensuring HiAP long-term sustainability.

The spread of Health in All Policies in California and the U.S.

California is one of many HiAP initiatives in the United States. In California, the City of Richmond launched a HiAP initiative in 2009, preceding the state Task Force and setting a precedent for this work occurring at multiple levels of government.[12] The Task Force's public input workshops provided an opportunity to disseminate the HiAP approach and tie state-level HiAP work to local priorities. Many local HiAP initiatives have sprung up across California in the last six years, including city and county ordinances, multi-agency working groups and strategic plans. Many local jurisdictions are leveraging existing work around healthy planning, equity, or other public health initiatives (e.g. Healthy Eating Active Living) to integrate a HiAP focus. HiAP staff have developed a HiAP training curriculum and frequently receive training and technical assistance inquiries, particularly from rural and traditionally conservative areas. HiAP is also spreading as an approach in the U.S. with formal structures adopted in the State of Vermont[13], Washington, D.C.[14], and Chicago (Illinois)[15] to name a few.

Establishing and maintaining partnerships

The success of this initiative is largely due to strong partnerships that staff and participating agencies have forged over the last seven years. These partnerships rely upon shared leadership, benefits to participating agencies and personal relationships.

Key partnership strategies

Shared vision. By engaging Task Force members in early discussions to create the Healthy Communities Framework, as well as a number of other visioning activities, partner agencies assume a sense of ownership over the HiAP Task Force and investment in its success.

Shared leadership. Staff encourage partner agencies to teach each other about health and equity. For example, California's housing agency used a strong health and equity lens in its recent state-wide housing assessment. HiAP staff arranged for a Task Force discussion on the topic, which allowed the housing agency to play a leadership role in developing the capacity of other agencies and supported cross-agency relationship-building.

Navigating differences. Disagreements frequently arise between government agencies. HiAP staff hold difficult conversations in confidence which enables participating agencies to be vulnerable and share their challenges openly. In some cases, the Task Force has created multi-agency working groups to address controversial issues.

Example: The Task Force created a multi-agency working group to address challenges that arise when transit-oriented development, which is an important strategy for promoting active transportation, social cohesion, and environmental sustainability, leads to increased air pollution exposures for residents, who are frequently low-income and/or people of colour. The group included housing, transportation, land use, and air quality agencies and met for three years, exploring issues together and providing collective input to guidance documents issued by the participating agencies.

Benefits to participating agencies. Because participating agencies contribute their own staff resources for participation in the Task Force, it is essential to ensure that Task Force activities benefit the agencies involved. HiAP staff put considerable effort into understanding other agencies' priorities and linking Task Force projects to those priorities whenever possible.

Individual relationships. In addition to facilitating multi-agency convenings, HiAP staff frequently meet with individual agencies or staff to identify priorities, challenges and needs. These meetings serve as an opportunity to explore new ideas and address concerns that agencies may not feel comfortable discussing in a group setting.

Box 1. Improving nutritional content of correctional facilities meals

In 2012, the Task Force convened a multi-agency workgroup of agencies that are involved in institutional food purchasing, to explore opportunities to increase purchasing of healthy foods as a way of promoting health.[i] The California Department of Corrections and Rehabilitation (CDCR) joined this group and requested assistance to address challenges in planning menus that align with federal nutritional guidelines.

CDCR is the largest state agency purchaser of food via state contracts and spends more than 150 million USD annually to serve approximately 120,000 inmates. Sodium levels in CDCR meals far exceeded nutritional guidelines. The largest barriers to success were a very tight food budget of less than 3.50 USD per inmate per day, and requirements to purchase food through state contracts, which included limited low-sodium options.

In 2013 the group adapted federal nutritional guidelines to develop "Nutrition Guidelines for Food Procurement and Service in Adult California Correctional Facilities".[16] Since 2014, the Department of General Services, which manages state purchasing, has applied the guidelines to approximately 45 food contracts as they have come up for renewal. This has resulted in several changes to products offered, including a 250mg reduction in sodium per serving of lunchmeat. As a result, CDCR has succeeded in significantly reducing overall sodium in their meals.

By focusing on preventative health measures through healthier food options, the State of California may be able to positively influence the health of people housed in state correctional facilities while also saving money on future health care costs. Now that healthier products are available through state contracts, these products can also be purchased by other government entities such as parks, schools, and hospitals.

i More information about California's food purchasing practices is available in "Leveraging Government Spending to Support Healthy Food Procurement Implementation Plan" (http://sgc.ca.gov/pdf/Leveraging_Gov_Spending_to_Support_Healthy_Food_Procurement_Implementation_Plan.final.pdf)

Outcomes

In 2016 staff surveyed government agencies to understand the value of the Task Force.[17] Fifteen agencies responded, and indicated that they most value 1) participating in multi-agency forums and identifying collaborative opportunities 2) learning opportunities and information-sharing with different sectors and 3) developing an increased understanding of how to promote equity. Nearly two-thirds of respondents reported that their agency does more to promote equity as a result of Task Force involvement and several respondents indicated that they work with health colleagues on health issues more frequently as a result of their involvement.[17]

The Task Force has accomplished a number of key policy and programmatic changes, in addition to those described throughout this chapter. For example:

- In 2012, the Departments of Education, Food and Agriculture, and CDPH established the California Farm to Fork Office to promote policies and strategies to improve access to healthy, affordable and locally-sourced food.[18] The office now "connects individual consumers, school districts, and others directly with California's farmers and ranchers."
- In 2015, the Department of Transportation added a health goal to its mission statement and incorporated health and equity metrics into its strategic management plan.[19] In 2016, the California Transportation Commission and Department of Transportation created a new health equity stakeholder group and developed a health equity appendix to transportation planning guidelines that are used by regional metropolitan planning agencies across California to make significant investment decisions. They have also incorporated health and equity metrics and criteria into local assistance grant programs.
- In 2015, the Task Force developed collaborative commitments from over ten state agencies to build state agency capacity and support coordination to address structural drivers of violence and promote violence-free and resilient communities. This includes the 2017 launch of a multi-agency "think tank" that brings together multiple agencies to share strategies and resources on preventing, addressing, and responding to youth violence.

Challenges and opportunities

Critical success factors

Several success factors have been identified through staff reflection, research, and evaluation.[8,20,21] These include:

- The Task Force has consistently had **high-level government leadership support**[21], beginning with the gubernatorial Executive Order, the Senate Concurrent Resolution, the codification in statute, and the move of PHI Task Force staff to the SGC. These statements formalise high-level governmental oversight and establish lines of accountability for staff and member agencies.
- **Clarity of values and principles** is a key feature of the Task Force. The explicit commitment to public health, health equity and environmental sustainability has allowed the initiative to maintain its focus and grow its impact over time, despite frequent turnover in government leadership. Non-government stakeholders have also played a key role in holding the Task Force accountable to its original purpose.
- The Task Force has been nimble in its ability to **respond to emerging opportunities**. This flexibility can be difficult to maintain within traditional governmental structures.
- Participants appreciate the **broad intersectoral membership** of the Task Force and that it helps them meet their agency goals.[21] One Task Force member reported that it "provid[es] a venue for cross-sectoral work that just happens to focus on health. It's one of the few places in state government where that happens. It promotes synergies that would not occur otherwise".[17]

- The Task Force relies on **backbone staff**[22], who convene meetings, research relevant issues, engage stakeholders, facilitate consensus, draft policy documents and ensure accountability. To be effective, staff must have access to high levels of government leadership and be allowed to speak freely on policy issues.

Challenges

Key challenges include:

- **Measurement and evaluation** are difficult because population health outcomes take many years to achieve, are distal to the state-level intervention point, and are actualised across a variety of sectors, each with already established reporting, tracking and measurement mechanisms.[8,23] In addition, the opportunistic and collaborative style of the Task Force means that staff may not be able to predict the outcome of an action at the outset, making it difficult to set quantifiable goals.
- As interest has grown, Task Force member agencies increasingly request assistance with issues that require **technical expertise**, such as how to quantify and score health and equity benefits in order to include these as criteria in grant-making programs. These requests often exceed staff capacity and answering these questions fully will require additional resources to research and develop health and equity measurement tools and metrics.
- California's state government leadership has experienced significant turnover during this project's tenure and will undergo a gubernatorial change in 2019. The Task Force has worked under two governors, four state health officers and two staffing restructures. HiAP staff dedicate significant time to orienting new partners and responding to changing priorities.[8] An ever-changing landscape of governmental leaders makes it difficult to secure long-term political will and demonstrates the need for further codification of the Task Force and its work.

Reflections and conclusion

The Task Force has developed a strong identity and role, and has changed the culture of California state government. Agencies now routinely consider health and equity in their planning and decision-making. Several have incorporated health and equity into their programmatic and policy goals, and some have included health and equity work in staff duty statements, which further formalises this approach as a part of normal business. The Task Force also provides one of the few places in California's very large state bureaucracy where people from multiple and diverse agencies have the opportunity to work together and build relationships over time, which has proven to be both valuable and enjoyable for participants.

As the United States faces significant cuts in public health spending by the new presidential administration, and California prepares for a new governor in 2019, the Task Force faces the challenge of ensuring continuity of the HiAP approach well into the future. The need for HiAP work is only growing, as agencies increasingly turn to Task Force partners and staff for collaboration and technical expertise. While political changes are inevitable, the Task Force has tremendous opportunities now to further build the capacity and commitment of state agencies to promote health and equity, and formally institutionalise those commitments as part of ongoing government processes. This institutionalisation can ensure that HiAP continues, regardless of structural and political changes.

Key Contact/s and Further Information

Julia Caplan, Program Director,
Public Health Institute
Email: julia.caplan@phi.org
Web: http://sgc.ca.gov/Initiatives/Health-In-All-Policies.html

Resources:

- Health in All Policies: A Guide for State and Local Governments (http://www.phi.org/uploads/files/Health_in_All_Policies-A_Guide_for_State_and_Local_Governments.pdf)
- Health in All Policies: Improving Health Through Intersectoral Collaboration https://nam.edu/perspectives-2013-health-in-all-policies-improving-health-through-intersectoral-collaboration/

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Health in All Policies

Applying a Health in All Policies approach to the Greater Christchurch Urban Development Strategy: the experience to date in Canterbury, New Zealand

Authors

Anna Stevenson[A], Sandy Brinsdon[A]

[A]Canterbury District Health Board, New Zealand

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Applying a Health in All Policies approach to the Greater Christchurch Urban Development Strategy: the experience to date in Canterbury, New Zealand

Introduction

Canterbury's Health in All Policies (HiAP) approach[i] began with efforts to create a local Healthy Cities interagency project modelled on the European WHO Healthy Cities project. Following a failed attempt in the late 1980s, an advisory group, led by the Public Health Unit (PHU)[ii] and the local municipal body, Christchurch City Council (CCC), was formed in 2001 to inaugurate 'Healthy Christchurch'. In 2002 the Healthy Christchurch Charter[1] formally set out principles and protocols after a wide-ranging engagement process involving both city decision-makers (high-level champions) and grassroots organisations. The diverse Charter signatories, from national government agencies to small non-government organisations (NGOs), confirmed their commitment to the values, principles and goals of Healthy Christchurch and to working together to "promote, protect and improve the health and wellbeing of the people of Christchurch". Incorporating the Ottawa Charter for Health Promotion and the Treaty of Waitangi[2] (the founding document of New Zealand/Aotearoa) into the Charter marked their intention to work collaboratively across silos to address the wider determinants of health.

Health Impact Assessments (HIAs) were promoted nationally in 2005 when the national-level Public Health Advisory Committee published the second edition of "A Guide to Health Impact Assessment" and supported it with nationwide training workshops over two years.[3]

Subsequently, a Healthy Christchurch hui[iii] recommended to CCC that all major policy should undergo an HIA. At that time CCC was developing the Greater Christchurch Urban Development Strategy (GCUDS) in partnership with three geographically adjacent local councils, the regional council Environment Canterbury (Environment Canterbury) and the New Zealand Transport Agency (NZTA). Canterbury District Health Board (CDHB), working with the GCUDS project team, led a high-level policy HIA on the GCUDS, addressing six determinants of health and wellbeing: transport, air quality, social cohesion, water quality, waste management and housing.

Early on, the working group identified that engagement with Ngãi Tahu[iv] was inadequate. A parallel project work stream was begun to gain better input from them.[v]

The final HIA report summarised the results of a process evaluation of the HIA[4,5] An impact evaluation[6] found unanticipated outcomes of the HIA, including that:

- Christchurch City Council and CDHB developed a shared role for a public health specialist
- An electronic network, the South Island Public Health Analysis Information Base, was established, providing an interactive bulletin board, archive, and e-discussion for public health and local government throughout the South Island
- Māori participation in the GCUDS Forum and final policy was facilitated
- The project's success and credibility enabled other HIAs, such as for the Central Plains Water Scheme (CPWS)[7] and the Christchurch Transport Interchange project[8]
- Strong collaborative working relationships developed between the agencies involved.

i As defined by the World Health Organization The Helsinki Statement on Health in All Policies (2013), "HiAP is 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."

ii New Zealand has a comprehensive publicly funded public health system. In 2001, regionally based Public Health Units delivered public health services funded by the Ministry of Health. More recently, PHUs are located within 20 district health boards, which deliver and fund the full range of health services.

iii The Māori word for meeting/workshop

iv For more information about the local tribe Ngãi Tahu see Manawa Kãi Tahu see http://ngaitahu.iwi.nz/communications/publications/manawa-kai-tahu-2016/

v In 2007 PHAC released the Whanau Ora HIA training guide. In an accompanying training workshop one of its authors stated the inspiration for this publication was the Ngãi Tahu work stream in the GCUDS HIA.

As momentum grew for the 'Healthy Public Policy' approach, facilitated by the CCC - CDHB public health specialist, four Healthy Christchurch signatories agreed to co-fund an HIA project officer role for two years. The funding partners formed an advisory group, the Canterbury Health Impact Assessment Partnership (CHIAP), to guide this work.

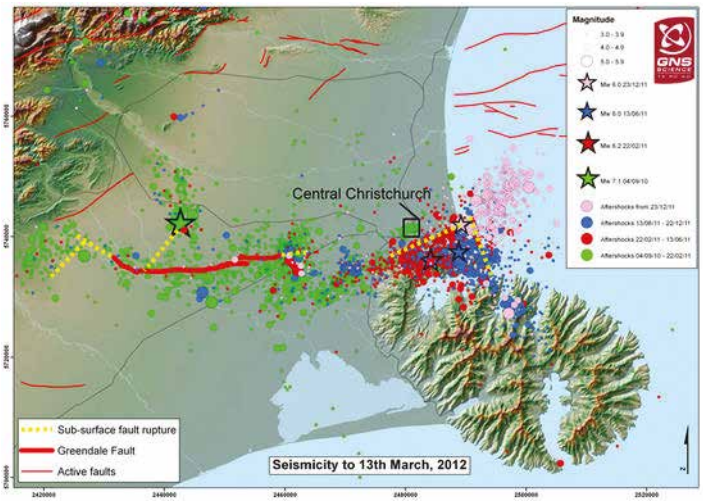
This period saw many large interagency HIAs on regional and local transport plans undertaken, along with literature reviews to facilitate a shared understanding of evidence, several training workshops and the start of the development of interagency work plans. The two-year position was evaluated throughout.[9] New Zealand Ministry of Health's HIA Support Unit financially supported some of the HIA work.

In the midst of this period, Canterbury was rocked by several devastating earthquakes and thousands of smaller aftershocks (see Figure 1).

Several thousand homes in the 'red zone' areas were destroyed in the earthquakes (Figure 2), and much of the inner city required demolishing (Figure 3).

In response, all government agencies' workloads and priorities were reoriented immediately. The Ministry of Health recognised a strong champion and resource for a HiAP approach would contribute significantly to long-term community wellbeing working with a process to identify mutual gain. It provided a one-off grant to restructure the PHU to frame its work using HiAP tools founded on a social determinants of health

Figure 1. Map of seismic activity from Christchurch Earthquake Sequence



Source: GNS Science, Te Pū Ao, Lower Hutt New Zealand, April 2014

Figure 2. Map of major Residential Red Zone area in Christchurch City

Figure 3. Aerial view of city centre post earthquake

Source: Christchurch City Council

model. A HiAP team was created at the PHU to lead this approach internally and to champion HiAP approaches with existing and new partner agencies. The Information team, the Communities team and the Environment team were also restructured around the determinants of health way of working.

Even before the built environment was severely damaged, the Canterbury community faced health and wellbeing challenges. These issues continue, with CDHB noting recently that of particular concern are type two diabetes, dementia, obesity and hazardous alcohol intake.[10]

The health sector needs to address all these issues in partnership with other sectors identifying co-benefits. Changes within the health sector were also a focus but the pressures on continued service delivery meant it was difficult to get traction within the health service delivery environment at this time.

While many challenges were identified following the major natural disaster it also provided an opportunity to move towards an explicit HiAP approach. One response was to re-form CHIAP as the Canterbury Health in All Policies Partnership (CHiAPP), a subcommittee of the Healthy Christchurch network (itself a HiAP 'tool'), with partners CDHB, Christchurch City Council, Environment Canterbury and Ngãi Tahu.[11] The HIA project officer became a senior member of the PHU's HiAP team. One of Healthy Christchurch's strategic goals is to support its signatories in using HiAP approaches. The CHiAPP subcommittee recognised working with HiAP approaches and tools was a significant reorientation for four large agencies and would require focus and capacity building to be successful. Throughout this time the PHU staff in the four teams took on a range of roles from practical assessments of water quality to high level strategic planning depending on the outcomes to be achieved. The staff have led pieces of work, supported partners to deliver their goals, provided background support and evidence as well as delivering capacity building initiatives.

Vision and purpose

The vision of CHiAPP is "To work together to ensure that health and wellbeing are embedded into the Partners' policy development, planning cycle and project development." Its objectives are for the:

1. CHiAPP Leadership Group, operating as a highly functioning and effective partnership, to develop and progress a HiAP approach in Canterbury
2. Treaty of Waitangi to inform CHiAPP's work
3. Partners to commit to a range of HiAP activities (e.g. capacity building both within partner organisations and externally; the use of specific resources and tools as well as undertaking impact assessments) in an annually planned approach
4. Partners to evaluate HiAP activities within their respective organisations to continually improve and assess value.[12]

Governance, reporting and monitoring

The CHIAPP Leadership Group met regularly to share experiences, generate projects and report on progress. Progress against the partnership's objectives was evaluated annually and annual reports published on the PHU's website.[13]

Other than the initial start-up funding, the Ministry of Health has not been involved in the governance structure locally. The Ministry of Health acknowledges the PHU takes an explicit HiAP approach in Canterbury and contract managers remain supportive and receive annual reports on these achievements. CEOs and governance bodies of CDHB and local and regional councils strongly support the HiAP approach and advocate for it at conferences and public meetings. At the 2016 scientific meeting of the NZ College of Public Health Physicians, for example, the CEOs of CDHB, Environment Canterbury, Ngãi Tahu and the Mayor of Christchurch explained how the approach was benefitting the community in the Christchurch

rebuild. Each speaker focused on a particular aspect of a HiAP approach that advanced their agency's goals such as explicitly acknowledging local Māori needs in the rebuild and equity of outcome.

Each agency has a nominated middle management HiAP lead who is the key contact for projects and regularly briefs senior management and governance about HiAP activity. They meet regularly to plan future work and report formally to each agency's governance body.

Mechanisms and processes

The working relationship between agencies began with ad hoc meetings between key personnel. The regular CHiAPP meetings deepened these relationships and built trust. As the number of projects generated from these meetings grew, it showed an obvious need for a clearer process of monitoring contacts between different divisions of organisations of varying sizes while also monitoring progress on projects.

Environment Canterbury and CDHB established a joint work plan in 2012. The first simple, paper-based version identified a few joint priority areas and projects under each area and set timelines. Progress was monitored by senior management staff and reviewed at an annual governance meeting between the two agencies. A similar process was followed with the Christchurch City Council a few years later.

As the value of this joint work plan was realised and its complexity grew, it became an electronic portal accessible via the web from any workplace. The agreed work areas can be updated with progress and monitored at a glance and the reviewer can easily locate project plans and implementation activities.

Partners recognise the functionality of the portal. The Greater Christchurch Partnership (GCP), which exists to deliver the goals of the GCUDS, asked to use the portal to manage its work programme with its nine partners (See Box 1 for a practical example).

The portal is the latest example of the institutional supports created for advancing a HiAP approach in Canterbury, as Figure 4 illustrates.

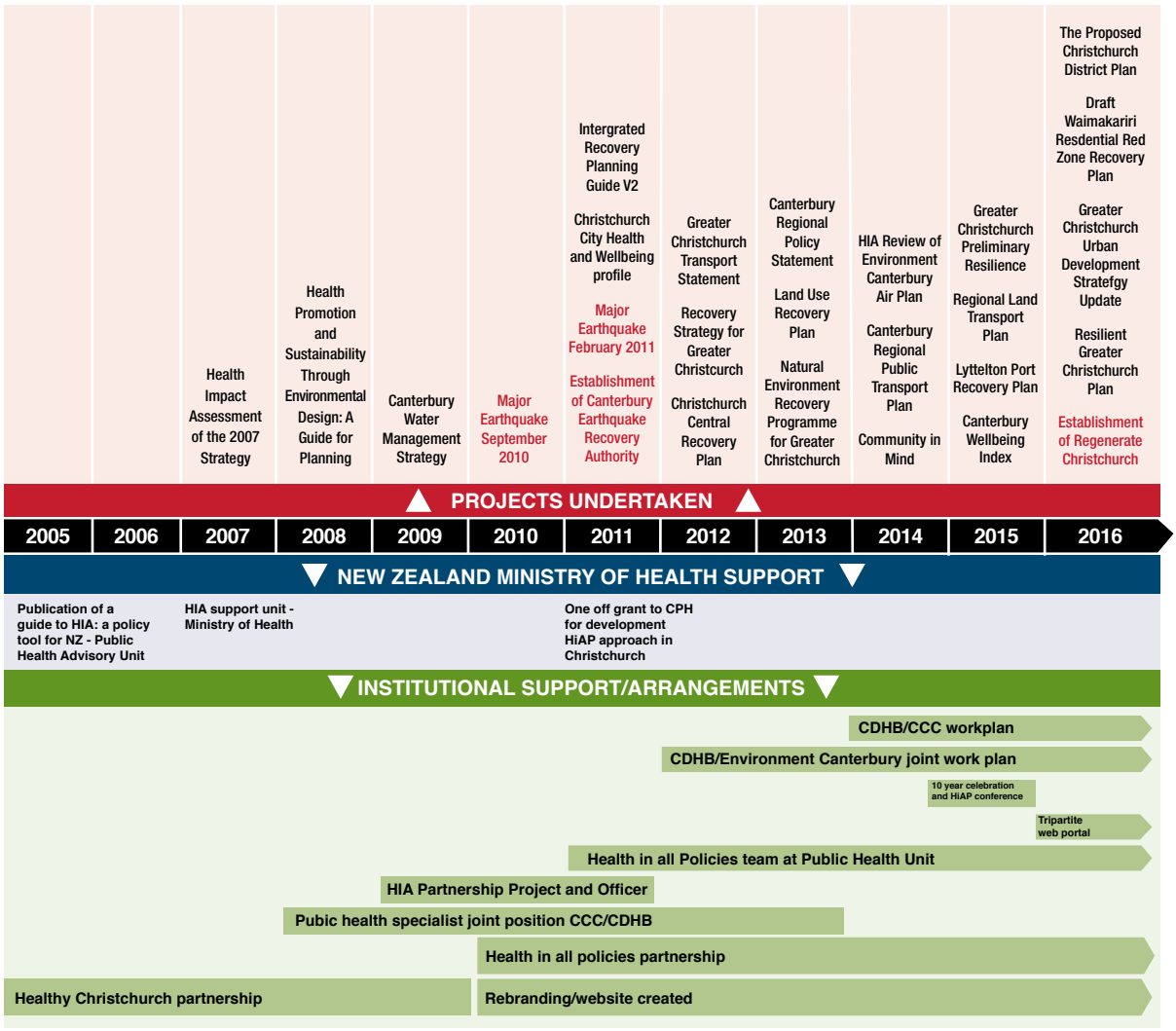
Establishing and maintaining partnerships

CDHB initially led and supported the HiAP work in Canterbury. The HIA on the 2007 GCUDS led to many HiAP projects and partnerships, which the government agencies and NGOs involved have actively supported.

Partnerships have been built and strengthened by regular meetings of Healthy Christchurch and CHiAPP, joint training and capacity building, shared 'learning by doing' projects, secondments between agencies, and joint conference presentations and journal publications. Fundamentally the partnerships are maintained by the shared work programmes and the evident benefits to all being involved in delivering higher-quality work that meets more of the agencies' objectives. Strong support of the CHiAPP partners' CEOs is evidenced in the ongoing financial support of the work programme.

Ultimately partnerships are based on trust – both interpersonal and between institutions. Trust is built incrementally over time. The process of 'learning by doing' on projects and developing institutional supports has continued strong working relationships. To this end the HiAP team at the PHU brings a wide range of technical experiences including medical and legal practice, research and policy development, community and workforce development.

Figure 4. Timeline of HiAP activity in Canterbury, New Zealand



Source: Canterbury District Health Board

Box 1. Updating the greater Christchurch urban development strategy

In 2015, to update the 2007 Greater Christchurch Urban Development Strategy, a small working group was formed with staff from CCC, Environment Canterbury and CDHB's PHU. The PHU seconded a senior public health specialist full time into this role, with full support of the partners. Having a HiAP member in the core working team demonstrated the value of working closely with partners as a 'critical friend' to maintain a focus on people, outcomes and wellbeing, avoiding a time-poor process that defaults to planning and systems. Over eight months the working group reviewed consultations from the previous five years, the original strategy and the post-earthquake governance and operational landscape, and prepared evidence to support an updated GCUDS.

One notable way in which 2016 GCUDS differs from its 2007 ancestor is that the health sector, through CDHB, joined the Greater Christchurch Partnership, with representation at governance, chief executive and management levels, and public health staff on all project implemention groups. The GCUDS notes CDHB's involvement "acknowledges the legislative requirements of district health boards to promote and protect the health of people and communities, promote the inclusion and participation in society and independence of people with disabilities and reduce health outcome disparities between various population groups".[14]

The Strategy's reconsidered principles[15] (see Figure 5) specifically include 'equity', defined as "Treating people fairly and with respect, and recognising the different needs and aspirations of people, groups and communities. Mō tātou, ā, mōkā uri ā muri ake nei – for us and our children after us."

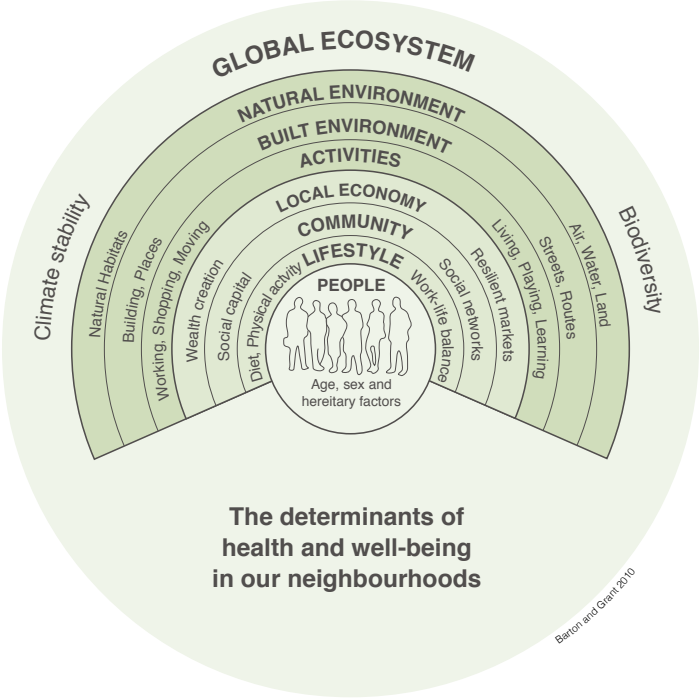
Figure 5: Principles of the Greater Christchurch Urban Development Strategy

It explicitly identifies the determinants of health and wellbeing, using Barton's health map, (Figure 6) as influencing the strategy.

The revised strategy's strong 'wellbeing' focus acknowledges the importance of land use planning for healthy and resilient communities as well as ensuring certainty for developers and infrastructure providers.

This project is an example of the ways in which the Canterbury Health Sector has contributed to Sustainable Development Goal (SDG) 11 Sustainable Cities and Communities.

Figure 6. The health map



Source: Barton H. and Grant, M. (2006). A health map for the local human habitat. The Journal for the Royal Society for the Promotion of Health, 126 (6). 252-253.

Outcomes

One important outcome of the HiAP work has been to explicitly acknowledge equity as a desired outcome. The resulting changes to policy, and their relationship to the SDGs, include that:

- equity is now a guiding principle of GCUDS (SDG Goals 1 and 10)
- the rollout of the Canterbury Clean Air programme changed significantly after considering social equity issues in the HIA (SDG Goal 11)
- transport governance groups recognise and discuss equity (SDG Goals 1, 10 and 11).

GCUDS priority actions include a HiAP approach and integrated assessments (IAs) (a methodology the HiAP team pioneered in post-disaster reconstruction). IAs, which governing authorities see as 'business as usual', have broadened over the last five years and have all been evaluated.[14] A consistent theme is that the parties have gained value from being part of a broad, inclusive process.

It is now standard practice for governing authorities to interact regularly and early in policy development and project implementation, addressing health and wellbeing proactively from the outset. Public health advisors are routinely requested to join other agencies' strategy development and project teams.

HiAP has strengthened regionally following the GCUDS refresh. Local authorities outside Christchurch have contributed to IAs more collaboratively, often including multiple partners.

The PHU continues to improve communication. It profiles its work in annual reports and newsletters, and publishes all significant documents and evaluations on its website. Capacity building within the health sector and with other stakeholders is an important focus.

Broadly Speaking, a compulsory two half-day training for all PHU staff, is offered to others in the health sector and non-health sector partners. It introduces health determinants and the HiAP approach and gives practical tools for the workplace. Attendees are also prompting their 'sending agencies' around New Zealand, ranging from the defence force to other public health units, to ask for help with setting up HiAP approaches.

Challenges and opportunities

Challenges

While health is an active partner in key decision making, challenges remain in reorienting the health sector to behave differently in its own day-to-day tasks. This is particularly difficult for a budget-constrained DHB that is managing high levels of post-disaster need.

Challenges remain in working closely and genuinely with Treaty of Waitangi partners. Acknowledging the huge call on the resources and skills of one iwi (tribal) authority means working smarter and harder to make the work relevant.

Many partner agencies have had significant restructures, building moves and personal stressors. As a result, the PHU needs to constantly upskill and orientate new staff to the HiAP approach and clearly demonstrate its value. Staff that have been through such changes are often overworked and fatigued so thinking differently and creatively is challenging. The strong trusting relationships discussed above have helped to walk this line of supporting while stretching colleagues.

Organisations in Canterbury are increasingly initiating conversations about their impact on health outcomes. Yet their prime responsibility and the responsibility of their elected officials are not always seen as aligning with this. HiAP has helped to create a pathway for these discussions but, with election cycles and changes in senior (and junior) staff, keeping HiAP top of mind becomes the role of many in and outside of organisations.

Above all, how to truly institutionalise the HiAP approach is a significant challenge. While partners' documents and language increasingly recognise it, it can be easily forgotten when projects begin. The need to show the value of engaging in systematic, co-ordinated ways does not diminish. Opportunistic interactions occur that might easily have been missed. Keeping partners engaged in such structures is difficult when they have multiple demands on their time.

Opportunities

One opportunity is building on the existing strong relationships. While staff turnover is a challenge, some staff have been involved with HiAP for a long period and some move between organisations carrying HiAP knowledge and skills with them. Their involvement has prompted some of the important opportunistic interactions noted above.

Another opportunity, made possible through strengthening the Greater Christchurch Partnership, is to streamline structures so that collaboration is easier and less time-consuming for partners. Organisations and individuals that previously met with a slightly different focus can now come together with broader, more collaborative terms of reference and purpose. An opportunity already being acted on is making Healthy Christchurch into a wider regional network. Both the Urban Development Strategy and Resilient Greater Christchurch Plan identified Healthy Christchurch to lead the implementation of a 'Health and Community' work programme. That work programme would also lead the expanded Healthy Christchurch partnership and ensure the key aspects of CHiAPP were maintained and supported.

Many opportunities exist to leverage off existing relationships locally and across New Zealand, as reflected in the interest in and attendance at the PHU's HiAP reflection day and conference in 2015.

The Sustainable Development Goals provide an opportunity to describe the work that the public health sector already does in the language and mandate of our partners. For example Goal 6 around water quality, Goal 4 working with Health Promoting schools programmes and Goal 1 as equity is a driver of all public health action.

As partnerships have grown and expanded, new opportunities have included:

- Early input into district and regional planning, with a central role for HiAP in guiding positive conversations about planning regionally and taking a broad, joined-up approach.

- The view of impact assessments as 'business as usual' from early in plan development. New organisations in the region are also embracing these frameworks. These developments provide for multiple positive outcomes for communties and health and wellbeing.
- The recently established Resilient Cities network, supported by the Rockefeller 100 Resilient Cities Challenge. It has been an invaluable opportunity to link this work with existing regional action and to include team members experienced in HiAP.

Reflection and conclusion

Canterbury has a long history of strong working relationships built before formal discussion around HiAP, HIAs and IAs began. The breadth and extent of the post-earthquake rebuild provided both challenges and opportunities to embed a HiAP approach and focus the rebuild of Canterbury explicitly on health and wellbeing for all.

These partnerships and opportunities to work together have had multiple positive outcomes. Where partners were previously constrained by their organisational structures and priorities, the joint work plans have enabled each organisation to come to better understand the drivers, the human cost, and the complexity of addressing prioritised issues.

Because of this growing understanding and established history of successes, CEOs support each other's messages, are open and honest about their challenges and trust each other well enough to acknowledge they don't always get it right. Not every project will be as successful as we hope but as long as the lessons are learned the project will not be a failure.

The PHU has significantly changed its method of working, both internally and externally. Siloed and contract-based activities have moved to a determinants-based approach using HiAP philosophies. Work with its partners at the policy development stage is prioritised over submissions at the end of the policy process. Intra-sectoral working teams have developed to respond comprehensively to its partners' priority issues often achieving co benefits.

Having health as part of the conversations and having equity as a focus are now business as usual for councils to the point where they no longer recognise these topics as unusual. The SDGs provide the goals for action and HiAP provides a credible approach to work in collaborative ways to achieve these shared goals.

Although the future holds many opportunities and challenges, a growing number of practitioners can now walk the talk and begin to make a positive difference to the lives of Cantabrians, New Zealanders and people globally.

Key contact/s and further information

Email: healthychristchurch@cdhb.health.nz

Web: Healthy Christchurch
http://www.healthychristchurch.org.nz

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Health in All Policies

Action plan for promoting healthy China—outline of the Healthy China 2030 Plan

Authors

Xiufeng Wang[A],Yue Xiao[B]

[A]National Health & Family Planning Commission of the PRC, China

[B]China National Health Development Research Center

6

Introduction

Background

Recent years have seen successful reforms and development in the health sector of China (mainland). In 2015, the average life expectancy reached 76.34 years; infant mortality, under-five mortality and the maternal mortality rate were reduced to 8.1%, 10.7% and 20.1 per 100,000 respectively.[1] Main health indicators out-performed the averages seen in upper middle-income countries, and fulfilled the national 12th Five-Year Plan targets and Millennium Development Goals (MDGs).[2] However, being a developing country with a large population, China is facing great health challenges. A national strategy is required to propose comprehensive solutions for key and widespread health determinants.

However there are key issues to grapple with. Firstly, there are prominent conflicts between health needs and health supply. With continuous economic development and increasing consumption, use of health care services has seen rapid growth. In 2015, there were 7.7 billion outpatient visits and 211 million inpatients in the country, with a respective increase of 93% and 213% when compared to 2004. The number of licensed physicians only increased by 52%.[3] The national health accounts (NHA) counted for 5.96% of the GDP in 2015, while the world average was 8.7%. But health spending had an average increase of 11.50% between 2009 and 2015, 1.38 times the increase in GDP.[4] The OECD has estimated that spending on health care and long-term care will increase two-fold in the next 40 years if nothing is changed.[5]

Secondly, multiple diseases and health determinants coexist. With industrialisation, urbanisation, an ageing population, a changing disease spectrum, ecosystem and lifestyles, China is confronted by health issues faced by both developed and developing countries. On one hand, prevention and control of traditional infectious diseases such as hepatitis and tuberculosis still need more effort. On the other hand, non-communicable diseases (NCDs) have become the leading cause of death and burden of disease. There are 260 million patients with NCDs and NCDs accounted for 70% of the total disease burden and 86.6% of the total deaths.[6]

Increasingly there is a move from the bio-medical model to a bio-psycho-social model, with prominent recognition of the influence of social factors, the natural environment, living conditions and behaviors. Health has become a cross-sectoral public policy theme. A disease-centered approach is unsustainable, and cannot solve the health issues of humans. The healthcare system cannot handle the complexity of the social determinants of health alone. With a slowdown in the expansion of the economy (the so-called 'new normal state'[7]), traditional costly healthcare delivery centered on disease should be transformed to a focus on health. Institutional arrangements for promoting Health in All Policies need to be built, to deal with complex health risk factors as a whole.

Process

The Communist Party of China (CPC) and the government have always attached great importance to the health of the population. As the General Secretary Xi Jinping pointed out, health is a must for human development, a basis for socio-economic development, and an important token of national wealth and prosperity, representing the common wishes of people of all ethnic groups in the country.[8]

In 2015, the fifth plenary sessions of the 18th CPC Central Committee agreed to "build a healthy China". Organised by the CPC Central Committee, the State Council, and the Health Reform Office of the State Council a compilation of the Outline was initiated. In March 2016 a working group to draft the Outline and an expert panel were set up, with participation by over 20 ministries, including the National Health and Family Planning Commission, National Development and Reform Commission, Ministry of Finance, Ministry of Human Resource and Social Security, General Administration of Sport, Ministry of Environmental Protection and the Food and Drug Administration. Over 20 parallel

research projects and international comparative studies were sponsored, to extract domestic and international experiences on national mid- and long-term health planning. Views and opinions from local governments, industry and public institutions, and social groups were solicited, and comments by the general public were openly collected. At the National Conference on Health and Medical Care on 19-20 August 2016, the opinions of participants were collected. On 26 August, the meeting of the Central Political Bureau reviewed and ratified the Healthy China 2030 Planning Outline (the Outline). The compilation of the Outline involved widespread participation and contributions, fully reflecting social consensus.

On 25 October 2016, the CPC Central Committee and State Council issued the Outline as an action plan for promoting healthy China development in the next 15 years. This was the first time China had developed a mid- and long-term national health plan since the foundation of the People's Republic of China. It is a major approach to maintain and protect the health of the population on the way to achieving an all-round moderately prosperous society and the modernisation of socialist society. It is a major means for the country to participate in global health governance and meet targets set in the 2030 Agenda for Sustainable Development.[9]

The Outline sticks to the WHO 'one health'[10] concept, and prioritises health on the development agenda, and defines guiding principles for health and medical care development, namely: "prioritise primary health care, gain momentum from reform and innovation, focus on prevention, give equal stress to the development of Chinese and Western medicine, incorporate health care into all policies, and encourage people to contribute and share". The Outline includes the requirement to put health development in the whole process of public policy making, facilitate the formation of healthy living, ecosystem, and socio-economic development models, and sustain all-round and lifelong health improvement for all the people.[11]

Vision, aims, objectives

Vision

Centered on population health, we shall incorporate health promotion in the whole process of public policymaking. Healthy lifestyles, the ecosystem, and socio-economic development models should be developed. Health determinants should be addressed in a uniform way. Balanced and coordinated health and socio-economic development should be pursued.

Aim

The fundamental goal of building Healthy China is to maintain a healthy population. Focusing on the lifelong needs of all people, we need to provide equitable, accessible, comprehensive and continuous care to achieve better health, addressing key determinants of health, such as lifestyle and behaviors, working and living environments and the healthcare system.

Firstly, to benefit all and achieve universal health coverage (UHC), it is necessary to innovate institutional arrangements, expand coverage, improve healthcare quality, ensure access to quality and affordable preventive, curative and rehabilitative health care, while focusing on priority groups such as women, children, the elderly, the disabled and low-income groups.

Secondly, to cover lifelong health needs, it is necessary to deal with key health issues, identify priorities, and step up interventions, to provide 'cradle-to-grave' care and protection and maintain and protect the all-round health of the people.

Figure 1. Staged goals of the Outline of Healthy China 2030 Plan

Objectives

Based on the goals of building a modernised society in Two Centenaries[12] and the SDGs, the Outline defines three-stage development goals for Healthy China for 2020, 2030 and 2050 (Figure 1).

Underpinning principles

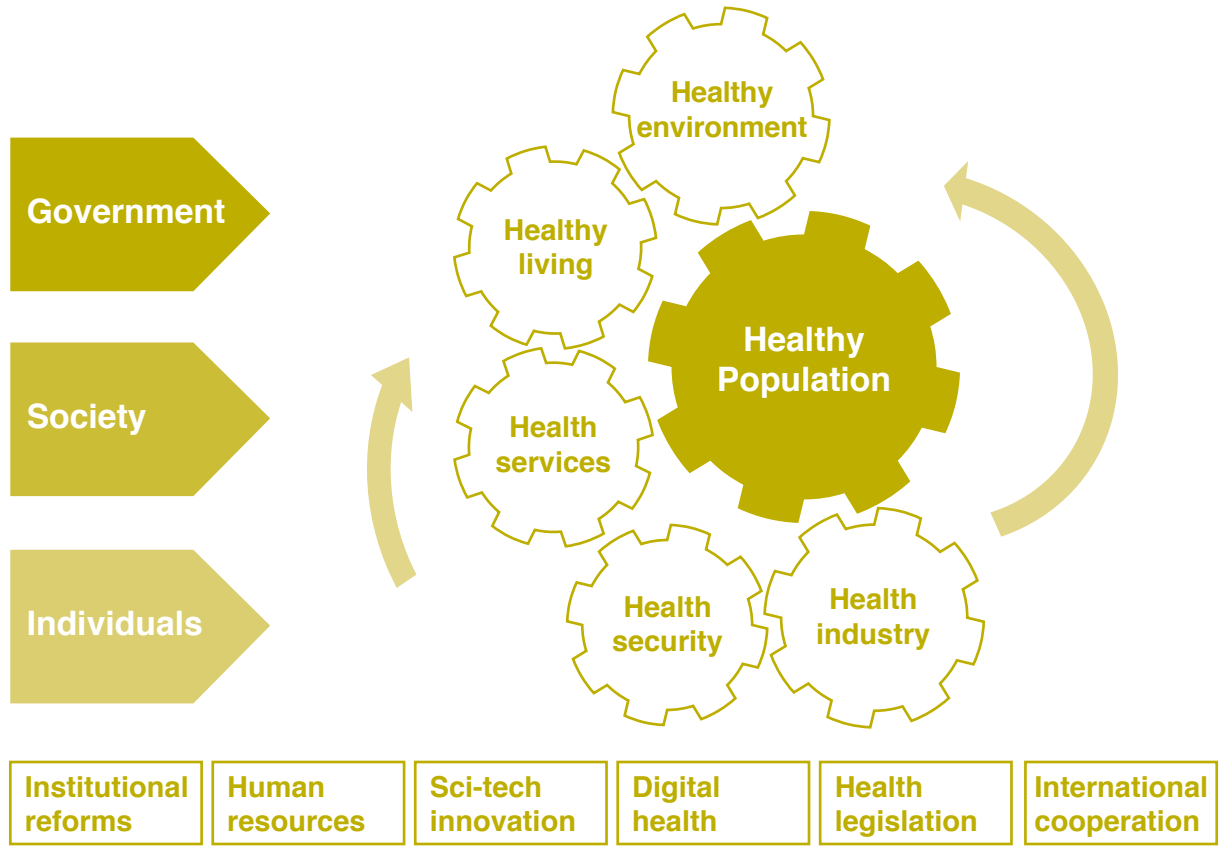
Health as a top priority. Health should be at the top of the development agenda. Premier Li Keqiang further defines the specifications of 'health as a top priority', including: keeping health as a focus in development ideology; stressing health goals in socio-economic development plans; prioritising health in public policy making and implementation; financing health needs with public inputs; and providing basic health and medical services for all the people.[13]

Reform and innovation. With respect to market forces, government-led reforms in the health sector will reform institutional arrangements and change the mindsets of all. Innovative measures and information technology will support institutional reforms.

Scientific development. We need to identify rules for health development, and adhere to "prevention first, combining prevention with disease control, and supporting both traditional Chinese and Western medicine." Healthcare delivery systems should become integrated and improved, moving from an extensive development mode based on scale to an intensive one focusing on quality and efficiency.

Equity and fairness. Rural and primary health will be prioritised. We will aim to achieve equity of public health services, ensuring improved access and the availability of non-profit basic medical care and health services to reduce urban-rural, regional and sub-group health inequalities. Universal coverage and social equity in health care services will be realised.

Figure 2. Framework of the Outline of the Healthy China 2030 Plan



Framework of the Outline of the Healthy China 2030 Plan

The Outline is centered on the goals of becoming a prosperous society and building a modernised society in Two Centenaries. Taking a 'one health' view, it will link with the requirements of the SDGs and Universal Health Care (UHC), deal with key health issues such as NCDs, and address health determinants, including biological factors such as heredity and mentality, natural and social environments, healthcare services, personal living environments and behaviors. Considering internal factors through to external ones and subjective factors to environmental factors, major health determinants are prioritised, including personal living and behaviors, healthcare services and protection, and production and living environments. It proposes five strategic tasks, namely healthy living, healthcare services, health security, healthy environment, and the healthcare market as shown in Figure 2.

Firstly, healthy living for all. From the starting point of health promotion, individuals should be held accountable for health. A health culture will be nurtured, health education strengthened, health literacy improved, campaigns on healthy living for all promoted, and household- and individual-based interventions and mentoring on healthy lifestyles increased. Self-disciplined healthy behaviors will be cultivated. Healthy lives based on well-balanced diets, physical exercise, smoking and alcohol control, and healthy mentality will be the result. Health education will be part of the national curriculum.

A national nutritional plan will be developed and implemented. Guidelines on sports and fitness exercises will be published, with a database of prescriptions for different population groups, different contexts and different physical requirements established to develop an innovative model of disease management and healthcare services, combining sports exercise with medical care.

Secondly, optimising healthcare services. Focusing on priority groups such as women, children, the elderly, the disabled and low-income groups, we will adopt both preventive and curative measures, promote equal provision of basic public health services, build integrated care delivery system, promote contract-based care provision by family doctors, innovate healthcare delivery mode, develop a coordinated system on NCDs prevention, control and management.

Thirdly, improving health security. Universal health insurance systems will be improved. Reforms of public hospitals, drug and medical device circulation systems and mechanisms will be pursued. National drug policy will be further developed. Disease burden will be reduced, and overall satisfaction improved. Linkages between various health insurance schemes will be strengthened and management of health insurance services will be reformed. Health insurance payment methods should also be reformed, and commercial insurance options developed to ensure sustainable health protection capacity.

Fourthly, building a healthy environment. In relation to environmental issues influencing health, prevention and management of air and water pollution will be strengthened. Comprehensive plans on discharge control of industrial pollution sources will be implemented. A comprehensive environmental and health monitoring, survey and risk assessment system will be built. Food and drug safety will be ensured. Production safety and occupational health will be improved. Road traffic safety will be enhanced. Injuries will be prevented and reduced. Patriotic public health campaigns will be deepened. Healthy cities, towns and villages will be built. Emergency management capacity will be improved. The health impact of external risk factors will be reduced to the greatest extent possible.

Fifthly, developing healthcare industry. The pluralistic structure of the medical industry will be optimised. Non-public hospitals will be encouraged to develop to a higher level and achieve economies of scale. Supply-side structural reforms will be strengthened. New types of health services, such as medical tourism and health management will be developed. The fitness, leisure and sports industry will be promoted. And the further development of the medical industry will be strengthened to meet the increasing health demands of the people.

To guarantee the realisation of these tasks, the Outline proposes six supportive measures, namely, institutional reform, human resource development, science and technology innovation, information services, legislation, and international exchange and cooperation. Health will be put in all policies. All-round healthcare reforms shall be deepened. Health financing mechanisms will be improved. Talent training and science and technology innovation will be strengthened. Information services will be developed. A health impact assessment system will be established, to make comprehensive assessments of the health impact of all socio-economic plans and policies, as well as major projects. Monitoring and supervision mechanisms will be improved.

Establishing and maintaining partnerships

'Contribute and share' is the basic method to building a healthy China. Supply-side and demand-side reforms integrating individual, institutional and social factors will provide momentum to maintain and protect people's health, so as to achieve 'health in all, health by all, health for all'. Firstly, there will be an emphasis on encouraging social participation. Cross-sector cooperation will be strengthened. Motivating initiative and the creativity of social forces will enable China to protect the

environment, ensure food and drug safety, prevent and reduce harm, control health risks and environmental hazards, and form a social co-regulation system encompassing multiple levels and multiple stakeholders.

Secondly, to drive supply-side reforms, sectors such as health, family planning and sports will deepen institutional reform in optimising health resource allocation and service delivery, developing underdeveloped areas, upgrading the healthcare industry, and meeting increasing healthcare needs. Thirdly, individuals will be held accountable for their own health. Health literacy will be improved. Self-motivated and self-disciplined living habits need to be explored by citizens based on their own needs, so as to control factors affecting their health, and create a social environment for nurturing, pursuing and supporting good health. Meanwhile, trade unions, communist youth leagues, women's federations, federations of the disabled, and representatives of other social organisations, non-communist parties and persons without party affiliation will be supported to play their roles. Social consensus will be reached and joint taskforces formed wherever possible.

With regard to financing mechanisms, multiple-sourced financing mechanisms will be established. Public financing for primary healthcare services will be ensured, and public input in health will be increased. The share of financing responsibilities between the central and local governments will be clarified. Economically underdeveloped areas will be favored in the transfer payment plans of the central government. Meanwhile, supportive measures will be developed, to motivate social organisations and enterprises. Products and services of financial institutions will be innovated. Charity, including social and personal donations as well as mutual assistance, will be encouraged.

Box 1. Member institutions of the current Patriotic Health Movement Committee

National Health and Family Planning Commission
National Development and Reform Commission
Ministry of Housing and Urban-Rural Development
Ministry of Agriculture
Ministry of Environmental Protection
The Propaganda Department
Ministry of Education
Ministry of Public Security
Ministry of Civil Affairs
Ministry of Finance
Ministry of Human Resource and Social Security
Ministry of Transport
National Tourism Administration
Ministry of Water Resources
Ministry of Commerce
State Administration of Press, Publication, Radio, Film and Television
General Administration of Sport
Food and Drug Administration
State Administration of Traditional Chinese Medicine
All-China Federation of Trade Unions, Communist Youth Leagues, All-China Women's Federations

With regard to supervision, comprehensive supervision and inspection mechanisms will be promoted and systems established, combining public regulation, industry self-discipline and social monitoring. On one hand, the function of government will be reformed further with health legislation developed. In the health sector, decentralisation and reduction of administrative interference, power delegation and regulation, and optimisation of public services will be further promoted. The approval policy of drugs and health institutions will be reformed. Public affairs and information will be disclosed. The system of health standards, protocols and guidelines will be further developed. Supervision of health, family planning, sports, food and drugs will be innovated. On the other hand, self-discipline and credit systems will be developed. The development of industry associations will be encouraged so that social forces will play a role in supervision. Fair competition will be promoted.

Based on the patriotic health movement committee, the Outline requires coordination of all efforts in developing Healthy China. At the moment, some provinces, such as Zhejiang, Shanghai, and Shandong have proposed to establish steering groups or health management committees led by the government to coordinate all the tasks.

Governance, reporting and monitoring

Governance

Reviewed and passed by the Political Bureau of the CPC, and issued by the CPC Central Committee and State Council, the Outline has a strong administrative power. Promoting development of the Healthy China is a systematic engineering project requiring an integrated approach and cross-sector and ministerial efforts. Currently implementation mechanisms at the national level are being studied and explored. These mechanisms will be applied in instructing work by different sectors and provinces, and in reviewing major programs, policies, projects, issues and work arrangements. Local governments, ministries and agencies will put Healthy China on the top of the policy agenda, and improve leadership and working mechanisms. Healthy China will be incorporated into local economic and social development plans, and key health indicators used for merit assessment of all Party committees and government departments. Assessment and accountability will be improved to ensure actual implementation of relevant tasks and missions.

Reporting, monitoring and evaluation

The implementation of the Outline will cover 15 years. In order to define details of targets and tasks, and make the implementation process operational, measurable, and accountable, the Outline defines 13 core indicators on 5 dimensions (see Table 1), namely: overall health status, health determinants, health services and protection, health industry and institutional arrangements. Meanwhile, it requires that the Five-Year Plan for Health and Family Planning and other policy documents will be formulated and implemented to provide the Outline with more details on major programs, key projects and policies for each stage, so as to ensure implementation of the Outline.

In actual implementation, the Outline requires the establishment of regular and standardised supervision and assessment mechanisms, as well as monitoring and evaluation mechanisms. Based on core indicators, working indicators and key tasks, detailed task distribution among main departments or agencies and monitoring and evaluation strategies will be developed, and an annual evaluation of progress and mid-review and final evaluation conducted. Assessment and accountability mechanisms will be established to ensure implementation. At the same time, good local practices and effective experiences will be summarised in a timely way, and actively scaled up during implementation.

Table 1. Core indicators

Domain	Indicators	2015	2020	2030
Health status	Life expectancy (years)	76.34	77.3	79.0
	Infant mortality (%)	8.1	7.5	5.0
	Under-five mortality (%)	10.7	9.5	6.0
	Maternal mortality (1/100,000)	20.1	18.0	12.0
	People meeting the fitness standards defined in the National Physical Fitness Standards (%)	89.6 (2014)	90.6	92.2
Healthy living	Health literacy (%)	10	20	30
	Frequent physical exercises (100 million)	3.6 (2014)	4.35	5.3
Health service and protection	Premature death rate from major chronic diseases (%)	19.1 (2013)	10% lower than 2015	30% lower than 2015
	Practicing or assistant physicians per 1,000	2.2	2.5	3.0
	Out-of-pocket payment as a share of total health expenditures (%)	29.3	Around 28	Around 25
Healthy environment	Percentage of days with good air quality in cities at prefecture or above level (%)	76.7	>80	Continuous improvement
	Percentage of surface waters at or above level III	66	>70	Continuous improvement
Healthcare industry	Total size of healthcare industry (trillion Yuan)	--	>8	16

Outcomes

Based on the requirements and instructions of the Outline, key reform and development plans for the health sector were issued, including the 13th Five-Year Plan for Health and Medical Care and the 13th Five-Year Plan for Healthcare Reform. All ministries and departments have strengthened cooperation, and conducted research on practical, operational policies, to fulfill their responsibilities. Sub-national conferences on health and medical care have been held, and provincial (prefecture, city) health plans made. These plans take population health as a key target of socio-economic policies, and aim to meet requirements set in the Outline.

As stated in the Outline, “Building healthy cities, towns and villages is an important project for Healthy China”. Based on local health needs, plans for healthy cities, towns and villages will be developed and implemented. Healthy communities, healthy enterprises and healthy households will be launched. Health will be included in urban and rural planning, construction and management processes, and urban development and residents’ health will be improved in a coordinated manner.

Challenges

Having had a good start with building a Healthy China, the Outline calls for the development of key mechanisms, especially national health impact assessment mechanisms. Legislation on health impact assessment will be needed, defining legal status, functions, implementers, targets, and the work scope of the mechanism. Guidelines and toolkits to assist the implementation of health impact assessments will be developed.

Box 2. Gansu Province example

Gansu Province has achieved good outcomes in putting Health in All Policies, and reforming health promotion models.

Firstly, health promotion has been adopted as a development goal for governments at all levels, facilitating multiple-sector cooperation. Gansu Province required officials at all levels to develop a 'one health' view, and include health promotion in their local development strategy. Health authorities have actively strengthened cooperation with other government agencies to maximise commonalities and join efforts, so as to coordinate goals and tasks of different sectors to improve population health. Steering committees led by top leaders of counties have been established to put reforms on health promotion models on the local policy agenda, and develop implementation plans. County governments have taken the lead in optimising all sorts of health-related resources in different sectors, and raised good resources to implement evidence-based interventions on major diseases and key health factors influencing the health of local rural and urban populations.

Secondly, institutional arrangements for putting Health in All Policies have been developed. Gansu Province has required 'population health impact' and 'health improvement' as two major outcome indicators in developing public policies and managing public affairs, to maximally control factors which have a negative impact on public health. Environmental impact assessments of key projects and major infrastructure development programs are required to consider the health impact. Governments at various levels need to review health contents with health authorities when reviewing the legality of regulations, guidelines and key public decisions. When examining and recording regulations and guidelines, the governments need to include health issues as key subjects for review. Timely rectification should be made to contents harmful for population health. Health impact assessment should be included in outcome evaluations of all policies. Review mechanisms will be developed gradually and scaled up after pilot work.

Thirdly, the healthcare delivery mode has been transformed. Under the leadership of county health authorities, relatively fixed working groups have been established to actively provide physical checks for local residents on a long-term basis. In so doing, healthy population, sub-healthy population, people with NCDs, geriatric diseases and other diseases will be identified, and their health information will be recorded in the digital health records. Health mentors and differentiated health and medical care will be based on the information. At the village or community level, health management teams are being established, led by officials at the township (street) level who are in charge of the village (community), and also including village (community) officials and family planning officials, village doctors (general practitioners in communities), team (block or courtyard) leaders, and personnel with skills of traditional Chinese medicine. Based on the results of physical checkups and recommendations of the medical team, patients will be referred to relevant health facilities to receive outpatient or inpatient care, and personalised health mentor plans will be made. Health management teams will identify key health factors concerning living environments and the quality of drinking water, and report to relevant government agencies for solutions.

Conclusion

Approved by the CPC Central Committee and State Council, Building a Healthy China is a major blueprint for improving health. The Outline defines the strategic goal of moving health up on the development agenda. The 'one health' approach calls for coordinating efforts, including those of various government ministries and departments, sectors, society and individual actors. We should incorporate Health in All Policies, and address complex social determinants of health, strengthen health interventions for priority groups, facilitate the formation of healthy living, ecosystem, and socio-economic development models, and sustain all-round and lifelong health improvement for all the people. A healthy China will have a practical and far-reaching impact on achieving an all-round moderately prosperous society and the modernisation of socialist society. It is a major means for China - a developing country with a large population - to participate in global health governance and meet targets set in the 2030 Agenda for Sustainable Development.

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Health in All Policies

Government Policy of Prevention in Health: A HiAP Approach in Quebec, Canada

Authors

Louise St-Pierre[A], J Simard[B], M-R Sénéchal[B], A-C Voisine[B]

[A]A National Public Health Institute of Quebec, Canada

[B]Ministry of Health and Social Services, Quebec, Canada

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Introduction

In 2016, the Government of Quebec launched its Government Policy of Prevention in Health[1], a policy that mobilises a range of partners to further enhance the population's health, with a view to ensuring health equity. Like Australia, Canada is a federation in which each province and territory is responsible for organising its own healthcare system. With a population of eight million, Quebec is the second most populated province of Canada, and is well known for its social policies. The Government Policy of Prevention in Health is a first for the province, but also for Canada. It is supported by the highest government authorities in Quebec, the Council of Ministers, and is placed under the leadership of the Minister for Rehabilitation, Youth Protection, Public Health and Healthy Living (part of the Ministry of Health and Social Services). Conceived as a whole-of-government approach to health, it urges 15 ministries and government agencies specialising in different fields of intervention to work together to achieve the goals of population health. The Policy is structured around 28 measures (ministerial commitments) and five areas of research jointly identified with the ministerial partners. The Policy comes with an initial budget of CAN$200 million for the deployment of activities over the next ten years.

The adoption of this government policy is a logical follow-up to developments over recent decades in Quebec relating to action on the social determinants of health. As early as 1992, the Ministère de la Santé et des Services Sociaux (Quebec Ministry of Health and Social Services, MSSS) adopted its Policy on Health and Well-Being, proposing a comprehensive vision of health and its determinants based on "an equal sharing of responsibilities among individuals, families, living environments, public authorities and all sectors of community life" (trans.).[2] These developments paved the way for the modernisation of the Quebec Public Health Act in 2001 which, in addition to the usual protection measures provided for in this type of law, included legal levers for prevention and health promotion. The most innovative section of this Act is that requiring all government sectors to ensure that their laws and regulations do not cause any negative impact on the population's health.[3] The strategy adopted by the MSSS to foster this requirement is one of supporting and assisting the other sectors and reaching a win-win situation.

Since 2003, the National Public Health Program has focused on intersectoral action strategies and the development of healthy public policies by recognising the legitimacy for public health actors to operate outside the traditional boundaries of their sector in order to establish partnerships for health. More recently, the Government Action Plan to Promote Healthy Lifestyles (2006—2012)[4], involving several ministries, civil society actors and a private foundation, aiming to create supportive environments for healthy behaviour throughout the province, gave rise to a formidable mobilisation of actors on the ground in favour of prevention in health, a mobilisation that remains vibrant and connected to the current political commitment to prevention. It is on this historical basis that the recent Government Policy of Prevention in Health, more inclusive and more ambitious than previous policies in this area, was launched in 2016.

As in many other jurisdictions around the world, the Policy also responds to the need to reduce financial pressures on the healthcare system, which, in Quebec, takes up nearly 45% of state budgets. The rapid ageing of the population and the persistence of chronic diseases are important issues in this regard. Lastly, it also responds to a generalised concern on the part of the public administration for greater coherence across government and the recognition of the relevance of a whole-of-government approach when it comes to acting on the complex issues faced by the government as a whole. Thus, the Policy is based on other approaches adopted elsewhere in the world. It is in line with an international trend, fuelled by the work of the World Health Organization, which advocates integrating health into all policies, to foster whole-of-government collaboration.

Following the adoption of the Policy in October 2016, an interministerial Action Plan is being developed for its implementation. This Plan, which will specify the methods of implementing the Policy measures, is being developed using the same co-benefits approach used during the development of the Policy. These two quite recent initiatives (Policy and Action Plan) are presented below.

Vision, aims, objectives

The Policy puts forward a uniting and mobilising vision to guide the current and future actions of prevention in health to be taken by partners both within the government and outside of it. In this sense, its long-term aim can be considered to be a whole-of-society approach. Supported by this vision of a healthy Quebec, the Policy intends, on the one hand, to act on a range of factors and determinants to improve Quebecers' health and quality of life and, on the other hand, to reduce the social inequalities that influence health. It is structured around the following elements:

A broad vision

A healthy Québec population, where everyone has the ability and conditions necessary to achieve their full potential and participate in the sustainable development of society. A forward-looking prevention policy that inspires and mobilises a range of partners to promote good health for everyone.

An overarching goal

Influence a range of factors to improve Quebecers' health and quality of life and reduce health inequalities.

Cross-cutting issues

- Sociodemographic changes, including the challenges caused by an ageing population, immigration, and new family situations
- Poverty and health inequalities, particularly among Aboriginal populations and socio-economically disadvantaged communities.

Guiding principles

- Consideration of the inextricable nature of the environmental, social and economic dimensions of sustainable development principles
- Effective measures that have an impact on people, communities, and environments
- Actions adapted to the circumstances and needs of various population groups
- Prevention partners that work consistently and in synergy within the government and with stakeholders in various sectors of activity.

With specific targets relating to social determinants of health
By 2025:

1. Increase to 80% the proportion of children who start school without being at-risk for a developmental delay.
2. Ensure that 90% of municipalities with populations of 1,000 or more people adopt measures to develop communities that foster sustainable mobility, safety, healthy living, and a good quality of life for their residents.
3. Increase affordable, social and community housing by 49%.
4. Lower the number of daily and occasional smokers to 10% of the population.
5. Achieve a high level of emotional and psychosocial well-being among at least 80% of the population.
6. Increase the percentage of seniors receiving homecare services by 18%.
7. Achieve a minimum consumption of five fruits and vegetables per day, by at least half of the population.
8. Increase by 20% the percentage of young people aged 12 to 17 who are active during their leisure activities and choose active modes of transportation.

9. Reduce by 10% the gap in premature mortality between the lowest and highest socio-economic groups. (Premature mortality refers to death at a relatively young age.)

The Policy presents the specific contribution of 15 ministries and government agencies, outlining the decisions to be made in their sectors that will influence one or more of these major health determinants. Several departmental commitments (policy measures) are related to the Sustainable Development Goals promoted by the United Nations and endorsed by the World Health Organization such as "fostering healthier cities through urban planning", "broaden the introduction of working conditions conductive to good health", "promote access to public buildings offering clean and healthy surroundings close to where people live" or "reducing risks with antimicrobial resistance" to name just a few among the 28 policy measures. Furthermore, concern for vulnerable populations is a cross-cutting issue that must be taken into account during the development of the action plan through impact analysis.

The resulting interministerial Action Plan will set out the roles and responsibilities of each party, as well as the implementation schedule, factors of success and evaluation measures.

Governance, reporting and monitoring

Governance of the Policy essentially takes place at the central level of government. It is viewed as a response to long-term criticisms by local authorities demanding greater coherence between the two levels of government with regard to intersectoral action for health. However, given that most of the measures stated in the Policy will be deployed on the ground (e.g. those regarding social housing, child care or healthy eating), strong ties must be developed between the central level and local level, integrating the mechanisms for territorial intersectoral collaboration.

The Policy was first spearheaded by the MSSS, with the support of several other government sectors. It was soon adopted by the new Minister when taking up her duties. Indeed, she made it a priority, launching the Policy in fall 2016 accompanied by several other government ministers, with a commitment to producing an interministerial action plan by October 2017. The Policy thus has the benefit of a firm political anchor. The leadership assumed by the health sector within the government has been central to the Policy's development and its position vis-à-vis the higher administrative and political authorities. This leadership is exercised at various levels. First, with regard to knowledge, through scientific credibility and awareness-raising regarding the social determinants of health; second, at the administrative level, by using existing legal and organisational levers within the government to foster interministerial and intersectoral collaboration; and lastly, at the political level, to some extent, by maintaining a strong and facilitating relationship with the Minister regarding her influential role with other ministers.

The Policy also announces the establishment of a monitoring and reporting strategy. This strategy is currently under development and is expected to be flexible and user-friendly to avoid weighing down the pre-existing administrative processes, one of the most frequently-criticised burdens related to horizontal management.[7,8] Tools adapted to shared accountability are being jointly developed by the parties to keep the government and ministerial authorities informed on a regular basis regarding the extent to which the objectives have been met. In addition to the implementation follow-up, the strategy will include indicators relating to intersectoral governance.

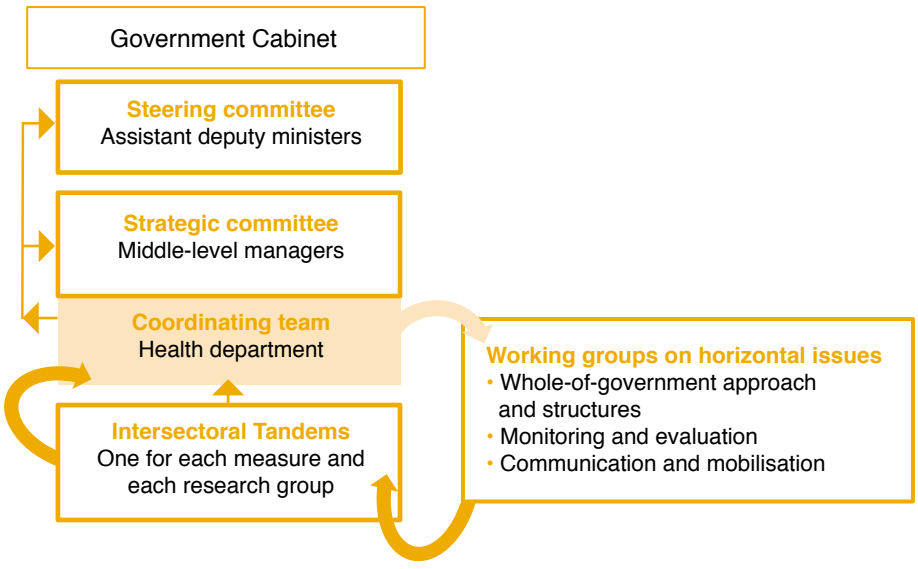
Mechanisms and processes

Although the Policy announced in fall 2016 involves a ten-year time horizon, the first action plan, expected for fall 2017, will cover a first four-year phase. Over the course of this year, substantial work will thus be accomplished by all the government departments involved, defining the actions to be undertaken over the coming years related to the commitments announced in the Policy. The organisational structure established to support the joint development of the action plan facilitates the actualisation of the two strategies inherent in the HiAP approach, namely, the systematic consideration of health in the decision-making processes of other sectors, and the search for synergy between sectors.[9] For each of the 28 measures and five research areas, a small working group (called a tandem) has been set up, bringing together actors from both the health sector and the sector responsible for the measure and its partners. This is a unique opportunity for the participating health actors to make the links between the various actions planned in each sector and the population's health. The work of the tandems is then discussed within the interdepartmental strategic committee composed of middle-level managers, and approved by a steering committee made of the assistant deputy ministers of the 15 sectors involved. These two interdepartmental committees, where managers of the 15 ministries and government agencies sit around the same table, are forums conducive to creating an integrated and common vision of the action plan and developing synergies between the sectors. Coordination and communication between these collaboration mechanisms are then facilitated by a small team at the MSSS (see Figure 1).

In addition to these interministerial collaboration structures, four working groups focusing on cross-cutting functions related to intersectoral governance are helping to prepare the Policy's implementation. These groups are: *approach to and mechanisms for horizontal management; funding, budget and accountability; monitoring and evaluation, and communication and mobilisation.* These groups will put forward orientations in their areas of expertise relating to the conditions of success for intersectoral governance.

Tandem members, responsible at their level for specifying the actions to be undertaken for their respective measures, have a demanding task before them. They must clarify the specific actions, schedule, budget, and risks and opportunities, and ensure that the cross-cutting concerns are integrated into all government decisions based on existing administrative obligations. Among these concerns are impacts on poverty, principles of sustainable development and gender-differentiated impacts.

Figure 1. Organisational structure for the Government Policy of Prevention in Health Action Plan



Establishing and maintaining partnership

It is important to mention that the deliberations leading to the 2016 Policy began in 2010, when the MSSS' public health sector held consultations with government partners entrusted with complementary missions. This Herculean task was then undertaken in 2013, encouraged by a clearly favourable political will. This phase mobilised more than a hundred representatives from a dozen ministries and agencies and well-known external experts. Their work led to the first Policy draft, taking account of evidence-based data on policy measures favourable to health and the context of government intervention (public policies already underway). However, this Policy statement could not be adopted before the election call and the change of government. Nevertheless, this background work, piloted by the health sector and respecting the legitimacy of all the participants in a spirit of mutual gains, helped establish a climate conducive to partnership. The satisfaction expressed by the different government sectors participating in the deliberations of 2013 facilitated the agreement to resume the deliberations in 2015. The strategy of supporting the other sectors adopted by the health sector over the last decade appears to have led to results in terms of partnership. However, this position requires that health actors make compromises along the way regarding the choices made by the other sectors and the rate at which the desired changes will take effect. One of the main contributions to this was the paradigm shift in the approach of the public health sector, going from a more prescriptive approach to a more win-win approach. In this respect, international developments in the HiAP approach and its related philosophy advocating the quest for mutual gains have strengthened Quebec's strategy.

Challenges and opportunities

The gains obtained to date (support from political leaders and ministerial partners) have enabled the parties to agree on the major Policy parameters. However, many challenges remain on the threshold of the Policy's implementation, the most important being:

- the difficulty of reconciling the logic of vertical management with that of horizontal management
- maintaining the political commitment over the long term
- the capacity to grasp the complexities (number of determinants targeted, number of actors, diversity of interests) and navigate and adjust to an ever-changing context
- the integration into or interface with other major intersectoral (or governmental) policies which also have impacts on the health determinants
- and more prosaically, the availability of the minimum (human and financial) resources required to ensure coordination and monitoring of the Policy as well as ongoing support for it.

The financial incentive (new money) is a vital impetus for sectors less open to becoming involved. However, while this is attractive to other sectors, it also constitutes a management issue for the health sector. It has to maintain strong leadership and coordination capacity while promoting ownership of the policy by other sectors. One of the ongoing challenges is to ensure that this policy is truly viewed as a joint policy and not as a policy from the health sector.

The lessons learned to date have led us to agree on the following three messages:

Message 1: This type of policy requires a long gestation period. The health sector must show determination and a strategic ability to grasp the opportunities and demonstrate the added value for the whole government of considering health in government decisions. The Quebec project involving the Government Policy of Prevention in Health has experienced progress and setbacks relating to changes in the parties in power and

individuals in positions of authority over the last seven years. However, each attempt has helped to develop a better understanding and skills within the health sector and the whole government.

Message 2: It is important that ambassadors outside the government have the ear of those at the political level. Efforts made within the public administration, such as the leadership exercised by the health sector, the awareness-raising conducted among other sectors and the inclusion of the project in the administrative priorities have paved the way for a more inclusive governance of health concerns. However, given the constraints of managing emergencies in each of the sectors and the difficulties related to horizontal management, an impetus from the political sphere is essential. Moreover, this impetus is most often the result of pressure from citizens, organised groups, individuals with positive and credible repute, and the media. In Quebec, this external pressure has been a determining factor in the political commitment. Ensuring links between the three pillars of an intersectoral policy – the political sphere, the bureaucratic sphere, and civil society – is a winning strategy worth supporting.

Message 3: The expectations of the health sector must be in tune with the capacity of the environment to absorb the changes in organisational and management culture recommended by a HiAP approach. In the case of the Quebec Government Policy of Prevention in Health, several ministries are involved. However, not all ministries show the same level of ownership of the objectives, with some having more distant interests than those driven by the health sector. The sectors' level of commitment can be diverse and it is important to allow the time and space needed for each to progress on its own path. The process is as important as the results.

Reflections and conclusion

The Quebec Government Policy of Prevention in Health is consistent with international recommendations in the area of population health. That is, the Policy helps government take action before health problems emerge by aiming at the social determinants of health; it carries a comprehensive and integrated vision of health issues, including recognition of their inextricable links with sustainable development; it is a cross-departmental policy and is inclusive; and it is supported by the highest government authorities. In addition, its implementation is based on best practices in intersectoral governance for health, such as exercising strong leadership from the health sector, establishing intersectoral collaboration structures, including a team dedicated to coordination, ensuring concern for adapted and shared accountability, and supporting a change in culture.[12]

However, this will not be an easy task. The challenges are manifold. Most of these challenges are known, being common to any horizontal management initiative. When such an initiative involves a topic with distant impacts, such as prevention in health, it is inevitably on the margin of government priorities, thus increasing the challenge of sustainability. Other, currently unsuspected challenges will certainly arise along the way. With regard to intersectoral governance for health, there is no single magical solution. The presence of a team dedicated to coordinating the project, with strategic abilities and able to recognise opportunities and pull the right strings and, especially, capable of determination, foresight and patience will undoubtedly be a major asset.

Key contact/s and further information

Sylvie Poirier, Deputy Director General ,
Public Health Directorate, Ministry of Health and Social Services
Email: Sylvie.poirier@ssss.gouv.qc.ca

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Health in All Policies

Legislating for sustainable development and embedding a Health in All Policies approach in Wales

Authors

Cathy Weatherup[A], Sumina Azam[A], Irfon Rees[B], Michael Palmer[C], Cathy Madge[C], Richard Lewis[A], Mark Bellis[A] and Andrew Charles[B]

[A]Public Health Wales

[B]Public Health Division, Welsh Government, Wales

[C]Office of the Future Generations Commissioner, Wales

8

Introduction

Wales, with a population of just over 3 million (Figure 1), is one of the four nations that make up the United Kingdom (UK).

The Welsh Government has 'devolved responsibility' with law making powers for certain policy areas: health, education, economic development, transport, agriculture, housing, planning and the environment. Other responsibilities, such as defence, welfare, and criminal justice, remain 'reserved powers' within the scope of the UK Government.

Sustainable development at the heart of devolution

In 1998, Wales became one of the first nations in the world to have a legal requirement in relation to sustainable development. Since devolution, Wales has developed successive schemes to promote sustainable development at a national and local level (Figure 2).

In 2011, the Welsh Government became increasingly aware of the need to tackle and respond to the changing demands of globalisation, climate change and new technologies. There was recognition that traditional models and levels of service would not be possible in future, along with a need to empower and develop a new relationship with communities. More specifically, public health challenges such as an increase in chronic diseases, an ageing population, health inequalities, and damaging health behaviours such as smoking and obesity required a more sustainable solution with the complex pattern of health determinants being addressed. In recognition of these trends, the Welsh Government pledged to make sustainable

Figure 1. Wales

Population:
3,074,067

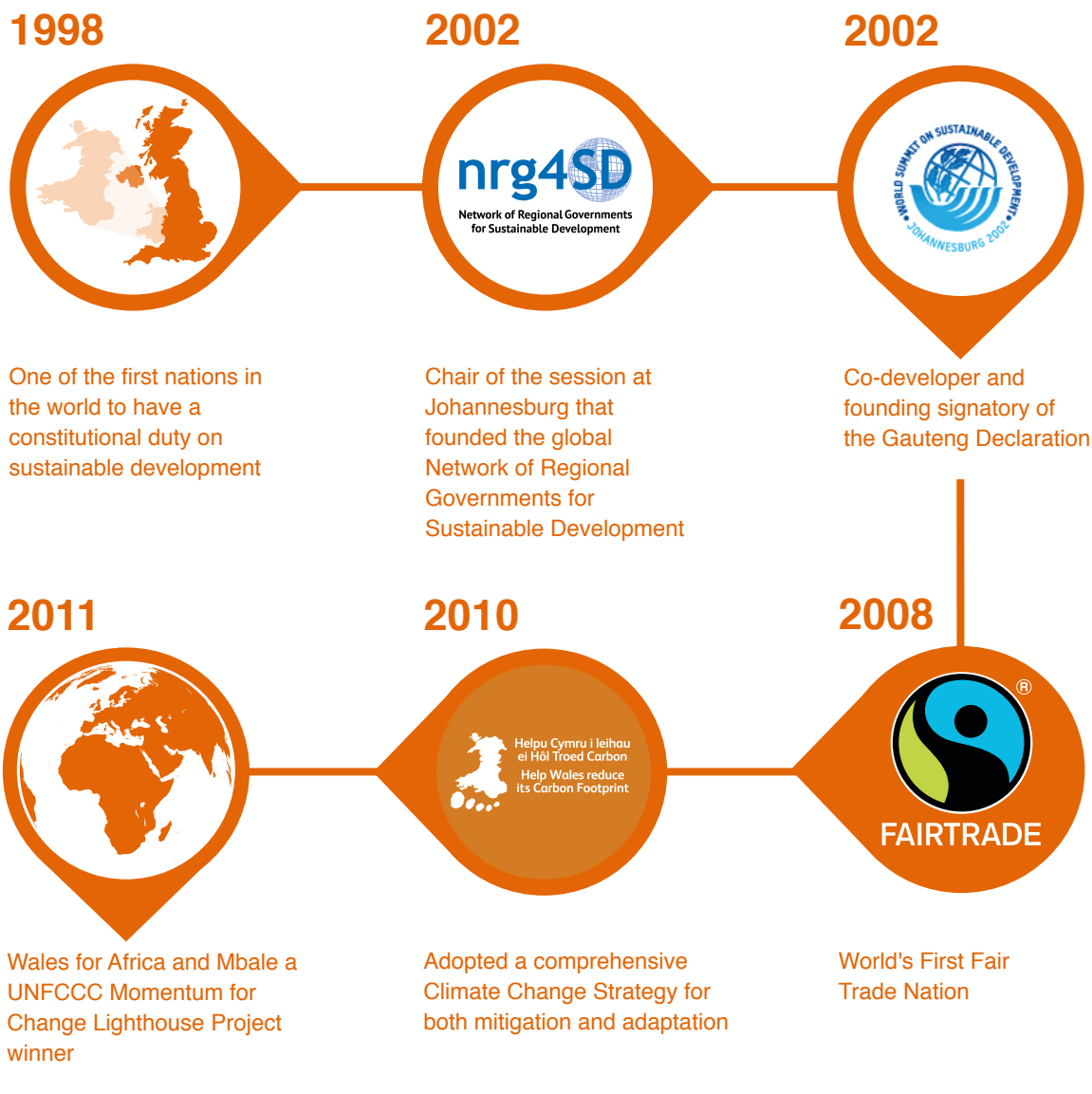
Area:
20,782 sq kms

Capital city:
Cardiff

Official languages:
Welsh, English

Source: www.wales.com

Figure 2. Steps to making Sustainable Development a core business in Wales



development the 'central organising principle of the public service'. This recognised health and well-being as being important prerequisites for the achievement of economic growth, reducing poverty, supporting social capital and improving labour productivity and coincided with the Minister for Environment and Sustainable Development attending the United Nations Rio+20 Conference, and launch of the United Nations Sustainable Development Goals (SDGs) development process.[1] With Ministerial support, Wales dedicated policy and legal resources towards developing legislative proposals in parallel to this emerging international agenda, including mirroring the United Nations conversation on 'The World We Want'[2] with the Welsh public – 'The Wales We Want' (Box 1).

The 'Wales We Want National Conversation' involved over 7,000 people and all major stakeholders. The results fed into the consultation and legislative scrutiny process where stakeholders had an opportunity to influence policy changes such as the addition of

Box 1. A national conversation about the future

"No society has the money to buy, at market prices, what it takes to raise children, make a neighbourhood safe, care for the elderly, make democracy work or address systemic injustices. The only way the world is going to address social problems is by enlisting the very people who are now classified as 'clients' and 'consumers' and converting them into coworkers, partners and rebuilders of the core economy."

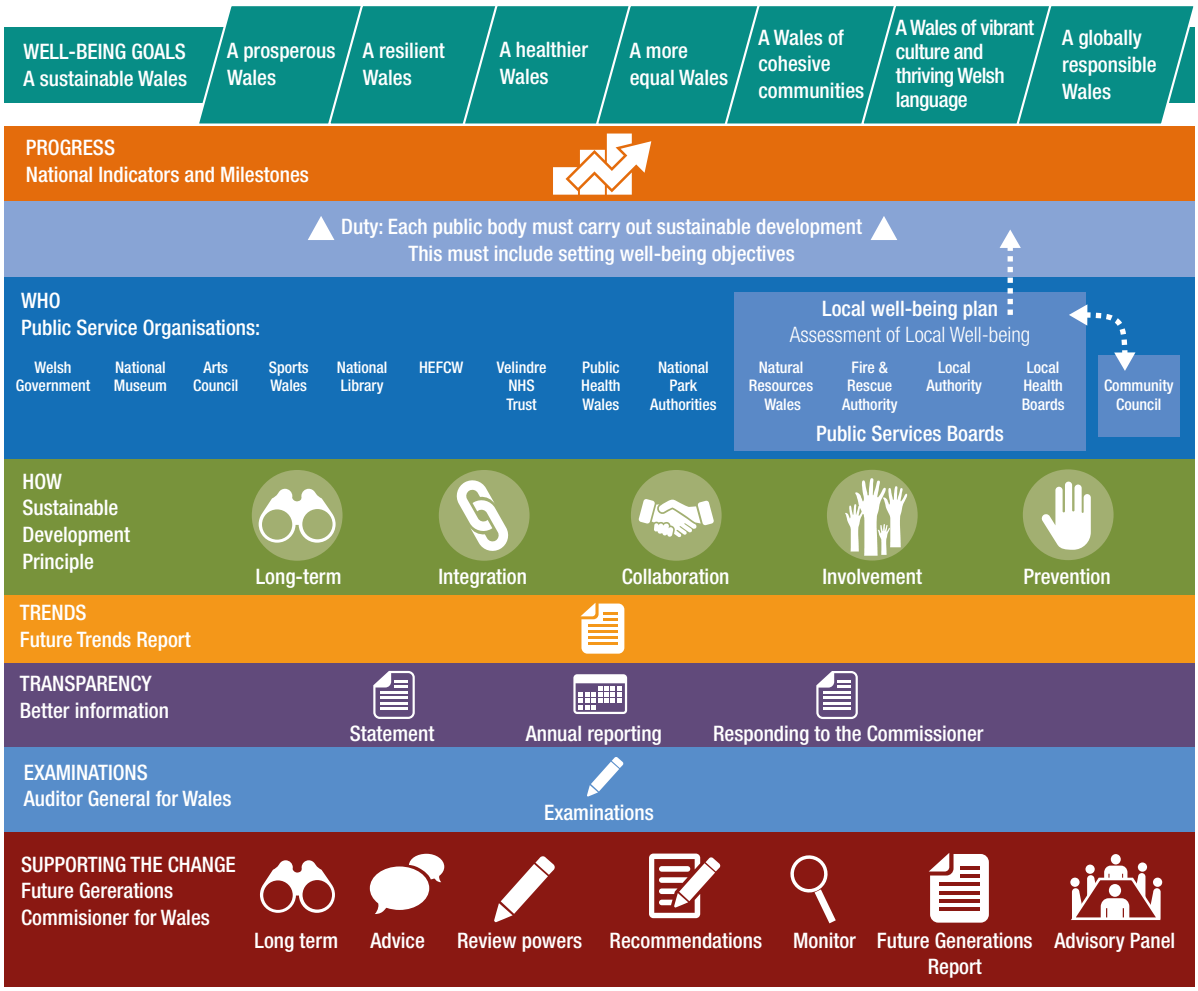
Edgar Cahn

a fourth 'cultural' pillar, alongside the economic, social and environmental pillars of well-being, and a name change from the 'Sustainable Development Bill' to 'The Well-being of Future Generations (Wales) Act'.[3] In publishing the Act and related guidance in 2015[4], Wales set out the step change required for public services to tackle the most complex health and societal problems and to mobilise civil society to serve and sustain future generations. It was envisaged that the legislation would provide organisations with a mandate for collective action, and consistency in how sustainable development would be embedded, whilst refraining from being prescriptive to allow for local discretion. Wales also became one of the first nations in the world to establish a legislative link to the international SDGs.

Vision for the Well-being of Future Generations (Wales) Act 2015

Legislation is arguably one of the most powerful tools available to Government to direct long-term policy goals, influence change and enable action for the benefit of whole populations. Factors attributed to the successful development and now, enactment of The Well-being of Future Generations (Wales) Act 2015 include: clear aims which all sectors can understand and sign up to; an attempt to strengthen governance for the long term; to provide greater transparency in how decisions are made across the public service; to create the potential for sharing evidence and learning from best practice; and to encourage a culture and understanding of collective responsibility and better alignment of action towards a common set of outcomes.

Figure 3. The Architecture of the Well-being of Future Generations Act



Mechanisms and Processes

The Act provides an enabling framework to support public bodies to work differently, as summarised in Figure 3.

From April 2016, all public bodies in Wales are working towards a legally binding common purpose, set out in Section 4 of the Act as seven statutory well-being goals (Figure 4).

As well as working to achieve the well-being goals, public bodies must use the sustainable development principle (Figure 5) to shape what they do, how they do it and how it is communicated. These new ways of working are familiar to those whose role it is to advocate for population health.

Figure 4. Seven Well-being Goals for Wales

Goal	Description of the goal
A prosperous Wales	An innovative, productive and low carbon society which recognises the limits of the global environment and therefore uses resources efficiently and proportionately (including acting on climate change); and which develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities, allowing people to take advantage of the wealth generated through securing decent work.
A resilient Wales	A nation which maintains and enhances a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience and the capacity to adapt to change (for example climate change).
A healthier Wales	A society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood.
A more equal Wales	A society that enables people to fulfil their potential no matter what their background or circumstances (including their socio economic background and circumstances).
A Wales of cohesive communities	Attractive, viable, safe and well-connected communities.
A Wales of vibrant culture and thriving Welsh language	A society that promotes and protects culture, heritage and the Welsh language, and which encourages people to participate in the arts, and sports and recreation.
A globally responsible Wales	A nation which, when doing anything to improve the economic, social, environmental and cultural well-being of Wales, takes account of whether doing such a thing may make a positive contribution to global well-being.

Figure 5. Applying the Sustainable Development Principle: the 'five ways of working'

Box 2. Membership of Public Services Boards

Public Services Boards must include:

- The local authority
- The Local Health Board
- The Welsh Fire and Rescue Authority
- The Natural Resources body for Wales

In addition, each PSB must also invite Welsh ministers, the chief constable, the police and crime commissioner, probation services and a voluntary sector representative body.

Establishing partnerships

Public bodies are required to set and work towards well-being objectives that maximise their contribution to achieving the well-being goals. The main statutory partners (Box 2) are required to work together, through newly established Public Services Boards (PSBs), to collectively assess and publish a report on well-being in their local area (a well-being assessment), which will inform the development of their local well-being plan.

Accountability

Monitoring and accountability structures are built into the legislation. An independent Future Generations Commissioner has been appointed to act as a guardian of the ability of future generations to meet their needs and to encourage public bodies to take greater account of the long-term impact of their actions. She has a role to monitor, advocate, challenge and review and public bodies must take all reasonable steps to follow her recommendations. The Commissioner is currently considering the best approach to prioritising her work.[5]

The Auditor General for Wales will seek evidence from public bodies, including the Welsh Government, to demonstrate how they have implemented the sustainable development principle (Figure 5) and is currently trialling innovative audit methods to do this.

Tracking Progress

Recognising the need to track progress in achieving the seven well-being goals, the Act puts in place a requirement to establish national indicators and milestones. In March 2016 the first statutory set of National Milestones were laid before the National Assembly for Wales, following public engagement. These cover a range of outcome measures to help tell the story of whether Wales is becoming more sustainable. These are population indicators, intended to measure progress in improving the long-term economic, social, cultural and environmental well-being of Wales.[6]

In September 2017 the first statutory Well-being of Wales report was published outlining progress against the seven well-being goals for Wales by reference to the 46 National Indicators for Wales. This work included mapping of the indicators to the 17 United Nations Sustainable Development Goals.

A Future Trends Report looks at the likely future well-being trends of Wales, in order to influence planning and priorities at a national and local level.[7]

Work is also starting on developing a set of national milestones for Wales as required by the Act.

Implementing the Act

Wales is now at the initial stages of implementing the Well-being of Future Generations Act. Three short examples give an illustration of the 'change' at a national, local and organisational-level.

1. Welsh Government

The Welsh Government is subject to specific duties under the Act - these cover duties that provide key building blocks for the implementation of the Act such as establishing guidance, national indicators, national milestones and future trends information, as well as the well-being duty it has as a public body.

In September 2016 the 'Taking Wales Forward' report was published, setting out Government's program to drive improvement in the Welsh economy and public services, delivering a Wales which is prosperous and secure, healthy and active, ambitious and learning, united and connected. In the context of the Act the program for government recognised the challenge of integration and the need to join-up better. The First Minister for Wales, Carwyn Jones said:

> *"The issues we face can only be tackled through new ways of working, including joined up programmes which reinforce and build on what people and communities are doing for themselves. Taking Wales Forward sets out how we will work across traditional boundaries to deliver our priorities. Four cross-cutting strategies will help us to maximise our impact in these uncertain times and deliver the promise of the Future Generations Act."*

In November 2016, the Welsh Government published its initial well-being objectives designed to contribute to the seven well-being goals, and committed to review and revise them as part of a different approach to joining up across Government; including the establishment of policy working groups focusing on themes and issues that span traditional departmental or ministerial portfolios. It also made a commitment to the development of a strategy on Healthy and Active, Prosperous and Secure, United and Connected, Ambitious and Learning, to guide all of Government's activity and support prioritisation; with an agreement to apply a Future Generations 'lens' to budget setting, business planning and policy development.

The Act provides a strategic framework for Government's Health in All Policies approach. Health Impact Assessments (HIAs) already take place across Wales and are considered an important way of ensuring health is considered across a range of activity. While a broad range of organisations have used HIAs, their use can be inconsistent and could be strengthened. Complementary to the Well-Being of Future Generations Act, The Public Health (Wales) Act[8], places a duty upon Welsh ministers to make regulations about the circumstances and ways in which public bodies must carry out a HIA. Using the same definition (comprising both physical and mental health), provisions in the Public Health (Wales) Act aim to realise the benefits of HIAs more widely, make a significant contribution to improving the health and well-being of the nation and its communities, and position Wales as a world leader in the application of public health policy and legislation.

2 Public Services Boards and local assessments of well-being – the challenge from the Future Generations Commissioner

The Act establishes Public Services Boards (PSBs) as mechanisms for collaboration between key public bodies and other partners at the local level (Box 2). The Future Generations Commissioner has provided robust and detailed feedback on draft Well-being Assessments, so that they provide a strong evidence base for public bodies to collaborate.

The Commissioner has published a report of the key themes, challenges, opportunities and learning from the Well-being Assessments. The report is called 'Well-being in Wales: planning today for a better tomorrow'.[5] It contains a number of recommendations for the public service in Wales focusing on key elements of the

Well-being of Future Generations Act, including:

- Ensuring that the ways Public Services Boards operate, best support the ethos of the legislation, facilitating the challenging of 'business as usual' and enabling new approaches and perspectives to be developed.
- Undertaking further work to provide a deeper understanding of people's lived experiences to understand how people experience and engage with services and what they want and need for the future.
- Building capacity, expertise and confidence to understand forecasting, future trends and the needs of future generations, including considering scenarios and trends which are less certain.
- 'Digging deeper into data' to better understand the causes and effects of key issues and trends, in relation to both community and individual well-being.
- Using evidence to identify and explore tensions between different policy issues and priorities, to enable an honest discussion about new approaches that need to be taken.
- Taking a more integrated approach to interpreting data across economic, social, environmental and cultural well-being, in order to better understand how different issues interconnect and what this means for well-being in particular localities.
- Developing mechanisms to gather and use qualitative place-based data and insights, particularly from the third and private sectors, and fully recognise the value it adds.

3 Public Health Wales – an organisational response

Public Health Wales, a public body with a national remit to protect and improve health and well-being and reduce health inequalities, recognises the unique opportunity presented by the Act. For the organisation, the Act reflects its commitment to Health in All Policies and finding sustainable solutions to some of Wales' complex and stubborn problems such as intergenerational poverty and health inequalities.

Public Health Wales, along with the Welsh Government and other public bodies, was required to publish its first well-being objectives and statement a year after the Act received assent. The well-being objectives were developed through applying a future generations 'lens' to identify areas that exemplified the sustainable development principle and where the organisation could maximise its contribution towards the well-being goals. Public Health Wales was mindful of the need to apply the 'five ways of working' (Figure 5) such as identifying objectives that support positive outcomes in the *long term, involving staff* from across the organisation, incorporating the views of stakeholders and identifying objectives that enable *preventative* action. The organisation will continue to collaborate with partners to develop a shared approach to achieving well-being objectives, building on and enhancing existing relationships and identifying areas for further integrated working.

The Act has already enabled the organisation to work differently, for example providing the framework for discussions both with the criminal justice sector and housing sector, leading to the agreement of Memoranda of Understanding and joint programs of work that focus on prevention and early intervention in a range of areas, including Early Years. Public Health Wales has published reports such as *Making a Difference: Investing in Sustainable Health and Well-being for the People of Wales*[9] and a series linking Adverse Childhood Experiences (traumatic experiences that occur before the age of 18) and health-harming and anti-social behaviours[10]; mental well-being[11]; and chronic diseases and health service use.[12] These resources can be used by public bodies and PSBs to identify evidence-based actions to help inform their response to the Act.

A baseline assessment of Public Health Wales' starting position in relation to the Act has been carried out, with the aim of understanding of the corporate, cultural and collaborative 'readiness' of the organisation. A key challenge identified through this process, as well as through staff engagement, has been the importance of

making the Act "real" for staff and enabling them to put the new ways of working into practice.

The well-being goal for 'a prosperous Wales' requires the transition to a low carbon society. Public Health Wales is playing its part in this vision, as a public body and employer, by implementing an environmental sustainability strategy to take forward actions to reduce the organisation's carbon footprint. Early work has included relocating around 500 staff from several smaller offices into one collaborative, social and learning-focused workplace, and delivering a 'marketplace' to provide staff with support and advice on their individual sustainability. Public Health Wales has received early recognition of their leadership in this area through the 2017 'NHS Sustainability Awards' which benchmark and reward action on creating a more sustainable National Health Service across the UK.

Embedding a Health in All Policies approach – challenges and opportunities

The 'Health in All Policies approach', as defined in the Helsinki Statement 2013[13], is embedded through the aspiration and the architecture of the legislation.

The Act provides a definition of health (physical and mental well-being) and places 'health' on par with other societal goals. 'Health' and 'equality' are both recognised as integral parts and prerequisites for sustainable development, as is echoed in the Shanghai Declaration[14], which positions health and healthy living as central to delivering on the Development Agenda 2030 and its SDGs.

The Act helps to articulate an understanding of the determinants of health, with good health not only a result of access to quality health care, but being based on socio-economic status, early intervention, prevention, enabling physical environments as well as individual genetics and behavioural choices, thus moving towards a position where health and equality are everybody's business.

The Act helps to facilitate a 'win win' strategy, creating a shared language and common purpose for intersectoral working at a national, regional and local level. It calls for an integrated approach to policy and service planning, thereby providing an opportunity to identify how and where 'health' supports other agendas and vice versa. The 'ways of working' (Figure 5) and the national indicators serve to underpin how a wide range of public services need to think and behave differently and act collectively to address complex, multi-faceted problems that require a joined-up response, involving key partners and local communities. The new accountability mechanisms place an emphasis on informed decision making that will lead to a positive contribution to the longer term outcomes of economic, cultural, environmental and social well-being of Wales.

Supporting implementation, the role of the Health & Sustainability Hub

The test of the legislation and its impact on 'business as usual' will need to be demonstrated and shared as quickly as possible in order to support and sustain the behavioural and cultural change that is intended.

The Health and Sustainability Hub has a unique role to drive this agenda and to support Public Health Wales, the NHS and the wider public service in:

- Raising awareness of the legislation
  By developing tailored, creative communications which will target different audiences whether from corporate functions, health services or in the executive team.
- Engaging on an individual level
  By producing a practical guide for staff to 'be the change'; demonstrating how they can contribute to sustainability on a personal level in their workplace.

Table 1. Timeline for Well Being of Future Generations Act

2015	
Well-being of Future Generations (Wales) Bill National Assembly for Wales agreed the Well-being of Future Generations (Wales) Bill.	17 March 2015
Royal Assent	29 April 2015
United Nations Sustainable Development Goals The 17 SDGs were adopted by the United Nations General Assembly.	25 September 2015
2016	
Future Generations Commissioner for Wales Future Generations Commissioner duties and functions commenced.	1 February 2016
Statutory guidance Publication of statutory guidance *Shared Purpose: Shared Future*.	24 February 2016
National Indicators Publication of first National Indicators to measure progress against the seven well-being goals.	16 March 2016
Well-being duties Well-being duties on public bodies and public services boards commenced.	1 April 2016
Public services boards established	1 April 2016
Role of Auditor General for Wales Auditor General's examination power and duty commenced.	1 April 2016
Public Services Boards First meeting of each public services board to occur no later than 60 days after the date on which the board is established.	By 31 May 2016
Well-being objectives (Welsh Ministers) Welsh Ministers' first well-being objectives must be set and published no later than 6 months after the National Assembly for Wales election.	By 5 November 2016
2017	
Well-being objectives (other public bodies) Public bodies' (other than the Welsh Ministers) first well-being objectives must be set and published no later than the beginning of the financial year following the commencement of section 9 of the Act, which was on 1 April 2016. Each public body is required to report on progress it has made in meeting its well-being objectives for the preceding financial year. Further detail on this can be found in the section on 'Annual Reporting' below.	By 1 April 2017
Future Trends Report The Welsh Ministers must publish the first report containing predictions of likely future trends on the social, economic, environmental and cultural well-being of Wales, and any related analytical data and information the Welsh Ministers consider appropriate.	By 5 May 2017
Public services boards – Assessment of local well-being Each public services board must prepare and publish their first assessment of local well-being. An assessment of local well-being must be published no later than a year before the publication of the local well-being plan.	By May 2017
2018	
Local well-being plans Each public services board must prepare and publish their first local well-being plan. A local well-being plan must be published no later than one year after the date of each ordinary election to the local authority.	By May 2018
Local well-being plans: role of community councils Those community and town councils to which section 40 of the Act applies must take all reasonable steps towards meeting the local objectives in the local well-being plan that has effect in their area.	From the date the first local well-being plan that has effect in their area is published
2020	
Future Generations Report First Future Generations Report must be prepared and published by the Future Generations Commissioner for Wales.	By May 2020
Auditor General for Wales Report First Auditor General's report to the National Assembly on examinations.	By May 2020

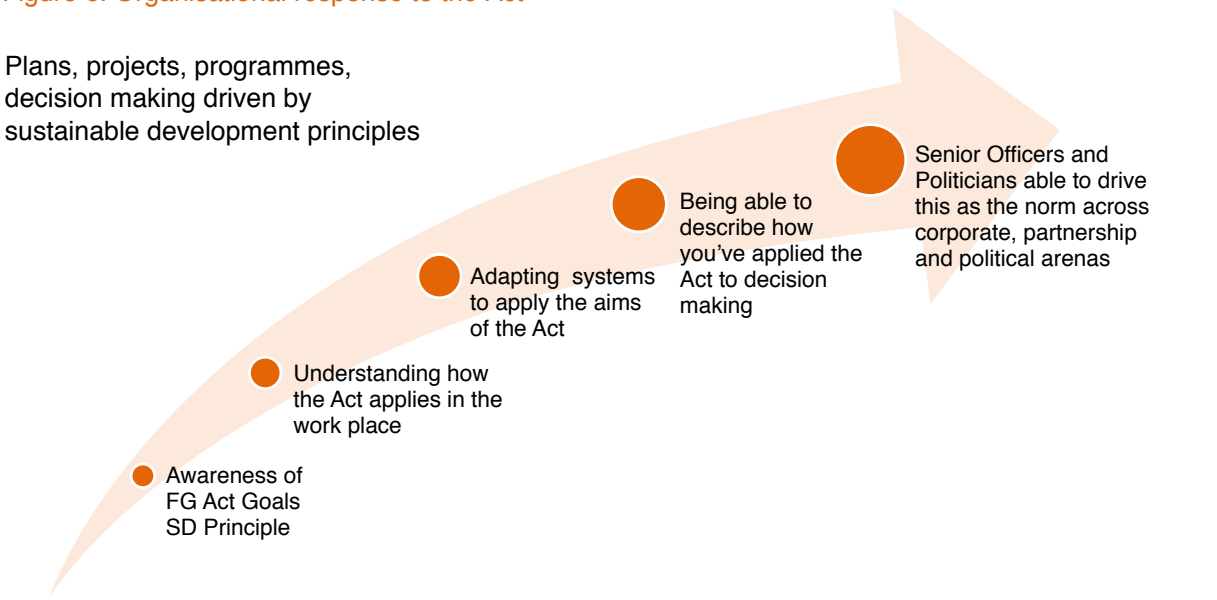
- Supporting Live Labs
  By drawing on the best evidence-based approaches to embedding the Sustainable Development principles. Utilising learning from Quality Improvement methods, organisational development and public service reform, the Hub will draw together these findings and develop an implementation framework or route map including key actions and enablers which will support and sustain system-wide sustainable development.
- Building capacity for systems-change
  By facilitating and supporting a network of public health professionals across Wales who are involved in the work of Public Services Boards (PSBs), including advocating and defining the leadership qualities needed to improve sustainable health and well-being.

Reflection

Wales has been consistent in attempts to integrate health considerations into policy-making and has articulated this in key strategic documents since 1990. Wales also has a strong track record in working to address social inequity with established skills and expertise in key sectors such as civil service, academia and public service. Despite this intent, health inequalities still remain a challenge and are evident with real differences in health outcomes between those who are least and most deprived.[15] At a local level, the feedback from the Future Generations Commissioner on the Well-being Assessments gives local health boards a new opportunity to reframe the focus and understanding of the determinants of health and to highlight how various partners can make upstream contributions throughout the life course.

The level of organisational and cultural change required is clearly an iterative process as indicated in the Welsh Government example, and the experiences from Public Health Wales. It will dictate the work of the Health and Sustainability Hub and necessitate creative and dynamic ways to engage and communicate how the Act will impact on staff and systems on a day-to-day basis. This task is not to be underestimated. Going forward, the emphasis will be placed on articulating the 'difference required' at all levels; for individuals, teams and organisations across the whole of public service, in order to move towards sustainable development being 'the central organising principle', as illustrated in the 'spectrum of response' in Figure 6.

Figure 6. Organisational response to the Act



Source: Netherwood Sustainable Futures: Sustainable Development and Climate Change Consultancy.

Conclusion

This landmark piece of legislation enshrines Wales' long-standing commitment to sustainable development and seeks to build on and strengthen efforts at a national and local level to tackle complex intergenerational challenges. It sets ambitious and long-term goals based on sustainability principles and is linked to the United Nations SDGs. The participative process that was utilised to develop the legislation and was instrumental in achieving 'buy in' from non government actors, stakeholders and the public alike is now reinforced at the implementation stage, which demands a truly participatory approach to the development of national and regional policy and services in Wales.

Alongside other legislation in Wales, such as the Social Services and Well-being (Wales) Act 2014[16], which is driving a change in the care system towards a more preventative approach, the Well-being of Future Generations Act provides an enabling framework so that we can think and work differently. For example, the new ways of working can be seen in a program of work to prevent Adverse Childhood Experiences (ACEs), which has Welsh Government Ministerial support. This has culminated in Cymru Well Wales, a collaborative partnership between different sectors, securing funding to set up a multi-agency *Adverse Childhood Experience Prevention and Support Hub* to address the prevention of Adverse Childhood Experience.

A devolution settlement with more powers for Wales and long standing commitment from the First Minister have been important enablers in this journey; helping to position Wales as a potential global model of how the UN Sustainable Development Goals can be translated into action at a 'sub-national' level and contributing to a Wales that we all want to live in, now and in the future.

"What Wales is doing today the world will do tomorrow"

Nikil Seth, Director of Sustainable Development, United Nations, April 2015[17]

Key contact/s and further information

Public Health Wales
Web: http://www.wales.nhs.uk/sitesplus/888/home

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Health in All Policies

Sudan's Health in All Policies Experience

Authors

Abdalla Elhag[A], Mohamed Elabassi[B] and Hind Merghani[A]

[A]Ministry of Health, Sudan
[B]Ministry of Interior, Sudan

9

Introduction

Sudan has taken great strides towards adopting and implementing the Heath in All Policies (HiAP) approach. A rapid assessment of the implementation of HiAP in Sudan was conducted in July 2015 (see Box 1). A Road Map was developed based on discussions with different ministries, analysis of national plans, and a review of the outcomes of a HiAP workshop held in August 2015.[1] Ultimately the Road Map aims to improve the health outcomes of the population by achieving Universal Health Coverage (UHC) for all, across all states and promoting health and health equity for everyone in Sudan. Several steps have been taken towards implementing HiAP; twelve Ministries signed commitments to health and twelve other ministries are in the process of doing so. The country's ministries have shown strong enthusiasm and political commitment towards health.

The main political driver for these initiatives was the National Health Policy 2007, which is the guiding policy document for health in Sudan.[2] The first principle of this Policy expresses a commitment to achieving equity and poverty reduction in Sudan. The National Health Policy also recognises the importance of tackling the social determinants of health and notes that health is a multifaceted issue, which requires the involvement of other sectors as enshrined in the Alma Ata Declaration on Primary Health Care.[3] The Policy acknowledges the importance of intersectoral collaboration and states that:

> *"the Federal Ministry of Health (FMoH), working through appropriate authorities in Government, will advocate and ensure, for example by becoming members of appropriate bodies, that the policies of other sectors are health-friendly. Emphasis, in this regard, will be on healthy residential conditions, occupational environments, social support and the promotion of health."*

Box 1. HiAP preliminary stakeholder assessment

The Public Health Institute (PHI) undertook a rapid assessment of the implementation of HiAP in Sudan covering states, sectors and policy-makers. The main findings were:

- A National Health Sector Coordination Council (NHSCC) chaired by H.E. the President has been established. Its membership includes the federal ministers, states' governors and other related governmental entities.
  - > The NHSCC meets biannually.
  - > It has an Executive Mechanism (EM) chaired by H.E. the first Vice President and meets every three months.
- There are six technical committees reporting to the EM.
- The Parliament and the NHSCC are not systematically informed about the health status and well-being of the population.
- There are many intersectoral groups (committees, task forces, steering groups etc.) already in place, however they cover limited and specific issues, are often ad hoc or ineffective, can lack a strategic approach and there are few systemic mechanisms to support collaboration or monitoring. Further, civil society is rarely involved and there are insufficient resources.

A review of the National Health Policy (2007-2016) was conducted in 2013 and found no clear guidance on how intersectoral collaboration should happen. The review document stated:

> *"The policy document refers to intersectoral coordination in the section on the social determinants of health. However, it does not provide a strategic direction on how this will happen, what would be the role of the Ministry of Health, how other sectors are critical and how the Ministry would assume the leadership roles in promoting intersectoral coordination; only brief reference is made to this in section 6.4 on involving a wide range of stakeholders. The policy also does not mention whether such intersectoral coordination can be undertaken at the program or at the grass-roots level using community based approaches. What would be an appropriate starting point for identifying intersectoral action and the common concerns of all stakeholders?"*

The National Health Policy review concluded that such issues need policy dialogue with other sectors to agree on these questions and recommended:

> *"Dialogue should be initiated between the FMoH and other stakeholders and Ministries e.g. the Ministry of Finance. Further, there should be dialogue with those Ministries responsible for improving social determinants directly linked to health e.g. the Ministry of Agriculture, Water and Sanitation, Ministry of Education and the Ministry of Environment. Solutions should be provided during discussions and responsibilities mandated."*

The updated National Health Policy (2017-2030) has considered all the pitfalls of the previous policy in relation to HiAP and through this policy dialogue developed a Road Map for its implementation (Box 2).

Box 2. Sudan's HiAP Road Map

The Road Map is based on:

a) discussions with different ministries

b) national plans and analysis

c) the outcomes of the HiAP workshop held in Khartoum 25-26 August 2015. About 80 senior level policy-makers from 17 sectors participated in the workshop and

d) a meeting of undersecretaries of all ministries on 12th January 2016.

Road Map Implementation Measures

1. Building accountability and strengthening the commitment of the National Health Coordination Council and Parliament

At the moment the Parliament and the National Health Coordination Council (NHCC) are not informed systematically about the status of the health and well-being of the Sudanese population, nor the core activities that different sectors undertake for the health and well-being of the population. It has also been suggested that there should be better accountability of the activities done by the ministries and that the NHCC and the Parliament would be the right bodies to oversee the work done in all sectors of the government.

Measure 1:

Prepare a national public health and well-being report that will be presented to the NHCC and Parliament every fourth year. The MoH would be responsible for preparing the report for the government and NHCC. All ministries would be obligated to provide MoH the information needed (i.e. what are the key policies, decisions, activities done during the last three years that have contributed to the health and well-being of the population).

2. Strengthening structures for Health in All Policies

The stakeholder assessment on Health in All Policies showed that there are many intersectoral groups (committees, task forces, steering groups etc.) already in place. However, it was argued that these do not always work as effectively as possible and sometimes there is a lack of strategic vision regarding what these groups are trying to accomplish. Many of the groups are also only meeting on an ad hoc basis. Institutionalising some of the groups was also suggested. Modifying existing legislation to better ensure effective, horizontal work across sectors has also been suggested.

Measure 2:

Undertake a situation analysis of existing taskforces, steering groups etc. How the different groups are related to each others, which sectors are involved/not involved, what group is working/not working, which groups need to be institutionalised to ensure they have regular meetings and a strategic way of working.

Measure 3:

Conduct a situation analysis of HiAP implementation at the state and local levels focusing in particular on how the community is engaged in the policy-making process.

Measure 4:

Conduct a legislative review to identify the laws (related to intersectoral action) available in different sectors and assess to what extent they facilitate, enable and promote the horizontal, effective intersectoral action. The intent is that laws are prepared in such a way that they achieve their objectives effectively. Better regulation ensures that policy is prepared, implemented and reviewed in an open, transparent manner, informed by the best available evidence and involves all ministries and relevant stakeholders.

3. Develop mechanisms for HiAP for better governance and increased transparency

Although there are relatively well-established structures for HiAP already, there is a lack of horizontal mechanisms that allow sectors to know other sectors' policies and law proposals in an effective and timely manner and assess their possible impacts on areas such as health, environment and employment.

Measures 5 and 6:

As a better regulation mechanism, the consultation and prospective, integrated impact assessment are introduced into the legislation process. Consultation means that the ministry that is drafting the law needs to send it for consultation to all ministries (civil servants) and relevant stakeholders before introducing it to the government. Prospective integrated impact assessment will be required for each proposal. Proposals need to include an assessment of possible impacts of the law on health, the economy, employment, environment etc.

Measure 7:

Develop a Social Determinants of Health/HiAP approach for specific priority programs like malaria, NCDs or others in order to increase the horizontal working culture.

4. Build capacity for effective implementation, better planning and evaluation

Respondents of the HiAP assessment survey and workshop participants both identified lack of resources (human and finance) as a challenge for the implementation of HiAP. Similarly, lack of proper monitoring systems was identified as a crucial gap for better policy planning and evaluation. Although there are several surveys in place, they don't replace the need for a health monitoring system that would be able to produce comparable and credible data showing the trends in people's health. The HiAP assessment survey also identified gaps in communication and negotiation skills, quality of data, coordination and collaboration and ability to integrate results to name just a few.

Measure 8:

Establish a health-monitoring unit, possibly within the Public Health institute.

Measure 9:

Strengthen the capacity of the key institutions (e.g. MoH, some committees, PHI) to advocate for the HiAP approach, to work with other sectors, and to ensure a critical mass sufficient to produce accurate policy analysis and research synthesis relevant for policy-making and policy guidance.

Measure 10:

Organise a WHO training course on Health in All Policies.

Vision, aims, objectives

Vision

The HiAP Road Map ultimately aims to improve health outcomes for the whole population.

Aim

To achieve universal health coverage for all the population across all states and to promote health and health equity for everyone in the country.

Objectives

1. Building accountability and strengthening the commitment of the National Health Coordination Council and Parliament.
2. Strengthening structures for Health in All Policies.
3. Developing mechanisms for Health in All Policies for better governance and increased transparency.
4. Building capacity for better planning, effective implementation and close monitoring and evaluation.

Road Map Values

Table 1 shows the key values underpinning the Road Map directions.

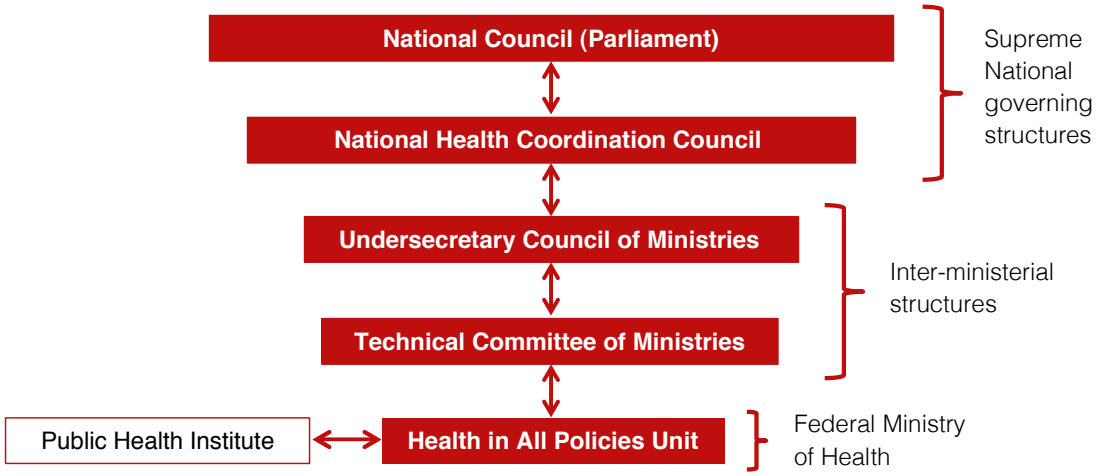
Table 1. Values underpinning Sudan's Road Map

Equity	All sectors should give as much advantage and consideration to health issues as is given to other issues
Shared responsibility	All sectors have a shared responsibility to promote and safeguard health
Collaborative effort	All sectors should cooperate together to promote health and health equity
Accountability	All sectors have an assigned responsibility towards the health of the population
Transparency	All sectors should be operating in such as a way that it is easy for each sector to see what actions are performed in order to assesses the potential impacts of the actions on health and health equity
Sustainability	All sectors should ensure that efforts meet the health needs of present and future generations

Governance, reporting and monitoring

The governance structure shown in Figure 1 was proposed during a workshop and agreed upon by all participants and has been endorsed by the Undersecretaries meeting.

Figure 1. Governance structure for intersectoral partnerships in Sudan



Source: Ministry of Health Sudan.

Sudan's HiAP governance structure is composed of the following:

- The National Health Council (Parliament): According to the Road Map the Parliament is to receive and discuss a health report every two years.
- The National Health Coordinating Council: The President chairs this governing body with the Vice President as co-chair. All ministers and governors of states also sit on the NHCC as well as representatives from the private sector. The NHCC has responsibility to endorse, monitor and supervise the implementation of the HiAP Road Map and hold members accountable.
- The Undersecretary Council of Ministries: It is responsible for preparing policy issues, which are to be endorsed by the National Health Coordination Council.
- The Technical Committee of Ministries: The committee is composed of representatives of the ministries who are the focal points for health within their ministries. The Committee is responsible for discussing operational issues and presenting them in a policy and decision format to the Undersecretaries' Council.

A HiAP unit is part of the health promotion department in the Ministry of Health. The Public Health Institute (PHI) has been assigned to develop a monitoring unit, which will prepare a health and well-being report to be submitted to NHCC and Parliament.

Mechanisms and processes

The concept of HiAP has been welcomed and easily understood by other sectors. The commitments to improve health and equity have been developed by each ministry rather than the Ministry of Health. The Federal Ministry of Health has played an important leadership role. A number of HiAP implementation milestones have been achieved to date:

✓1. Stakeholder assessment for HiAP **- July 2015**

✓2. HiAP policy dialogue workshop **- August 2015**

✓3. Development of HiAP Road Map for Implementation **- August 2015**

✓4. Endorsement of HiAP Road Map **- November 2015**

✓5. MOH policy-makers' meetings **- January 2016**

✓6. Ministries Undersecretary Meeting **- January 2016**

✓7. Prioritising health challenges using HiAP Approach **- March 2016**

✓8. Bilateral intersectoral meetings **- April 2016** (Ministry of Water Resources)

✓9. Workshop for 12 Ministries (Development of Ministry Commitments & focal points) **- November 2016**

✓10. Undersecretaries signing of commitments **- January 2017**

✓11. Workshop for other ministries (approximately eight) **- January 2017**

✓12. Ministry of Interior formulated a high level committee **- January 2017**

Prioritising health challenges using a HiAP Approach: a situation analysis

A situation analysis was conducted to prioritise health challenges using a HiAP approach and identify major diseases or health problems that require immediate action. Data was gathered from two main sources: a desktop review of national documents and interviews with key policy makers in the Federal Ministry of Health.

The major diseases and challenges extracted were rearranged according to their prevalence rate. This was regarded as a primary identification exercise. For prioritisation of the health challenges, a questionnaire was distributed to nine key policy-makers in the Federal Ministry of Health. The data collected from the policy-makers was categorised and analysed statistically. The frequencies were calculated to assist with prioritising diseases/ challenges. Finally, for each health problem considered a priority, relevant sectors to be involved were determined.

General Objective

To address priority health challenges by using a Health in All Policies approach.

Specific Objectives

1. To identify and prioritise the major health challenges that require immediate action.
2. To determine the key Ministries (sectors) which have a role in managing specific health problems to adopt an intersectoral approach to action.
3. To build programs targeting major health challenges for different population groups.

Results

Identification of diseases revealed by the desk review, included 27 major diseases and health challenges as shown in Table 2 below.

Table 2. Priority health conditions

Priority health conditions	
Malaria	Renal diseases
Tuberculosis	Visceral Leshmaniasis (kalazar)
Respiratory diseases (asthma, pneumonia, tonsillitis)	Schistosomiasis
Malnutrition and micronutrient deficiencies	Measles
Water borne diseases (diarrhoea, typhoid fever)	Bilharziasis
HIV	Oncocerciasis (river blindness; guinea worm or dracunculosis)
Diabetes	Typhoid fever
Hypertension	Maternal haemorrhage
Cancer	Maternal sepsis
Heart disease	Maternal hypertension
Arthritis	Tobacco and drug abuse
Thyroid diseases	Irrational use of medicines
Epilepsy	Road traffic accidents
Guinea Worm or Dracunculosis	

A prioritisation exercise divided the identified diseases and health challenges into four categories:

1. high need, high feasibility
2. high need, low feasibility
3. low need, high feasibility and
4. low need, low feasibility.

Only diseases with 'high need high feasibility' were targeted and focused upon in the exercise. Diseases in the other three categories were excluded at this stage.

Out of the 27 diseases and health challenges identified in the desk review, six were considered by policy makers to be 'high need, high feasibility' and therefore high priority warranting allocation of sufficient resources. Diseases in this category were ranked according to the number of votes given by policy-makers. Malaria had the highest number of votes. Table 3 sets out the key Ministries required to address the top six health priorities.

Table 3. Priority health problems and key ministries

No	Major health challenge	Key ministries
1	Communicable diseases: Malaria	Ministry of Electricity and Water Ministry of Agriculture Ministry of Justice Ministry of Information Ministry of Environment
2	Communicable diseases: Schistosomiasis	Ministry of Electricity and Water Ministry of Agriculture Ministry of Environment Ministry of Information Ministry of Education Ministry of Human Resources Development
3	Road traffic accidents	Ministry of Transportation, Roads and Bridges Ministry of Interior Ministry of Information Ministry of Engineering Ministry of Education Ministry of Industry Ministry of Electricity and Water Ministry of Justice
4	Noncommunicable diseases: diabetes, hypertension	Ministry of Youth and Sport Ministry of Information Ministry of Education Ministry of Industry
5	Respiratory diseases, pneumonia	Ministry of Environment Ministry of Industry Ministry of Education State Ministry of Engineering Ministry of Information
6	Nutritional disorders: malnutrition, micronutrient deficiencies, diarrhoeal diseases, typhoid	Ministry of Electricity and Water Ministry of Agriculture Ministry of Industry Ministry of Finance Ministry of Welfare and Social Security Ministry of Interior Ministry of Youth and Sport Ministry of Information

Ten Ministries signed commitments with the Federal Ministry of Health, while another twelve Ministries are in the process of signing. Seven ministry commitments are detailed below out of the ten ministry commitments as examples. There are three main categories or types of commitments made:

Categories/types of commitments to health:

- general commitments to health made by other Ministries
- specific commitments for different Ministries
- Ministry of Health commitments provided to other Ministries.

Box 3. Examples of ministry commitments to health

A. General commitments to health made by other Ministries include:

- Integrate health equity in policies and programs where appropriate
- Institutionalise consultations on health impact when preparing legislation and policies
- Institutionalisation of Health Impact Assessment as a routine procedure for new projects.

The Ministries that have signed commitments and their details are set out below:

B. Specific commitments for different Ministries

1. Ministry of Agriculture

We commit to target all our laws and legislation towards ensuring food security and hence limiting poverty through:

- Adhering to recommendations of the Food Constitution Commission and ensuring fair international trade
- Raising awareness about food security
- Increasing agricultural production and productivity
- Monitoring agricultural pesticides and fertilisers
- Using organic agriculture
- Using research, guidance and technology in agriculture
- Reducing desertification
- Regulating importation and exportation of agricultural products
- Maintaining an optimum level of coordination with other relevant sectors.

2. Ministry of Social Welfare and Security

We commit to provide adequate social support and social security especially for the vulnerable groups through:

- Policies, plans and national programs that focus on health
- Development of a comprehensive program of social security
- Training and capacity building
- Improving the socioeconomic status of poor families
- Providing health insurance and achieving universal health coverage
- Maintaining an optimum level of coordination with other relevant sectors.

3. Ministry of Finance

We commit to fully coordinate with the health sector in order to improve the health status of the population through:

- Providing sufficient funds for the health and other health-related sectors
- Providing social and financial protection for poor families, under-five children, and heart, kidney and cancer patients
- Providing sufficient funds for primary health care
- Formulating specialised health-related committees for health budgets
- Implementing the GPP and the single vault system in the health sector
- Development of a health accounting system for follow up
- Maintaining an optimum level of coordination with other relevant sectors.

4. Ministry of Foreign Affairs

We commit to develop protocols that support health policies, distribution of resources and capacity building through:

- Information exchange especially in war and conflict zones
- Provision of health services in conflict-affected areas
- Implementation of the international health regulations
- Facilitation of international trade in health
- Maintaining an optimum level of coordination with other relevant sectors.

5. Ministry of Interior

We commit to having a positive effect on the population's health through applying full coordination with the health sector which includes:

- Improving civil registration system (birth and deaths observation)
- Monitoring foreigners' movements
- Direct provision of quality health services for police forces and their families
- Providing health services for prison inmates
- Protecting the population during emergencies
- Reducing road traffic accidents
- Maintaining an optimum level of coordination with other relevant sectors.

6. Ministry of Water Resources, Irrigation and Electricity

We commit to improve the quality of water, electricity, and sanitation services provided to the population through:

- Activating water legislation
- Water examination and quality control in compliance with the national standards
- Providing sufficient safe drinking water
- Providing electricity in a secured and stable manner
- Development of a proper sanitation system
- Maintaining an optimum level of coordination with other relevant sectors.

7. Ministry of Environment, Natural Resources and Constructional Development

We commit to develop and target our policies and legislations for the protection and promotion of the environment which includes:

- Monitor, observe and protect earth, water, soil and food from pollution
- Minimise CO2 emissions
- Proper management of chemical and non-chemical wastes
- Development of the prospecting and mining program
- Maintaining an optimum level of coordination with other relevant sectors.

C. Ministry of Health commitments provided to other Ministries

1. Provide capacity building services for workers in each sector
2. Provide training in Health Impact Assessment and provide assistance in the institutionalisation process
3. Develop monitoring and evaluation systems
4. Develop implementation mechanisms.

HiaP and SDGs in Sudan

Sudan is committed to the Sustainable Development Goals (SDGs) and implementation of the SDGs and HiAP will reinforce each other. The SDGs provide an additional impetus for working with different sectors of government and society to address the determinants through policies and legislation towards improving health and preventing harm. Further, the horizontal mechanisms being developed through the HiAP Road Map will allow sectors to have timely knowledge of other sectors' policies and law proposals and assess their possible impacts on health, environment, employment etc. The Road Map is also supporting the introduction of prospective, integrated impact assessments into the legislation process. Through these proposals HiAP is facilitating and paving the way for implementation of the SDGs. The general commitment from different ministries to consider equity when developing their policies will also help achieve the important SDG concept of "leaving no one behind".[4]

Outcomes

The Health in All Policies approach has been generally received with huge enthusiasm across all sectors. Several workshops were held that emphasised the concept of the social determinants of health and health equity leading to a better understanding of these issues among all Ministry stakeholders. There was general consensus that there is a lack of coordination and collaboration between sectors necessitating the establishment of a horizontal governing body. There is high political commitment at the level of the Ministry of Health, other ministries and the Presidency. The Road Map has been endorsed by the Universal Health Care conference held recently in Khartoum and been integrated in the UHC Khartoum declaration.[5] The declaration has been operationalised and will be monitored by the NHCC.

Challenges and opportunities

Although a number of steps have been taken to adopt and implement a Health in All Policies approach the journey is still long and much effort is needed. One of the key success factors that enabled Sudan to implement the Health in All Policies approach is the high level of commitment to health that was found across different ministries. But despite that there are several challenges the country is currently facing:

- limited capacity of the PHI (few staff, competencies)
- limited capacity in the MOH
- the need to restructure MOH
- the need to establish a monitoring unit in PHI
- coordination between focal points of the different Ministries and
- weak capacities of Ministries.

The way forward

The following steps need to be undertaken:

- conduct bilateral meetings with the identified ministries to develop operational plans for ministry commitments
- costing of operational plans and commencement of implementation
- build the capacity of PHI and sectors in HiAP
- monitoring of implementation by PHI
- compilation, analysis and synthesis of health-related information from other ministries together with Ministry of Health reports
- PHI to develop a national health and well being report every two years to present to the National Health and Coordination Council (NHCC).

Conclusion

To move the HiAP agenda ahead and towards implementation, operationalisation of ministries' commitments and the development of a monitoring framework are prerequisites. Despite the huge efforts that have been made to date, there is still a lot more to be done and some major implementation challenges for Sudan.

Key contact/s and further information

Dr Abdalla Sid Ahmed Osman, Director of the Public Health Institute

Email: abdalla.sd52@gmail.com
Web: www.phi.edu.sd

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Health in All Policies

Reducing the burden of disease and health inequity through HiAP – the case of Suriname

Authors

Maureen Wijngaarde-van Dijk[A], Pierre Pratley[B], Erik Blas[C]

[A]Ministry of Health, Suriname
[B]Pan American Health Organization
[C]Independent Public Health Consultant

10

Introduction

Suriname, a middle-income country with a total population of 540,000, is facing a major burden of disease even compared to other similar countries. Policy makers in the South American country recognise the potential for collaboration and synergies to address this challenge. Health promotion is mentioned in Article 36 of the Constitution[1] and given its ethnic diversity health equity is of importance to the Surinamese people. However, policy makers have long felt restricted in solving policy problems in an intersectoral manner and have been looking for ways to institutionalise a mechanism that allows for negotiation on the inclusion of health goals in the policies of other ministries, and vice versa.

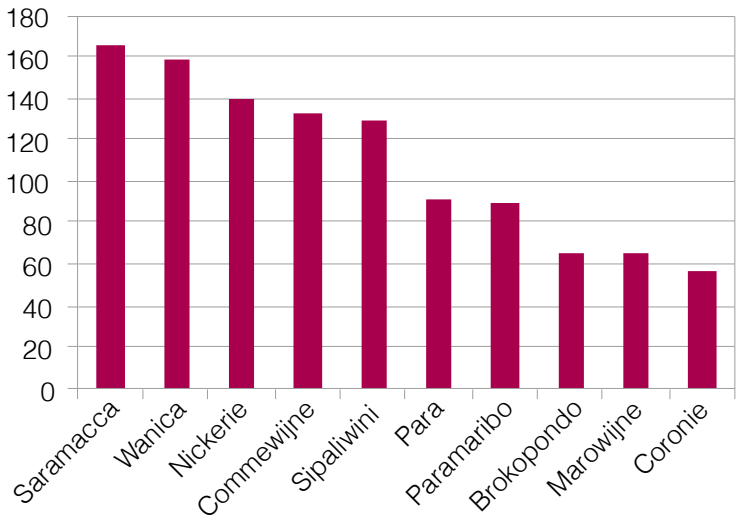
Every year Suriname loses about 170,000 DALYs due to ill health. This seriously affects the social and economic development of the country. The top 15 contributors to the burden of disease (BoD) are: HIV/AIDS, stroke, preterm birth complications, ischemic heart disease, self-harm, major depressive disorder, road injury, diabetes, iron-deficiency anaemia, low back pain, neonatal encephalopathy, congenital anomalies, lower respiratory infections, chronic kidney disease and adverse medical treatment. The main risk factors are an unhealthy diet, tobacco smoking, alcohol consumption, lack of exercise, domestic violence, sexual abuse and neglect, high or low maternal age, incomplete vaccination coverage, low use of antenatal care services, multiple pregnancies, high blood pressure, co-existence of noncommunicable diseases, obesity, coexistence of communicable, maternal, neonatal and nutritional disorders, genetics and high blood cholesterol.[2]

In the Global Burden of Disease study's benchmarking with 14 other countries with similar GDP per capita, Suriname comes off worse than most for the top 15 diseases.[3] Suriname's economy is based primarily on low exports other than those related to the extraction and export of natural resources (gold, wood and bauxite) and high imports. The country has, even before the start of the HiAP process in mid-2015, been seriously hit by the fall in global commodity prices. Suriname is a very diverse country – ethnically and geographically. The country has 8 languages and 7 major ethnic groupings (Amerindians, Chinese, Creole, Hindustani, Javanese, Marron, Europeans).[4] Suriname has a vast, jungle covered and lowly populated interior and a narrow and densely populated coastal strip, where the capital city of Paramaribo with over 80% of the total population of the country is situated.

All available data for the top 15 diseases and their risk factors show large inequities across a range of dimensions including: geographical location, wealth, education, ethnicity and gender. However it is not always the case that the same ethnic group is worse off for all diseases and risk factors. A number of social determinants influence each other and both the level and the distribution of health within the population including education and jobs, social norms, gender roles, the built and work environment, food supply, potentially harmful and toxic substances and social disadvantage. The health system, itself a social determinant, also contributes to the high level of disease and inequity through, for example, access; performance; structural, financial and legal ramifications and barriers; education of staff and suboptimal incentives. Figures 1 – 4 illustrate variations in health indicators location, ethnicity, gender and income.

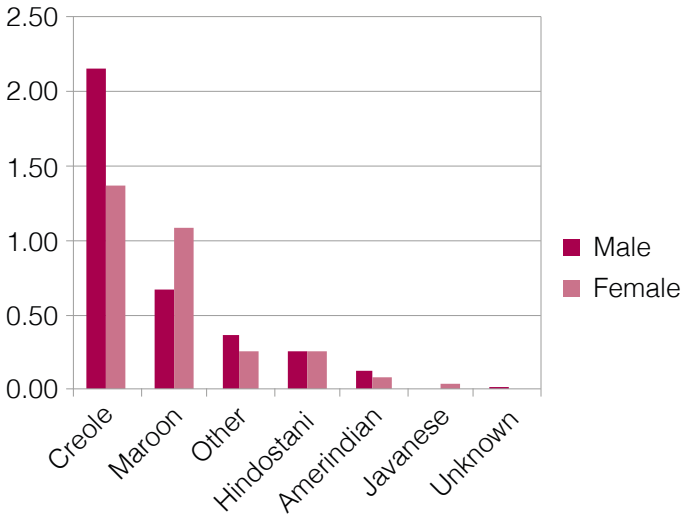
The Health in All Policies (HiAP) approach provides an opportunity not only for addressing the level and distribution of health in the country but also for implementing the Sustainable Development Goals under WHO's Health in the SDG Era framework, where collaboration between sectors is essential.[5] Fortunately, Suriname has an educated workforce in the public and private sectors, committed politicians and dedicated managers as well as a rapidly expanding and active civil society.

Figure 1. Chronic kidney disease incidence by district per 10,000



Source: Census data, Suriname Bureau of Statistics (2012)

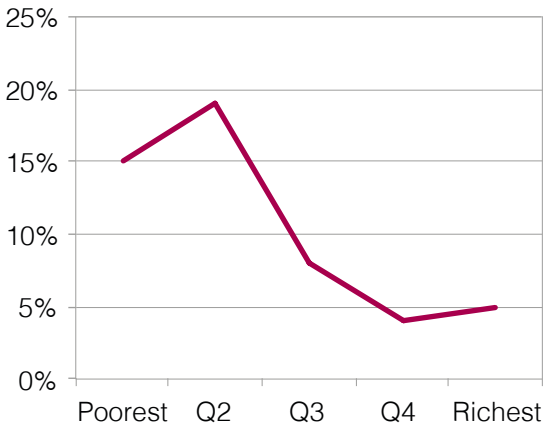
Figure 2. Prevalence of HIV by ethnicity and sex per 10,000



Source: Suriname Ministry of Health. HIV infections, Academic Hospital Surveillance data (2014).

Figure 3. Rate of diabetes mellitus by wealth quintile

Figure 4. Prevalence of smoking by wealth quintile



Source: Suriname Ministry of Health and PAHO/WHO Suriname, Suriname STEPS survey, 2014. Available from: http://www.who.int/chp/steps/Suriname_2013_STEPS_Report.pdf

Vision, aims and objectives

The vision is to institutionalise HiAP in Suriname to sustainably reduce the BoD and health inequities through concerted policy and "hands-on" action on the risk factors and the major social determinants of poor health in Suriname; and to enhance the evidence base for action through improving data collection and analysis, research and community participation.

These aims will be achieved by fostering political, managerial and public understanding, responsibility, and accountability for health and health equity. Specific objectives include the establishment of intersectoral groups to draft and facilitate implementation of relevant policies; implementation of a comprehensive monitoring strategy; and mainstreaming and anchoring of HiAP at national, district and resort (neighbourhood or municipality) levels.

Governance, reporting and monitoring

Governance

In order to achieve these objectives, a governance structure was set up at the request of the national authorities. First, a monitoring steering and strategy (MSS) group was established, chaired by the Vice President's (VP) office, with secretariat services provided through the office of the Permanent Secretary of Health. Members come from key ministries such as Trade and Industry and Regional Development, the statistics bureau as well as civil society. Commitment was achieved during several conferences with the Vice President's office, and through the VP's office and Ministry of Health with the Cabinet of ministers and chief executives of all 17 ministries. Existing structures for local governance were also involved through the Ministry of Health and the Ministry of Regional Development to ensure reach at the local level through district and resort councils.

At the national level, the overall governance lies with the Cabinet of ministers headed by the Vice President. Twelve policy implementation teams have been established, with each to implement, facilitate and oversee one cross-cutting intersectoral policy area. Participation, responsibility and accountability were ensured throughout the process. A National Health Forum is scheduled for mid-2018 and will inform, and further engage and communicate with the Surinamese society, by presenting the collected data, research findings, pathfinder project outcomes and the results achieved as well as providing an opportunity to discuss remaining gaps.

Reporting

Reporting will take place at three different levels: institutional, district and resorts. At the national institutional level an annual or biennial population health report will be prepared and presented to Parliament, summarising achieved results and presenting the latest data on health and health inequity. The report will be organised by the MSS group in collaboration with line ministries and others.

Monitoring

Monitoring is a vital and challenging component of the HiAP process in Suriname. It will be based on the vision, aims and objectives to achieve action on evidence and is guided by a monitoring strategy that was developed using participatory Delphi-rounds and a national consensus workshop. The monitoring strategy aims to improve service and administrative data in order to capture information on the top diseases and related risk factors and to disaggregate them according to selected inequity dimensions including geography, composite socio-economic status, migratory status, age, sex, ethnicity and religion. The strategy also aims to enhance repeated and ad hoc surveys to better capture the same information on diseases, risk factors and inequity dimensions. There will also be studies commissioned and reanalysis of existing data bases to better understand the level and causes of health and health inequity. Lastly, community logs are being developed to empower communities, foster ownership and participation and capture, communicate and share exposure to key risk factors and the effects of the social determinants of health at the local level.

Mechanisms and processes

HiAP in Suriname was initiated in May of 2015 through a WHO/PAHO sub-regional training workshop for high-level decision-makers in the Caribbean. As a follow up, the Ministry of Health requested a quick assessment of the health situation and health-related inequities in Suriname. This was a participatory study conducted with national experts through three consecutive Delphi rounds. A National Consensus Workshop (NCW) was held to peer-review deliverables, present plans and policies and choose the most promising policies. The NCW concluded with two statements, one on the importance of establishing a structure to institutionalise HiAP through intersectoral policy working groups, and another to establish a steering group to monitor progress and improve data collection in order to take action on health inequities. A two-year work plan was

Figure 5. The four milestones of the first Suriname HiAP cycle

also developed (see Figure 5) covering a first HiAP cycle comprising four milestones. The first milestone was reached in January 2016 when eight intersectoral policy working groups (PWGs) and the MSS group became a reality.

Right from the beginning the HiAP process in Suriname enjoyed high-level leadership and support from champions. The process was led by the Permanent Secretary of Health who personally participated in the HiAP training event in 2015. The then Permanent Secretary of Foreign Affairs, the Nestor among the Permanent Secretaries, acted as a HiAP champion in bringing all the government sectors together and committing them to work with the HiAP Secretariat. The Speaker of the Parliament, herself a public health physician, brought HiAP thinking to the political level, organised a briefing on social determinants and health equity in Parliament with Sir Michael Marmot[6], and requested that the HiAP be monitored through the national development plan and budget.

At the very beginning of the process, the HiAP team hired a local consultant with well-established extensive networks into civil society, government administration, and political circles. Together with the abovementioned champions the consultant helped mobilise participation from across society to undertake a situation analysis (quick assessment), progress consensus building and the formulation of feasible policy options. The Vice President had committed that his Cabinet of Ministers would provide the institutionalised governance for the HiAP with the Minister of Health overseeing the secretariat function. The PWGs were established after a call for participation during the Permanent Secretaries' meeting and circulation of the terms of reference for group members among ministries. They worked towards developing a number of promising intersectoral policy proposals based on guidance notes. The second milestone was reached in April 2016 when each PWG presented three policy proposals and the larger HiAP community then

selected the six most promising draft policies for further refinement. Milestone three was reached in August 2016 when another six policies were selected and the previous six proposals were peer-reviewed.

The MSS group meets regularly to coordinate action on data improvement and collection and to guide and monitor progress towards milestones within the PWGs. The MSS also serves as a steering group to identify challenges, act on them and to report to the Office of the Vice President.

The process is currently moving towards milestone four that will complete the first HiAP cycle. This includes implementation of policies, pathfinder projects - one school and one community based - tracking progress through interim reviews and evaluation and workshops in preparation for the Population Health Report and the National Health Forum currently planned for mid-2018.

Table 1. Policy implementation teams and sectors involved (ministries alphabetical)

Policy short-name	ARB	BIZ	BUZ	DEF	FIN	H&I	J&P	LVV	MNH	MOW	MRO	OWC	RGB	SJZ	SZV	TCT	VOG
1.1 Education for health participation								*			*	L		*			*
1.2 Healthy workplaces	L	*		*		*	*	*		*	*	*				*	*
2.1 Space for health						L	*			*	*		*				*
2.2 Zonal planning for health						*	*	*	*	*	*		L			*	*
3.1 Clean and healthy resorts							*	*		*	L	*					*
4.1 Health equity for the upcoming generation							*				*	*		*	L		*
4.2 Local solutions to local health challenges	*	*				*	*	*	*	*	L	*	*	*	*	*	*
5.1 Food-labelling for health					*	L	*	*			*						*
5.2 Healthy fresh local food for local stomachs					*	*		L		*	*	*				*	*
6.1 Educating professionals for health equity	*	L				*	*	*			*	*			*		*
7.1 Investing for population health		*	*		*	*					*						L
7.2 Re-engineering the health system for effectiveness and equity		*				*	*			*	*		*		*		L

Explanation to table: L = Policy leader, * = Key public sector player

Acronyms: **ARB**: Ministry of Labour; **BIZ**: Ministry of Internal Affairs; **BUZ**: Ministry of Foreign Affairs; **DEF**: Ministry of Defence; **FIN**: Ministry of Finance; **H&I**: Ministry of Trade and Industry; **J&P**: Ministry of Justice and Police; **LVV**: Ministry of Agriculture, Animal Husbandry and Fisheries; **MOW1**: Ministry of Public Works - Directorate of Civil Engineering; **MOW2**: Ministry of Public Works - Directorate of Built Environment and Services; **MOW3**: Ministry of Public Works - Directorate of Public Green Spaces; **MRO**: Ministry of Regional Development; **MNH**: Ministry of Natural Resources; **OWC**: Ministry of Education, Science and Culture; **RGB**: Ministry of Spatial Planning, Land use and Forestry; **SJZ**: Ministry of Sports and Youth; **SZV**: Ministry of Wellbeing; **TCT**: Ministry of Transport, Communication and Tourism; and **VoG**: Ministry of Health.

Establishing and maintaining partnerships:

The PWGs, which will soon be reorganised into policy implementation teams (PITs), will commence implementation of the selected 12 most promising policy options (Table 1). These teams will work with results chains and policy deliverables and commitments that are drafted by PWGs for the promising and implementable candidate policies. The results chains define the contribution sectoral policies (new and changed) can make to reducing the level of, and inequities in, ill-health through influencing exposure and addressing risk factors as well as important social determinants.

Key steps for continuity also include securing political clout and ensuring mutual accountability at the sectoral level by adoption of the policy packet of the 12 policies by the Council of Ministers. This is due to be achieved by mid-2017 through a Permanent Secretaries' meeting specifically called by the MSS for this purpose. To secure local participation and buy-in, anchoring implementation and accountability at the district, resort and community levels will be pursued through implementation of community logs in selected key communities.

Box 1: Implementing policy priorities

The PWG on Education and Employment chaired by the Ministry of Education has fostered a Policy Implementation Team addressing the policy area "Education for health participation". This includes an overhaul of the current curriculum for primary schools to include specific educational components to equip students to better participate in decisions about health – as individuals and as citizens. This includes reducing the level of disease and heath inequities by addressing two large risk factors (unhealthy diet and lack of physical exercise) as well as relevant social determinants. Through a review committee Ministry of Education and Ministry of Health officers both provided input to the curriculum. The Ministry of Health together with local government (resort council), the Ministry of Agriculture and the Ministry of Regional Development also established a pathfinder school project that includes a gardening centre where children can learn about and engage in planting local healthy food as well as get physical exercise in the process of learning.

Another PWG addressing consumables, including processed food, fostered a multisectoral Policy Implementation Team to introduce food labelling for health, as a first step in regulating food content in the country. As a result, the Suriname Bureau for Standards has established, at the request of the working group chaired by the Ministry of Trade and Industry, a technical committee comprising individuals from all relevant sectors to draft and implement a progressive standard for nutritional labelling following regional PAHO/WHO guidelines, including front of packaging labelling.[7]

Another pathfinder project resulted from the "Local solutions for Local Health Problems" policy proposal in which the Ministry of Regional Development will facilitate training, with technical input from the Ministry of Health, to support action on environmental and social determinants of health and major risk factors in ten pilot resorts (one in each District).

Examples of action from the MSS group include changes to data recording and monitoring systems at the country's Academic Hospital, Suriname's largest hospital, and the Medical Mission, Suriname's primary care system in the interior of the country. These modifications now allow policy makers, managers and researchers to examine disease data and exposure to risk factors by key inequity dimensions, consistent with Sustainable Development Goal target 17.18.[8]

Outcomes

Of the planned outcomes, the first - adoption of the policy packet by the Council of Ministers - is slated to be completed by mid-2017. Meanwhile, a successful policy proposal under the training and employment PWG has yielded tangible results as two HiAP courses based on WHO's international guidelines, and adapted to the Surinamese context, have been conducted at the Nursing college. Currently another course is being taught at the Social Science Faculty at the University of Suriname. Enrolment was twice the available capacity for the course with over 50 requests for participation and only 25 seats in the class.

Challenges and opportunities:

The largest challenge since starting the two-year plan for institutionalising the HiAP approach in Suriname has been the economic downturn resulting from a drop in commodity prices. Since late 2015, the country has been hit by an economic recession resulting in the world's second highest rate of inflation in 2016, which has significantly shrunk government budgets and seriously affected the purchasing value of government employees in particular. This means that staff are often occupied with austerity measures at work and are concerned about making ends meet at a personal and family level. Further, because Suriname is categorised as a middle-income country donor funds to kick-start or seed-fund action are meagre.

In order to sustainably implement HiAP, institutionalisation is key. Institutionalising the HiAP approach within government is a challenge and opportunity. The challenging aspect relates to the institutional nature of a unit or directorate that could coordinate and track all HiAP-related activities. To this end, participants in the process have indicated that the MSS group could be institutionalised into a unit under the Vice President's Cabinet or Planning bureau. Alternatively, a HiAP bureau with staff from all sectors could be a way to continue to champion the leadership role of the Ministry of Health in this process.

Lastly, the Sustainable Development Goals and 2030 Agenda for Sustainable Development offer a unique opportunity to build on the structures developed in the HiAP process. HiAP should not be seen as a burden on public resources but rather as an opportunity to reprioritise resources to effectively and sustainably contribute to a healthier population, a population that is more socially and economically productive and consumes fewer healthcare resources.

Reflections and conclusions

The institutionalisation of HiAP in Suriname has shown that such intersectoral work is a vehicle to organise policies and programs and monitor and track progress towards the reduction of burden of disease through concerted action on the social determinants of health, and also to make progress towards achieving SDG targets (Table 2). Intersectoral work, however is not a silver bullet and needs to be heavily contextualised and managed. It takes time and commitment to ensure HiAP institutional structures can embed intersectoral collaboration in the way government drafts, negotiates and implements policies, programs and projects. Almost certainly several cycles will be necessary before HiAP really gets traction and is institutionalised.

Table 2: Policies and Sustainable Development Goals (SDGs)

Policy short-name	Sustainable Development Goal																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1.1 Education for health participation	+	*	*	*	*			+	+	*	*	*	+	+	+	*	*
1.2 Healthy workplaces		+	*	+	+			*		*	+	+			+		
2.1 Space for health			*					*	*	*	*	+		+	+	*	
2.2 Zonal planning for health	*	*	*			*	*	*	*	*	*	+			+	*	
3.1 Clean and healthy resorts	*	*	*	*	+	+			+	*	*	+			+	*	
4.1 Health equity for the upcoming generation	*	*	*	*	*			+		*						*	
4.2 Local solutions to local health challenges	*	*	*	*	*	+	+	+	*	*	*	+	+			*	*
5.1 Food-labelling for health		*	*	*				+		*		+	+			*	
5.2 Healthy fresh local food for local stomachs		*	*	+	+			*	*	*		*	*	+	+		
6.1 Educating professionals for health equity	*	*	*	*	*	+	+	*		*	*	*		+	+	*	+
7.1 Investing for population health	+		*							*	+					*	+
7.2 Re-engineering the health system for effectiveness and equity	*	*	*	+	*					*	*	+				*	

Explanation to table: * = strong link between policy and SDG; + = link between policy and SDG

Acronyms: **SDG1** = End poverty in all its forms everywhere; **SDG2** = End hunger, achieve food security and improved nutrition and promote sustainable agriculture; **SDG3** = Ensure healthy lives and promote well-being for all at all ages; **SDG4** = Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; **SDG5** = Achieve gender equality and empower women and girls; **SDG6** = Ensure availability and sustainable management of water and sanitation for all; **SDG7** = Ensure access to affordable, reliable, sustainable and modern energy for all; **SDG8** = Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all; **SDG9** = Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation; **SDG10** = Reduce inequality within and among countries; **SDG11** = Make cities and human settlements inclusive, safe, resilient and sustainable; **SDG12** = Ensure sustainable consumption and production patterns; **SDG13** = Take urgent action to combat climate change and its impacts; **SDG14** = Conserve and sustainably use the oceans, seas and marine resources for sustainable development; **SDG15** = Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss; **SDG16** = Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels; and **SDG17** = Strengthen the means of implementation and revitalize the global partnership for sustainable development.

Key contact/s and further information

Secretariat of the Permanent Secretary
at the Ministry of Health of Suriname
Email: secretariaat.directeur@health.gov.sr

Dr. Pierre Pratley, Specialist, Sustainable Development and Health Policies,
PAHO/WHO Country office
Email: pratleypie@who.int

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Health in All Policies

Healthy Neighbourhoods – closing the gap in health inequality, City of Quito, Ecuador

Authors

Jose Ruales[A], Francisco Obando[A], Rene Loewenson[B]

[A]Municipio del Distrito Metropolitano de Quito (Municipality of Quito), Ecuador
[B]Training and Research Support Centre (TARSC), Ecuador

11

Introduction

The vision for the City of Quito in Ecuador is that it becomes a city that stands in solidarity with its vulnerable populations, a smart city of opportunity that is people-centred and made up of healthy and sustainable neighbourhoods. This vision guides the work of Health in All Policies in the municipality of Quito.

This case study reports on the work of the municipality and communities in the Metropolitan District of Quito (MDQ) and the 1,298 neighbourhoods that have emerged over time as the city has grown and changed. The residents of Quito have a sense of belonging to their neighbourhoods and organise to make community-led decisions and implement actions at this geographic level.[1] The Health Department of the Municipality of Quito leads the efforts to promote health and prevent disease. A key component of these efforts is the implementation of a project called *Healthy Neighbourhoods - closing the gap in health inequality*. This case study describes how this project is working to improve the health and well-being of Quito inhabitants, through integrating health in local public policy, urban planning and local investment decisions by promoting community participation in health and leading advocacy work to include health considerations, with input from the community, in the policies of relevant sectors of the local government.

Ecuador's 2008 Constitution[2], Organic Health Law[3], National Plan for Good Living 2013-2017[4], and recent reforms to the Organic Code of Territorial Ordering, Autonomies and Decentralisation in 2014 and 2015[5], and Metropolitan Ordinance 0494[6] regarding the organisation and articulation of the health actions of the Municipality of the Metropolitan District of Quito, all set an enabling legal framework for a Health in All Policies approach and for a more holistic rights-based approach to and for social participation in health. Article 32 of the Constitution provides for health as a right whose implementation is linked to the exercise of rights to water, food, education, physical culture, social security, healthy environments and other areas that sustain good living.[2] The *buen vivir* (good living) model in the Constitution conceives that personal well-being is reached when humans' basic needs are satisfied in harmony with the community and the environment.[7] The Ecuador National Plan for Good Living 2013-2017 locates health within *buen vivir* in a holistic intersectoral perspective, which encompasses life habits, food culture, promotion of physical activity, health services, sexual, reproductive and intercultural health and a healthy environment within a social and solidarity economy.[8] This is located within the right to the city and its democratic management.

The DMQ is an autonomous local government according to the Ecuadorian Constitution. It has decentralised powers to plan and exercise control over various aspects of urban development to implement rights to these different dimensions of wellbeing, such as to allocate land, and to plan, build and/or regulate road and public transport systems, public services for drinking water, sewerage, wastewater treatment, solid waste management and sanitation, physical infrastructure, health promotion and prevention and education services and spaces for social, cultural and sports development, in ways that preserve the architectural, cultural and natural heritage of the city. The *Organic health law* identifies the role of schools, communities and municipalities as key spaces for delivering on health through inter-institutional and intersectoral approaches with participation and oversight of the community.[3] The *Organic Code of Territorial Ordering, Autonomies and Decentralization* provides for these needs to be met in ways that involve citizen participation, oversight and accountability.[5] The *Metropolitan Ordinance 0494* 2014 requires that municipalities promote a culture of civic coexistence based on respect, recognition and appreciation of diversity, gender equality, generational and inter-cultural diversity, with special protection for priority groups, and citizen participation in health actions.[6]

In 2016 the City of Quito joined the Healthy Cities movement; the mayor signed a letter of intent to participate in the Ecuadorean National Program of Healthy Municipalities (see Box 1) led by the Ecuadorean Ministry of Health (MoH)[9] and the Pan American Health Organization (PAHO/WHO).[10] This program provided a point of entry to work in coordination with departments of the city that have jurisdiction over determinants of health in order to take into account the impact of environmental, economic development, public spaces, urban planning and other relevant policies on health outcomes.[11]

Box 1. Healthy Municipalities Program, Ministry of Health of Ecuador

The Healthy Municipalities Program guides municipalities through a three-step process to improving social determinants of health, culminating in certification as a 'Healthy Municipality'. The Ecuadorean Ministry of Health created the program to help municipalities address the health and well-being of the population and to make the connection between health and its determinants. The program has four objectives: to promote the certification of healthy municipalities; to provide technical assistance and support to participating municipalities; to leverage national technical and financial resources from various ministries to support the work of participating municipalities and finally to promote citizen participation in health.

There are three main steps:

1. A public declaration and letter of intent from the mayor and council of the city that actions that have a high impact on health will be prioritised.
2. Undertaking a participatory analysis of information for the health 'situation room' of the Ministry of Health.
3. The municipality is evaluated based on their performance on a scorecard that includes indicators of the municipality's provision of basic services, healthy spaces, the promotion of healthy practices, promotion of active transport, and participatory and inclusive planning.

The scorecard uses a stop light system that helps a municipality to self-evaluate for each indicator. When the municipality has 85% of the indicators in green it is eligible for certification as a Healthy Municipality.

The intersectoral effort was focused on getting action on the determinants of non-communicable diseases (NCDs) onto the agenda of the various relevant departments, agencies, and public corporations of the city. Issues related to NCDs are well researched and understood by the Department of Health but the policies, projects and services of the various departments of the city are well-positioned to change the environmental, social, and economic environments of the city that impact on NCDs, in close collaboration with citizens and civil society.

One element of the program is the adaptation of the WHO Urban Health Equity Assessment and Response Tool (Urban HEART) methodology to the Quito context.[12]

Vision, aims, objectives

Health inequalities were identified based on preliminary analysis of the available information on health[13-15] and its determinants. For example, in 2014 the rate of deaths from diabetes was 9.64 per 10,000 people in Cotocollao, an urban parish of Quito, whereas the rate for the Metropolitan District of Quito was 1.86.[16] The rate of chronic respiratory disease for every 10 000 habitants in La Magdalena, a parish of Quito, was 6.53 whereas the rate for the DMQ was 1.3.[17] In 2011-2013 the rate of child malnutrition in Ecuador was 25.3% for children under 5 and the rate for the DMQ was 21.6%[18], but strong inequities are evident in neighbourhoods in Quito ranging from 7.2% in Iñaquito to 42.9% in Solanda.[19]

Therefore, while the legal and policy environment promotes social participation in health, and while important information on health and its determinants is available, the Department of Health identified two key barriers to a Health in All Policies approach that integrates community input. First, municipal actors responsible for generating and implementing policies that impact on the social, economic and physical environments, do not systematically analyse health data as part of their policy generating process. Secondly, the input and active participation of the community is not part of the policy development process. Relevant health information is not in a suitable format to support local decision-making and has not been shared or discussed with relevant civil society actors or with organised neighbourhood groups. Citizens were thus not empowered about their health and had no access to mechanisms to influence local public policy.

Finally, the mayor and council´s clear mandate to invest in the well-being of the inhabitants of Quito made it possible for the Department of Health to propose and initiate the implementation of the project Healthy Neighbourhoods - closing the gap in health inequality project. The program was initiated in 2015, to address the barriers mentioned through a more concerted effort to create the conditions for social participation in health, promotion of healthy spaces and promotion of healthy local policies. With the support of the Secretary of Health, a coordinator of health determinants and territorial action and an officer were hired and the participatory interventions integrated within the Healthy Neighbourhoods project. It was given a small seed budget for 2017 (US$114,000) that will be increased based on demonstrated value of the work.

General objective

To contribute to the improvement of the health and quality of life of the population of the Metropolitan District of Quito (Municipality of Quito) by addressing the determinants of health and local public policy decision-making, generating and sharing local best practice with other medium sized cities of Ecuador.

While the immediate beneficiaries are the 129,581 inhabitants of the parishes of Ponciano, Centro Histórico and Chimbacalle, these dissemination and outreach processes mean that the work will be shared with and reach all neighbourhoods in DMQ and their 2,781,641 inhabitants by 2020 as well as other communities and services through exchanges with other cities in the Americas.

Specific objectives:

- Create the conditions for dialogue and intersectoral action on health among the departments of the Municipality of Quito through the implementation of coordination, analysis and decision-making mechanisms.
- Promote the participatory monitoring of health risks and the collective evaluation of the impact of local public policies through mechanisms of coordination and social participation in health.
- Generate applicable information from primary and secondary sources, on the trends in health and illness and their determinants.
- Communicate local policies and interventions that benefit health and its determinants by sensitising decision-makers at the political

and technical level of the Municipality to the impact on health of social, economic and environmental initiatives.

- Encourage social participation in health and the involvement of civil society in the generation of local public policies for the benefit of health.
- Ensure the sustainability of the mechanism of inclusion of health as a factor to be considered in the generation of policies of the Municipality of Quito.

The DMQ Healthy Neighbourhoods project aims to improve the health and well-being of the inhabitants of Quito through integrating health in urban planning, local investment decisions and the creation of local public policy, by promoting community-led initiatives and sharing them with other cities. It identifies the means to achieve this change through three intermediate pathways:

1. Increased local public policies generated and implemented with the participation of Quito residents taking disaggregated health data and the social determinants of health (SDH) into account.
2. Increased creation of healthy environments (physical, economic, and social) as a result of citizen participation in and action on community health and its determinants.
3. Increased access to knowledge and best practices in urban health for local governments in the region.

Governance and monitoring

An inclusive institutional mechanism, a Steering Committee, was designed by the DMQ Health Department to be a flexible mechanism to resolve issues that come up at the local level and keep communities informed on the work. A broader intersectoral Technical Health Committee was established with DMQ and external stakeholders' participation. The DMQ asked each internal agency and relevant departments for a delegate to this technical committee. The Ministry of Health delegated the District Director of Health Promotion, responsible for work on the SDH; the DMQ Health Department and 20 agencies of DMQ, MoH and PAHO to be involved in the Technical Health Committee.

Community health work teams at the city and neighbourhood level are being formed and trained by DMQ to bring the voice of the local community to the processes. Work teams are made up of members of the neighbourhood (or geographic area selected) with representatives of the DMQ Health Department and the Secretariat for Territorial Coordination and Citizen Participation. These teams aims to promote participatory work on healthy physical, economic, and social environments.

The community work teams represent the following five sectors of each neighbourhood (or geographical area) and include community representatives from:

1. The community: addressing SDH relevant to the entire community, such as access to natural foods, access to walkable or cycling spaces, smoke-free spaces, or personal safety.
2. Community institutions or organisations: including those that provide social services such as day care centres, churches, senior centres, community centres, and universities.
3. Local health care: including all places where people come to receive preventive care or treatment or health-related emergency services such as hospitals, clinics, and doctors' offices.
4. Primary and secondary education: including private and public schools.
5. Workplaces: including private and public workplaces.

Other sectors include opinion leaders of their sector (education, health, etc.) within the parish. The selection process for interested candidates for the community teams is being led by the DMQ Health Department and is currently underway.

Mechanisms and processes

The mechanisms are being set up within the context of Municipal Ordinance 102, which outlines the various mechanisms for citizen participation. The leaders of the parish (district/ neighbourhood) level assembly define the process for electing the representatives and the voice and capacity they have in the neighbourhood and district level assemblies. The establishment of these assemblies was facilitated in Quito by the Secretariat for Territorial Coordination and Citizen Participation. There are 65 parish level assemblies that are required by municipal ordinance to meet three times per year.

To generate and implement policies and programs that address health equity in a holistic manner and with participation of the residents, the city is producing, gathering and processing information on health and the SDH to communicate with residents and hear their priorities on the state of health in the different neighbourhoods. Through intersectoral coordination, the existing databases of various DMQ departments are being reviewed. Surveys are then designed and implemented to collect missing information. The findings are organised as accessible visual charts to show their importance for population health. The work has also used the United States Centers for Disease Control Healthy Communities program.[20] DMQ staff are being trained on the methods and on initiatives that impact on health and are also developing a virtual platform to display updated and accurate health data and health determinants information disaggregated by districts of Quito, including slum neighbourhoods[21], to make the information publicly accessible.

Residents are involved in and build ownership of the process through their own awareness raising and local 'priority setting' workshops that DMQ holds in local neighbourhoods. These workshops use the evidence gathered by DMQ but also address the issues identified by the communities. In 2017 DMQ will engage further with civil society organisations and explore additional methods for participatory mapping and needs assessment by communities. The workshops with civil society review the health evidence from DMQ, add or collect additional information of interest to residents, prioritise health problems in each locality and develop a road map with activities for both the neighbourhood and city level. The responses are organised in an intervention proposal that is presented to the mayor for approval and implementation.

Article 87 in the framework of Municipal Ordinance 102 includes a provision for the creation of 'citizen observatories'. Citizen observatories are made up of groups of citizens or organised civil society from different sectors, for a period of time, with the purpose of evaluating and providing technical recommendations to promote, evaluate, and monitor public policies. This information then supports the policy-making and implementation processes of the different sectors within the municipality that have an impact on health.

DMQ supports the capacity of residents to generate these intervention plans, or Community Health Plans within their health teams (described earlier). The interventions chosen are those that are seen to have high impact, or that draw on examples of promising practices from the region and from national and international evidence, such as from the Ecuadorean Association of Municipalities, the Resilient Cities initiative and from PAHO. DMQ is providing incentive funds of between $2,000 and $5,000 on a competitive basis to promote community involvement in the development and implementation of plans and initiatives for health. It holds events to provide wider community awareness of the findings of the local health situation, and to launch the contest and award.

The local health teams and wider community set their local plans for improvement of health in their neighbourhood, as proposed by key community stakeholders in the neighbourhood, sports associations, collective neighbours and neighbourhood committees. They then submit these to the competition. The district health

teams develop the criteria for receiving the seed funds based on the preliminary analysis of the health issues in their parish, and determine the winner. These funds support initiatives from the community to improve health and raise awareness, and benefit the wider community, rather than a small group of individuals. This initiative is being piloted in areas of the city where there is institutional capacity to implement the model and show results, but the intention is to target the funds towards, and stimulate participation in, those with higher health needs and where there is a need for support for participation in action on health issues.

Another element of the Healthy Neighbourhoods initiative is that of facilitating a community-led certification of 'healthy spaces' (such as in fresh food markets and schools) within the municipality. The criteria for school certification are developed by the DMQ Health Department in collaboration with the Ministry of Education, the Ministry of Health and PAHO. In the longer term it is intended that responsibility for certification of these healthy spaces will be delegated to the Community Health Teams.

For food markets, DMQ discusses the standards for health promotion and food safety, and the evidence available. Teams from the community, such as the users of the market from the community, the administrative staff, the workers and municipality assess the markets and develop work plans for health improvements on prioritised gaps in the standards. Similar work is done in schools, and for healthy public spaces selected by community teams such as equipped parks or streets in residential neighbourhoods. In all cases the participatory action plans are implemented in coordination with relevant actors, and a participatory process is also used for the review.

The certification process aims to support the administrators and users of spaces like markets and schools to prioritise how to best invest limited resources to address those issues that are important to preserve and promote health and to address any gaps identified. It is expected that the initial effort around receiving a certification will forge a working relationship between the relevant actors to ensure continued improvement of these spaces even after certification.

The involvement of citizens in the policy-making process, of the different sectors of the City of Quito, creates a powerful incentive for sectoral policies to consider the full breadth of impact they have on Quito inhabitants. Citizens that are empowered with the tools and knowledge of how their environment is affecting their health support the health sector to ensure that policies work to improve health and the determinants of health. The project works to identify allies for health and a base of supporters for healthy policies. At times this may not be the most economically beneficial strategy, at least in the short run.

Establishing and maintaining partnerships

These processes being facilitated by DMQ are designed to empower and guide the different community sectors (education, health, community institutions) to act within their area of influence, so that they have the power to implement these changes. Out of this work DMQ expects to identify valuable input that informs the creation of public policy and guides the prioritisation of tasks for the municipal government. These tasks will be part of the agenda of the Secretary of the Health Department, who will in turn negotiate with the mayor's office, other departments and agencies and the City Council on behalf of the community, to ensure inclusion in their plans, budgets, policies or ordinances. For the communities, these approaches resonate well with collective approaches customarily used for improvements that have wider social benefit. For health sector personnel, engaging communities and strengthening their understanding of the health implications of the decisions, activities and choices being made on priorities and resources is clarifying the health impact of people's decisions and embedding health within their thinking and priorities. DMQ's key role in promoting population health is accepted by the

Ministry of Health and making the link between health and its determinants is strengthening health promotion and population health improvements within the community.

In addition to the partners already outlined, the DMQ also works in partnership with local universities and international organisations. DMQ has negotiated internships in the Metropolitan Health Units and graduate students have led workshops in physical activity. PAHO has supported the work through both international specialists and local teams, providing technical support and skilled facilitators for the work with the community. PAHO is also supporting efforts to exchange best practices with other cities in the country and Latin America and Caribbean (LAC) region. For example, in October 2016 a meeting was held with several cities on *Urban Health and Chronic Non- Communicable Diseases* to share experiences with other cities in Ecuador and with Mexico City. In 2017 similar workshops are planned to share experiences.

DMQ also plans to hold meetings with other cities to share knowledge and local best practices that improve health. This exchange is important to strengthen and support local capacities and build networks for urban health.

Box 2. Health in All Policies and risk prevention at the local level: HEALTH ON THE GO. From risk prevention to cross cutting action on SDH

The frequency of NCDs in the city, which is characterised as being in epidemiological transition, is growing. The majority of the major causes of death are due to NCDs and there is a high prevalence of associated risk factors for NCDs such as overweight, obesity, raised blood pressure, hyperglycemia (high blood glucose levels), hyperlipidemia, tobacco use, unhealthy diet, harmful use of alcohol and physical inactivity in all age groups.[22] In response, the Health Department of the Quito Municipality implemented a program to screen for NCD risk factors, provide nutritional education and counseling in physical activity.

In more than one year of implementation of the program, 12.8% of the population of the Metropolitan District of Quito (MDQ) was screened. The results showed there was a high prevalence of overweight and obesity in primary school aged children (33.2%), adolescents (23.7%), adults (64.1%) and older adults (46.9%), especially in adult women; of the total of overweight and obese adults, 60% were women), There was also low access to healthy foods such as vegetables and reduced opportunities for physical activity, especially in the neighbourhoods of the historic centre and in areas of greater poverty.

It was identified that determinants such as income and education influence the consumption of foods of low nutritional value and low cost.[23] The restricted availability of recreational spaces in more disadvantaged districts with deficiencies in the urban infrastructure and greater security risks, also limits the practices of physical activity and sports, especially in women.

The notion of common public policy across agencies in the Municipality was discussed with key partners, and programs were identified in different agencies to contribute to increasing healthy lifestyles and risk reduction. In coordination with local teams (zones, parishes and neighbourhoods) of the Municipality and other municipal agencies, intersectoral actions have been identified that positively influence the social determinants that have the capacity to modify the detected risks. CONQUITO, an agency of the Municipality that promotes economic development has developed more than 200 hectares of urban organic vegetable gardens that

provide healthy food to families that produce and also sell the products in their neighbourhoods; the Department of Sports also implements activities to promote physical activity in parks and public spaces targeted mainly at adult women, such as 'Bailoterapias'[1]; the Department of Transport and Mobility promotes the use of bicycles to get around the city and has implemented safe cycle paths; the Department of Education in coordination with the Department of Health monitors the weight/height of students and promotes healthy eating in school cafeterias; and the Commerce Agency has improved the conditions and quality of fresh food markets in collaboration with the Department of Health to ensure food safety and promote the availability and access of healthy food to name just a few. These collaborative actions between the different departments of the municipality and civil society have the common goal of creating healthy living conditions in the city. As a result, 25% of those who were diagnosed with lower levels of NCD risk at screening points can be monitored for lifestyle changes and significantly reduced or eliminated risk of NCDs, as conditions were created to increase access to nutritious foods and the practice of regular physical activity.

1 A dance/exercise activity with elements of zumba, aerobics and salsa.

Outcomes

The city has identified the program, and health equity outcomes it hopes to achieve, and has set up an interactive electronic system to store, update and give public access to the health information included.

It has set the following outputs for the two-year program:

- 20 participatory health diagnoses in selected neighbourhoods
- 4 technical reports on the environment and health of the MDMQ published
- 3 small grants provided to implement initiatives that improve the environment for the health
- 15 face-to-face or virtual workshops held on knowledge sharing and inter-municipal cooperation for local good practice against health challenges and health determinants with municipalities in Ecuador and the Americas region
- 8 training/knowledge transfer workshops on processes and projects with a high impact on health
- 10 exchange workshops with provincial capital cities in the country and the region.

By December 2018 the outcomes sought are:

- a DMQ representative health work team with increased knowledge and awareness of HiAP is carrying out high impact actions in improving health policies and environments
- 3 community health work teams representing selected geographic areas in DMQ, with increased knowledge and awareness in HiAP, and performing high impact actions in improving health policies and environments
- 100 MDMQ staff trained in tools and techniques for advocacy on health determinants
- 20 Neighbourhood Health Action Plans, developed in a participative way with implementation and financing schedules that involve the Municipality departments and agencies, among others responsible for influencing environmental and socio-economic determinants of health
- 3,300 people, including the district's leadership, with increased awareness of health determinants
- 14 schools implementing health promotion activities
- 15 markets taking health promotion and food safety into consideration.

There have not yet been measured social, health or health system outcomes or changes identified to date. While the investments in the processes and information needed to support assessment of these outcomes have been described earlier, it is still too early to see changes in outcomes.

Areas for shared learning

Key informants in DMQ note that the pre-conditions for the practices are important in any discussion of their adaptation or adoption. The approaches being applied in Quito depend on the municipality having a recognised role for, orientation to and competencies in population health and implementation of prevention, promotion and public health activities. This is critical for engaging other sectors and for the participatory processes. The practices aimed at involving the community in solving their problems draw on a culture of collective work for common goals, and a legal and policy framework that support this.

At the same time, there are practices that could be adapted elsewhere. The steps and processes in Quito related to information gathering, analysis and priority setting in the community, encouraging coordination across sectors, and for ensuring this work supports both community and cross-sectoral roles in solving problems can be shared with other settings. Exchange of these participatory approaches for health promotion is already underway with other municipalities in Latin American countries.

For those in Quito this is a work in progress. There is thus interest to know how other cities and settings are managing their processes. How are they organising information, resources, with what media and mechanisms to support community priority setting, decision-making and action? How have others transformed and communicated the information on health and its social determinants in a way that is meaningful for the concrete realities in communities and for community processes? How have others disaggregated information to show and integrate the diversity of settings and groups, both in decision-making and in assessing progress on outcomes?

Similarly, in progressing a health lens analysis or similar process in the work of various departments of the city, Quito will require support to adapt available tools to the local context. The Health in All Policies approach is still emerging within the Municipality of Quito and technical support in its continued evaluation and implementation will be important.

Challenges and opportunities

Factors and inputs affecting the participatory practices: there is a risk that the mechanisms used do not adequately represent specific groups like youth, women or children. In some areas the culture of participation is weaker than others. To address this, the program is setting up specific efforts to incorporate these groups into the participatory mechanisms, and ensure that people elect their representatives.

DMQ is also aware of the need to ensure that private actors like companies are included in the process and have a role to play and that all actors get the necessary capacity support to play their role. The process raises expectations from community members, and these need to be managed, especially as building the capacities and shared understanding take time, and there are only limited DMQ resources to address stakeholder expectations.

The coordination across sectors is also challenging. Sectors have historically had separate administrative procedures and resources. Historical siloes have to be broken to generate the shared planning, shared indicators of success and shared results for intersectoral action in a way that does not compromise the individual goals of each sector. The resources for health exist at three different levels: the local health sector resources; in those applied across sectors for (intersectoral) work; and in those that are mobilised locally by residents and private actors. To direct these individual resources toward shared goals, all sectors and the community involved need to know their roles, to be part of the identification of problems, priorities, needs and interventions, in processes that are effectively and professionally facilitated. Key informants from DMQ perceive that this

needs time and needs to progress step by step. The evidence being gathered should build the confidence of the sectors and communities involved, in the links between health and key social determinants and the outcomes from the work. As important are the relationships being built, and the focus on priorities identified by the community.

Key contact/s and further information

Dr. Jose Ruales, Secretario de Salud, Distrito Metropolitano de Quito
DMQ Health Department, Quito, Ecuador
Email: jose.ruales@quito.gob.ec

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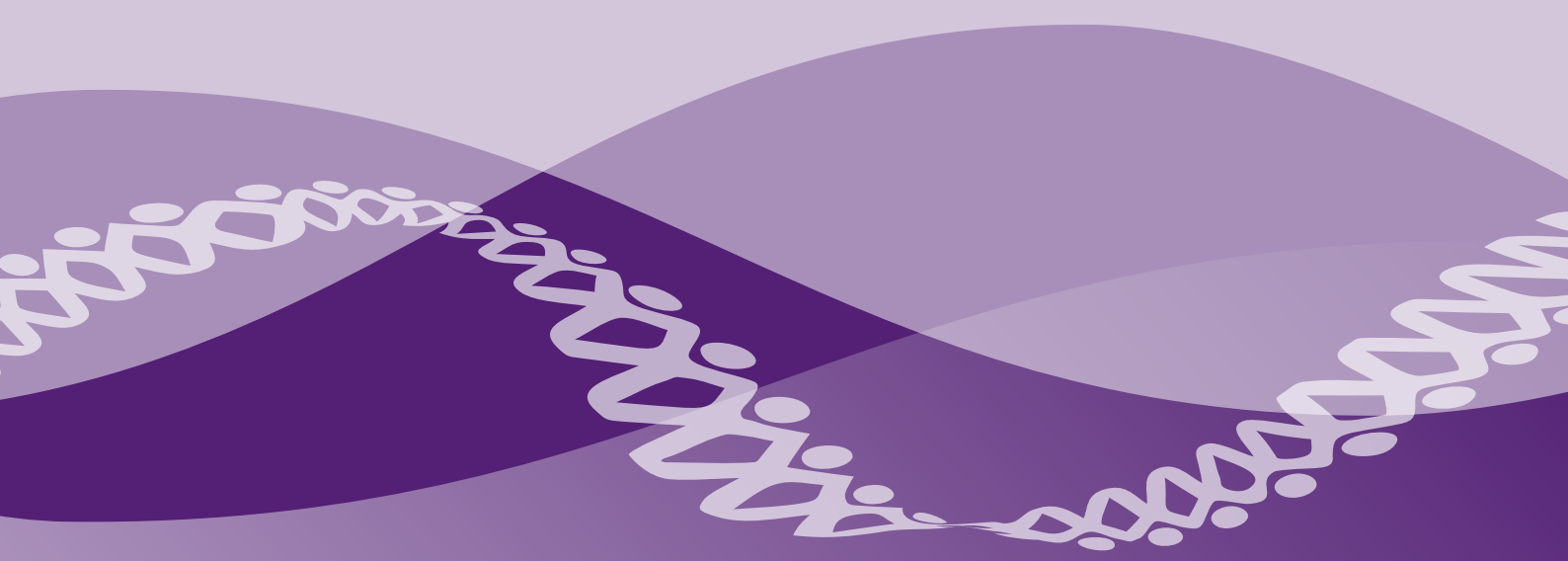


Health in All Policies

Namibia: Developing a National Strategy on Health in All Policies

Authors

Axel Tibinyane[A],

[A]Ministry of Health and Social Services, Namibia

12

Introduction

Namibia has an estimated population of 2.3 million inhabitants and one of the lowest population densities per square kilometre. Distances between settlements are far, and remote areas are often not readily accessible. Two-thirds of the population live in the five northern regions, while one-tenth live in the vast areas of southern Namibia. Women of child-bearing age and children less than 15 years of age constitute over 70% of the population – children under 15 years alone represent 36% of the overall population.[1]

Although categorised as an upper middle-income nation, the distribution of wealth in Namibia is one of the most unequal in the world and a large proportion of the population live below the poverty line. It is estimated that 27.6% of the population is poor and 13.8% are severely poor. The government spends 4.7% of its GDP on health care.[2]

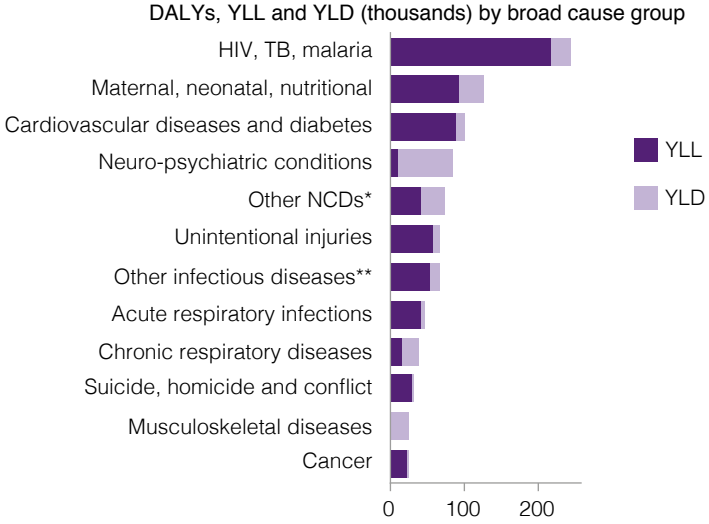
Top 10 leading causes of loss of productive life-years

Poor health and health inequities cause personal suffering and missed opportunities for social and economic development. Each year Namibia loses approximately 920,000 productive life-years due to ill-health and premature death.[3] The top four are: (1) 'Communicable diseases', (2) 'Maternal, neonatal, and nutritional disorders', (3) 'Noncommunicable diseases' and (4) 'Injuries' accounting for: 26% (236,000 DALYs), 27% (246,000 DALYs), and 36% (344,000 DALYs), and 10% (94,000 DALYs) respectively. The specific top 10 leading causes of disease are seen to reflect the mixture of infectious, maternal and noncommunicable diseases and injuries (Figure 1).

Benchmarking against 15 comparator countries with similar levels of national income (GDP per capita) shows that in relation to Namibia's 15 largest contributors to the burden of disease, there is considerable room to improve compared with the *'best-in-class'* (Table 1).[4]

Figure 1. Burden of disease data Namibia 2012

Disability-adjusted life years (DALYs) are the sum of years of life lost due to premature mortality (YLL) and years of healthy life lost due to disability (YLD).



*Other noncommunicable diseases (NCDs) including non-malignant neoplasms; endocrine, blood and immune disorders; sense organ, digestive, genitourinary, and skin diseases; oral conditions; and congenital anomalies.
** Infectious diseases other than acute respiratory diseases, HIV, TB and malaria.

Source: Namibia: State of the Nation's Health. WHO, Namibia 2016.

Table 1. Ranking of Leadership age-standardized of DALYs

Country	HIV/AIDS	Diarrheal diseases	Lower respiratory infections	Tuberculosis	Interpersonal violence	Stroke	Preterm birth complications	Iron-deficiency anemia	COPD	Major depressive disorder	Malaria	Diabetes	Neonatal encephalopathy	Ischemic heart disease	Mechanical forces	Low back pain	Congenital anomalies	Road injury	Epilepsy	Hypertensive heart disease	Asthma	Neck pain	Other cardio & circulatory	Maternal disorders	Cardiomyopathy
El Salvador	12	8	7	3	15	1	9	7	1	12	5	7	4	7	1	4	11	15	11	7	10	10	5	6	5
Albania	8	1	8	1	8	9	1	3	3	9	6	2	3	9	11	15	2	8	5	6	4	12	13	1	10
Ukraine	14	4	4	11	7	10	3	5	5	2	7	3	9	14	13	14	13	11	4	4	5	13	1	2	12
Marshall Islands	1	12	12	13	12	12	14	4	10	13	10	15	10	10	7	7	9	6	12	11	14	4	12	13	13
Tonga	1	9	6	9	11	4	7	8	7	5	11	12	6	6	2	10	7	5	9	2	13	6	6	11	7
Turkmenistan	11	11	11	12	5	14	10	11	12	14	3	6	15	15	12	6	3	10	8	12	6	11	4	4	8
China	9	2	2	5	1	8	2	1	14	1	9	4	8	3	5	3	6	14	1	8	1	8	3	5	3
Namibia	**15**	**15**	**13**	**15**	**13**	**11**	**15**	**15**	**15**	**6**	**15**	**10**	**14**	**4**	**15**	**1**	**10**	**4**	**15**	**15**	**11**	**15**	**14**	**15**	**14**
Samoa	1	7	10	8	10	5	4	2	9	3	12	13	5	2	6	8	1	3	10	3	12	7	8	10	9
Egypt	6	10	9	4	2	13	11	12	11	10	1	5	1	13	4	12	14	12	3	14	7	2	15	8	15
Guatemala	13	14	15	10	14	2	13	14	2	11	13	9	7	5	8	11	4	1	14	5	3	9	7	12	4
Armenia	10	6	5	7	3	7	5	6	8	7	4	8	12	12	14	5	12	9	7	10	2	14	2	3	6
Jordan	5	5	3	2	6	6	8	10	4	15	2	11	2	8	9	13	15	7	2	13	9	1	9	9	1
Vanuatu	1	13	14	14	9	15	12	9	13	4	14	14	11	11	10	9	8	13	13	9	15	5	11	14	11
Maldives	7	3	1	6	4	3	6	13	6	8	8	1	13	1	3	2	5	2	6	1	8	3	10	7	2
Ranking Legend		1 - 3				4 - 7				8 - 11				12 - 15											

Source: GBD profile Namibia. Institute for Health Metrics and Evaluation, p4.

The Ministry of Health and Social Services (MoHSS) has found it difficult to achieve improved health outcomes for the past two decades and this is partly attributed to the non-engagement of other sectors in relation to policies, planning and implementation.

Although there were attempts to engage other sectors such as through the Healthy Cities initiative, road safety and injury prevention strategies, there has not been a targeted government-wide approach to consider how other sectors' policies impact on health. The endorsement of the Sustainable Development Goals[5], which link health more strongly with other sectors' work, necessitates a conscious, well-coordinated system which monitors the development of other sectors' policies and the ways in which they interact with health goals.

Typically, individual health care only explains 20% of the level of population health outcomes. The remaining 80% is shaped by a range of social determinants (50%) and individual health behaviours (30%).[6] Health behaviours and exposure to risk factors are also shaped by social determinants (e.g. lack of access to basic services, good quality education, food, etc.). This reinforces the need for intersectoral collaboration.

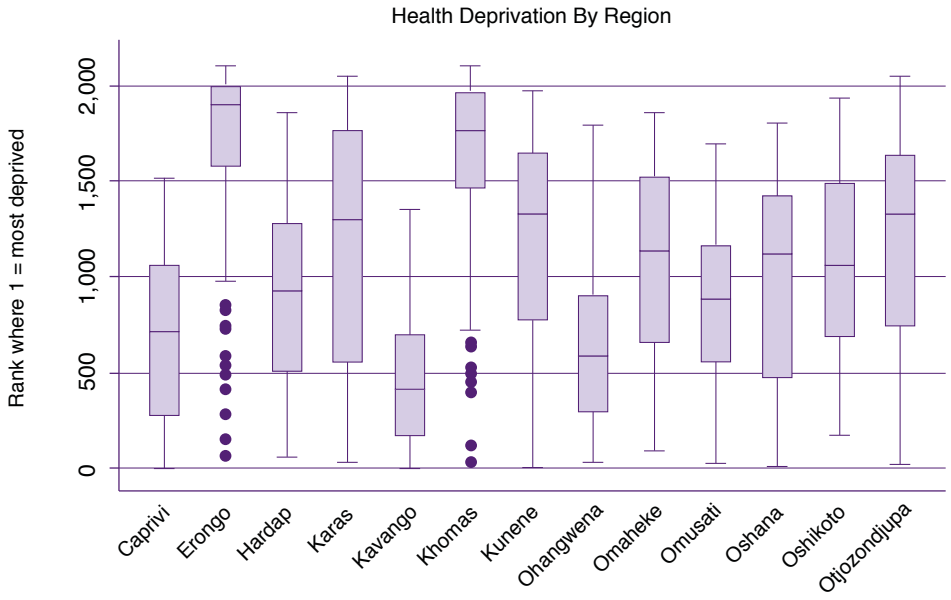
Dimensions of inequity

Societal policies and norms shape the conditions in which people are born, live, and work. The conditions in which people are born, live and work are the most important determinants of population health and health inequalities.

Amongst key development forces at play in shaping population health, health services and policies to extend universal health coverage are critical. Yet while primary health services undertake critical targeted prevention (e.g. immunisation), health services are left to respond to health conditions largely determined by social, economic and political systems, development agendas and social norms. These driving social determinants cause health inequities and influence health and development. They can be addressed through public policy and intersectoral action.

Health deprivation frequently coincides with environmental, economic, and political disadvantage. The pattern of health deprivation of households and individuals can be described for families living in different geographic areas of Namibia. The National Planning Commission estimated health deprivation in 2011, using

Figure 2. Interquartile Range of Datazone Level NIMD2011



Source: National Planning Commission. Namibia index of multiple deprivation. Chart 4(B) Windhoek, NPC

the years of potential life lost (YPLL) indicator by area of the country (an age and gender standardised measure of premature death i.e. death under the age of 75). Areas with low life expectancy, high levels of HIV, and perinatal and child mortality, have higher deprivation and are ranked first (Figure 2).[7]

Local government, development and environmental factors affect the health of the population in different regions. But the spread within regions is also affected by socioeconomic class, gender and occupation, which shape deprivation across the whole of society in Namibia, cutting across geographic boundaries.

Vision, aims and objectives

Vision

The Namibian Government addresses the social determinants of health in all public policies with improved health outcomes at the population level.

Aims

Through the Health in All Policies Strategy, ensure that all public policies systematically take into account the health implications of decisions, seek synergies and avoid harmful health impacts on population health and health equity.

Objectives

- Establish a coordination and monitoring mechanism to implement policies that impact positively on the health of the population across all sectors in government.
- Create a shared vision of population health (healthy society) and buy-in across all sectors in government.
- Create a shared understanding of the driving determinants of health and the social distribution ('social determinants of health inequities') across sectors and industries.
- Create shared responsibility for health across the public sector and the whole-of-society through appropriate engagement, capacity building, implementation and accountability and governance mechanisms, tools and institutions.

Governance, reporting and monitoring

On return from the 2016 World Health Assembly the Minister of Health and Social Services presented a paper on Health in All Policies to Cabinet making the case regarding other sectors' impact on health. Cabinet then directed that the Ministry lead the process of developing an implementation strategy for Health in All Policies (HiAP). The Ministry requested WHO provide both technical and financial support to Namibia to progress this strategy. WHO Geneva and AFRO, with Zambia and Botswana Country offices, undertook a scoping mission and laid the foundation for the development of the strategy.

In February 2017, the Ministry of Health, with support from WHO, facilitated a national workshop on HiAP with stakeholders from the health, transport and social welfare sectors. The workshop served as a follow-up to the scoping mission but was also designed to craft a roadmap for the National Strategy on HiAP. Although MoHSS, had led the introduction of the Health in All Policies approach, the workshop recommended that the Office of the Prime Minister and the National Planning Commission be brought into the governance of a process in order to ensure appropriate coordination with the other sectors. A key role for the MoHSS is providing secretariat support and catalsying the process. To respond, MoHSS has established a Technical Working Committee. This Committee is comprised of representatives from the Office of the Prime Minister, National Planning Commission, City of Windhoek, University of Namibia, WHO and MoHSS. The terms of reference for this Committee are to draft the Health in All Policies Implementation Strategy and oversee the first year of activities according to specific prioritised themes.

Thematic working groups will be established once the HiAP implementation strategy is developed. These thematic working groups will report on progress to the Technical Working Committee and also use the TWC as a sounding board to overcome barriers to intersectoral work. The thematic working groups will work within a specific timeframe towards set goals and may be dismantled once the objectives are met.

Mechanisms and processes

The involvement of the Office of Prime Minister, National Planning Commission and Local Government will be critical in taking forward the governance aspects of the HiAP approach. Government ministries, private sector, civil society and communities will all be involved in addressing specific issues and fast tracking action on key determinants of health. The involvement of communities is critical to ensure broad-based consensus on the priority determinants driving health and patterns of health inequalities. Following the consultation workshop, six entry points for first-wave policy action were identified. These include road safety, education, water and sanitation, nutrition and other modifiable risk factors contributing to major noncommunicable diseases, gender and gender related violence. Taskforces involving key stakeholders will be the driving force, linking to the overall coordination led by the Office of the Prime Minister and ensuring periodic reporting. A national Health and Social Welfare committee is proposed under which HiAP will be coordinated, although this will have a broader mandate and serve as an advisory body on all health related issues.

Discussions across different ministries have emphasised the importance of involvement of development partners. They can play a supportive role in the process if their work is aligned to the National Development Plans (NDPs) which should be in line with the Sustainable Development Goals (SDGs).[5]

Vision 2030

Vision 2030 is the overarching long-term strategic development framework for Namibia and it incorporates health and social determinants as key development priorities. The implementation of Vision 2030 is through National Development Plans. It provides the basis on which HiAP can be integrated in the NDP, reminding sectors and industries of their responsibility to ensure the attainment of quality health for all.

Namibia National Development Plan (NDP) 5[8]

This plan defines the policy and development agenda for government for the next five years and provides an excellent opportunity to incorporate Health in All Policies as a key approach to how government will develop and approve policies.

NDP 5 focuses on 20 thematic areas aligned to the Sustainable Development Goals. Some of the examples that provide a window of opportunity for introducing intersectoral action include: road safety, education, water and sanitation, nutrition and other modifiable risk factors contributing to major noncommunicable diseases, gender and gender related violence. Key determinants of social conditions for health and the links to SDGs and proposed first wave of intersectoral action include:

- Environmental conditions: SDG 6.1. Access to safe drinking water; SDG 6.2 Sanitation; SDG 7.1 Modern energy; SDG 11.1 Adequate housing and basic services
- Inclusion conditions: SDG 16.7 Ensure responsive, inclusive, participatory, representative decision-making; SDG 16.10 Ensure public access to information; SDG 17.19 Birth and death, registration coverage, routine population census
- Livelihood conditions: SDG 1.3 Implement social protection systems; SDG 2.1.Ensure access by all people to safe, nutritious, food; SDG 4.2 Ensure that all girls and boys have access to quality early childhood development; SDG 8.8 Protect labour rights and promote safe and secure working environments.[5]

There are several ongoing activities which provide an opportunity for the consolidation of these priorities into a coordinated Health in All Policies approach. This includes collaboration with the education sector (school health); social welfare sectors (gender based violence and social ills); agriculture and water (sanitation). Other opportunity to exploit HiAP strategies include building linkages with the environmental sector, energy sector and rural development, local and regional government sectors. It is clear from the NDP 5 that many of these sectors have considered the key targeted populations and how their strategies can improve on health outcomes. The Ministry of Health and Social Services has also adopted two strategies in the NDP 5 which will propel the development of HiAP: effective governance (legal and policy framework) and improving communication and stakeholder engagement. These are key strategies that will serve as pillars in the proposed HiAP Strategy and will link to the existing strategies of other sectors.

Further, the Ministry is actively engaging stakeholders to develop a Universal Health Coverage model, which in itself makes HiAP an important and key strategy to improve quality of health.

Key Institutions

The Office of the Prime Minister and the National Planning Commission: cross-sectoral health lenses for Health in All Policies

- The National Planning Commission maintains a catalogue of new policies. Providing the Commission with a health lens tool/mechanism will help them improve screening of policies for population health impacts.
- The Office of the Prime Minister (OPM) is proposed to lead the HiAP process through an existing structure.
- Requests for health lenses are to be submitted to Cabinet by the lead sector. Further:
  - A Memorandum of Understanding is to be co-signed by the Ministry of Health and Social Services and the lead sector to conduct a health lens *prior to the completion of the proposed policy or programme or investment design*.
  - A final report will be prepared including proposed recommendations for coordinated actions and responsibilities by the sectors involved and this will be submitted to Cabinet or other existing structures. The agencies involved will report annually on progress as part of routine reporting.

The National Institute of Public Health unit in the Ministry of Health & Social Services

The National Institute of Public Health is being established as a unit within the Ministry of Health and Social Services. Once established the Institute will support cross-sectoral engagement for Health in All Policies.

- These capacities are important to support the National Planning Commission and other sectors in implementing health lenses and coordinating action for Health in All Policies.
- Capacities for tracking health determinants using disaggregated data to show progress on areas of high population deprivation and vulnerabilities, and reductions in social inequities will be introduced into the new health information platform of the Ministry of Health and at the President's Office.
- Capacities for analysing the links between health, health inequalities and determinants are built into the investment budget and structure of the new National Public Health Institute. The partnership with the University of Namibia, School of Public Health needs to be strengthened for further capacity development.

Table 2. HiAP Timelines

Milestones	Date
Presentation of the HiAP concept for Namibia (OPM and MoHSS) including presentation and briefing note	Week of 3 Oct 2016
A description is prepared (using a briefing tool) outlining how health and sustainable development will be addressed through each pillar and theme	According to the NDP5 planning
National Planning Commission coordinates and validates finalisation of the health impact write-up with technical support from the Ministry of Health	
OPM to activate the HiAP steering/ coordination process and issue a position statement	
Intersectoral stakeholder workshop	February 2017
Implementation strategy launched outlining the accountability process including monitoring and evaluation plans, priorities for health lenses and roles and responsibilities (including budget alignment and additional seed funding where needed)	November 2017
Implementation of Health Lenses and capacity development	March/ April 2018
Health determinants report (two yearly)	2018
A national health forum 2018	June 2018

Establishing and maintaining partnerships

The Health Ministry have already established partnerships and collaboration across some sectors including the Ministries of Education, Works and Transport, tertiary institutions and some civil society organisations. However these are not functioning optimally and need to be strengthened while new partnerships with non-traditional sectors need to be forged. With the onset of the development of the National Strategy on Health in All Policies, most stakeholders have been engaged through a national workshop as well as subsequent one-on-one consultations and through the establishment of mechanisms for collaborations.

Consultations on HiAP started in October 2016, with a team of WHO Technical Officers from Geneva, Brazzaville and Harare involved following the Health Ministry's invitation. They held round table meetings with various Ministries with existing partnerships with the health sector. Additional consultations with the National Planning Commission were held seeking opportunities to include HiAP in the draft NDP 5.[8]

Outcomes

Intersectoral action for improved population health outcomes is at its initial stages and it will not be possible to report on outcomes until after the first two years of implementing the NDP 5. However there has been good progress on structures designed to support HiAP.

Challenges and opportunities

The WHO team of technical experts identified key challenges and opportunities during their four-day in-country visit.

Key Challenges

- A range of existing collaborative and coordination mechanisms exist. Non-legislative mechanisms are frequently supported by memoranda of understanding and inter-ministerial committees. These mechanisms are not functioning optimally given that inter-sectoral representation is frequently absent or, when present, sectors are represented by more junior staff.
- Strategies, polices and action plans exist to support intersectoral work for health (e.g. Department of Trade, Industry and control of unhealthy products; Department of Transport and road safety issues). However, at the level of implementation, budget lines and allocated human resources are weak.
- Oversight of policy and planning coherence is being undertaken and has been given increased importance by the National Planning Commission. To equip the relevant unit to assess the health implications of these policies as part of their normal work, tools such as a determinants of health checklist and a signalling system need to be developed.
- Policy coherence for health and health equity at the local and national levels and between different arms of government needs strengthening (e.g. coherence between local ordinances and a revised public health act, parliamentary submission of bills to allow open-trading and liquor licences in communities, Ministry of Health five-year development plan proposed targets for reduction of alcohol consumption by children (9% to 7%) and Ministry of Education plans for improving health education in schools).

Opportunities

- *Child welfare:*
  - > The burden of disease for nutrition is the second leading cause of lost productive life-years (2012) and a driver of future increases in the incidence of chronic diseases.[3] Due to the high prevalence of HIV, many households are caring for AIDs orphans, placing enormous burdens on individual families. They require broader-based social support.
  - > Areas for cross-sectoral action include: pre-school nutrition at community centres, school-feeding programmes, improvements to targeting of social welfare grants and alcohol policy coherence.
  - > Education sector work on health through school health policies, substance abuse programs, skills training, changes to the education curricula including health literacy and healthy school environments will be key points of intervention with multiple benefits for country development and population health.
- *Women's well-being*
  - > Preventing and addressing situations of domestic violence is a major concern of the health sector (see five year plan).
  - > The Ministry of Gender Equality and Child Welfare will be key partners with respect to strengthening the initiatives for the child welfare grant and community-based interventions for well-being for women and children.
- *Improved housing and amenities to informal settlement populations in urban areas*
  - > Diseases, including tuberculosis, thrive where populations have poor housing and living conditions and insufficient basic water and hygiene services.
  - > In the Windhoek metropolitan area around a quarter of the population are living in informal areas; local solutions are required to meet the housing and basic needs of these populations while also balancing the needs for infrastructure and employment opportunities in rural areas.
- *Remoteness and rural services*
  - > The department of defence highlighted their role in remote areas, and increases in cross-border malaria; health deprivation indices highlight the general primary health care needs in these areas.
  - > Opportunities to improve primary health services, while at the same time strengthening tourism and environmental sanctuaries in remote areas can provide sustainable employment options for rural communities and improve health outcomes.

Reflections and conclusions

Intersectoral action in Namibia is not new, however a HiAP approach provides an opportunity to strengthen and broaden these partnerships to improve health outcomes at the population level. It will also provide an opportunity for sectors and industry to be accountable for their decisions and actions that may have contributed to negative health outcomes. HiAP provides excellent opportunities for all sectors of government to take the health of the population into account and to allocate more resources to health promotion and disease prevention.

Key Contact/s and further information

Axel Tibinyane, Deputy Permanent Secretary, Ministry of Health and Social Services, Windhoek Namibia

Email: Axel.Tibinyane@mhss.gov.na

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Health in All Policies

Zambia's experience in national policy formulation and how it informs the HiAP process

Authors

Kennedy Malama[A], Crusivia Hichikumba[B], Nora Mweemba[C],

[A]Ministry of Health, Zambia

[B]Cabinet Office, Policy Analysis & Coordination Unit, Zambia

[C]World Health Organization, Zambia

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Introduction

Zambia faces a high burden of communicable and non-communicable diseases while maternal and child mortality are still a major concern. Structural and social deprivation including poverty, income inequalities and marginalisation remain major threats to health. The Government of the Republic of Zambia recognises that the broader determinants of health lie outside the health sector and is committed to ensuring that the responsibility for building healthy lives and promoting well-being for all is not confined to the health sector alone. Health in All Policies (HiAP) is a valuable approach in tackling the determinants of health and risk factors through public health policy and practice across sectors in order to improve population health and equity. This intersectoral approach to promoting better health is intertwined in the national policy process.

The Government's vision regarding health is the attainment of "a high quality of life for all both in rural and urban areas by 2030".[1] This entails reducing the disease burden to the lowest levels possible based on the realisation that health, like education, plays a significant role in the development of the nation. A healthy population is a productive one while poor health due to diseases and inadequate nutrition, hygiene and health services further limits the prospects of poorer people for work and from realising their mental and physical potential.

The objective of this paper is to demonstrate that, although it is only now that efforts are being undertaken to institutionalise the HiAP approach in promoting good health, Zambia has in place a national policy framework that provides for mainstreaming the HiAP approach and other cross-cutting issues in the policy process.

Zambia's national policy process

Zambia's policy formulation process is well documented in two Cabinet documents - the Cabinet Handbook[2], and the Guide to Preparing National Policy Documents and Cabinet Memoranda (the Guide).[3] These documents were first published in 1996 as part of the reforms on policy formulation and implementation, with a view to facilitating the effective discharge of responsibilities and functions by the Policy Analysis and Coordination Division.

To foster adherence by ministries to the standard format of preparing Cabinet documents and thereby improving the operation of the government system, the Guide is provided to all ministries. It is the main guiding document for facilitating the interface between the Cabinet Office and all ministries on matters pertaining to the policy process and cabinet business.

The Cabinet Handbook lays down the principles, processes and procedures by which the Zambian Cabinet system operates. It is designed to assist members of the executive wing of government in the effective and efficient day-to-day handling and processing of matters requiring Cabinet consideration.

These structured mechanisms and processes facilitate mainstreaming crosscutting issues such as the HiAP approach in Zambia's policy formulation process. So, what is the process like?

The policy formulation process

In the Zambian context, the policy process refers to the collective procedures and/or mechanisms for effective policy formulation, adoption, implementation, monitoring and evaluation as well as the consultation that takes place at all stages. The overall goal of the process is to formulate and implement robust and quality policies through extensive consultations.

The Handbook and Guide cover all four stages of the policy process however in this paper the focus is on the formulation stage.

How it is done

There is an institutional framework within the central government with the Policy Analysis and Coordination (PAC) Division at the centre. The PAC Division is one of several divisions in the Cabinet Office. Cabinet Office itself is in the

Office of the President. Others playing critical roles in this institutional framework are the ministries and the Cabinet itself.

The Policy Analysis and Coordination Division

This Division plays a pivotal role in Zambia's policy process. Its main responsibilities include:

- the coordination of policies and programs of ministries to ensure that they are compatible with each other and the overall policy of the Government
- ensuring that policy proposals reflect national, and not just ministerial or sectoral perspectives
- coordinating and facilitating the implementation of Cabinet decisions and
- monitoring and evaluating the implementation of Cabinet decisions.

In this regard, the core responsibilities of this Division in the national policy process entails provision of an oversight function, ensuring that everything that needs to be considered vis-à-vis cross-cutting issues are indeed mainstreamed. Officials in ministries involved in the preparation of policy documents are required to comply with the above principles through adherence to the set standards and format as prescribed in the Guide.

One of the key components of these standards is consultation. Consultation is an integral part of the development of policy proposals, from conceptualisation until the initiating minister approves the final document. Consultation is essential at all stages of the policy process to ensure that implementation is well coordinated and various actions are harmonised by all implementers in order to achieve the intended objectives.

Consultation mechanisms

Just to underscore the point, consultation is deemed critical as it is meant to ensure that ministers and officials in ministries share a common understanding of each matter and that key stakeholders have been given ample opportunity to contribute to the policy proposal. Also, it helps resolve any differences within the ministry and with other ministries. Above all, consultation helps in ensuring the speedy decisions by Cabinet on the documents that are prepared for its consideration.

The coordination mechanism for consultation is institutionalised as follows:

Ministries wishing to introduce a new policy must seek clearance from the PAC Division regarding their policy proposal. In turn, PAC will:

- advise whether introducing a new policy is the best way forward or suggest other options that should be considered
- call for in-depth research on the issues involved and wide consultations among all key stakeholders and
- require the initiating ministry to take into account views of persons or institutions affected by the policy proposals or proposed actions.

To enhance this consultation within a given ministry and between ministries, provision has been made for the establishment of a Cabinet Liaison Committee (CLC). This Committee comprises the relevant minister, permanent secretaries who are the controlling officers in ministries, directors (technical personnel) and the Cabinet Liaison Officer (CLO) who usually comes from the planning unit of the ministry.

The major functions of the CLC include:

- considering and approving memorandum prepared within the ministry before such memoranda are circulated to other ministries for comments
- preparation of comments for the minister on memoranda circulated by other ministers
- monitoring the implementation of Cabinet decisions and
- preparing feedback reports on the implementation of Cabinet decisions.

The Cabinet Liaison Officer

The CLO deserves special mention because, among other things, he/she is responsible for:

- ensuring that all major stakeholders are consulted in the preparation of policy proposals
- providing the central point of contact between their ministry and the PAC Division on the one hand and the other ministries on the other
- ensuring that Cabinet memoranda are prepared in accordance with the guidelines provided in the Guide. This includes ensuring that cross-cutting issues which need mainstreaming have been mainstreamed
- ensuring that the PAC Division is informed of any special circumstances affecting cabinet memoranda submitted by their ministry.

Thus, the CLO is responsible for co-ordinating all Cabinet business within their ministries, including the preparation and handling of cabinet documents.

Inter-ministerial Committee of Officials

As mentioned earlier Ministries wishing to introduce new policies must seek clearance from the PAC Division regarding their policy proposal. As it decides on the ministry's proposal, PAC will have to establish whether or not the proposal impinges on the mandate of any other ministry. If it does, then the PAC Division will, in liaison with the initiating ministry, constitute an Inter-ministerial Committee of Officials (IMCO) for the purposes of facilitating and ensuring effective consultation. IMCOs are convened and facilitated by the PAC Division. The membership of the IMCOs include:

- PAC official, as the facilitator
- Cabinet liaison officer and relevant technical experts from the initiating ministry
- Cabinet liaison officers and relevant technical experts from relevant ministries and
- any other experts as deemed necessary by the committee.

Among other functions the IMCO will lead the discussion and consideration of alternative solutions to the identified problem or issue.

Finalisation and adoption of the policy proposal

Once the initiating ministry has satisfied itself that it has followed all the required procedures and standards in the formulation of their policy proposal, it takes the next step of submitting the draft policy document to PAC for inclusion on the agenda of Cabinet.

However, before PAC includes the draft policy document on the Cabinet agenda, it undertakes a final verification by ensuring that, when submitting the draft policy, the Minister personally endorsed the finalisation of the document signifying not only ownership but also compliance to prescribed standards and procedures. The evidence of this endorsement is submitted to PAC along with the draft policy document and any attachments that come along with the proposal. Without this proof, the PAC Division will not accept a submission of that draft policy for inclusion on the Cabinet agenda.

Mainstreaming the HiAP strategy

As noted earlier, Zambia is yet to institutionalise the HiAP approach in the policy process. The National HiAP Strategy has been developed and is in the process of being submitted to Cabinet for approval.

Once approved, the PAC Division, through the institutional arrangement elaborated above, will have to ensure that the Ministry of Health is adequately consulted so that consideration of the social determinants of health is mainstreamed into all policies from various sectors before submission of such a policy for approval. Box 1 provides an illustration of the application of the policy process to the issue of HIV/AIDS.

Box 1. The HIV/AIDS case study

Zambia has successfully mainstreamed crosscutting issues in various national policies using the institutionalised policy formulation framework. Examples include issues related to the environment, gender and HIV/AIDS.

By the mid-1990s HIV/AIDS had reached epidemic levels. In 2002, 16% of the population aged between 15 and 49 was living with HIV/AIDS.[1] Some 25% of pregnant women were HIV positive and nearly 40% of babies born to HIV positive mothers were infected with the virus.[4]

Recognising the two-way link between HIV/AIDS and poverty, drastic measures to combat the disease were designed and implemented. This entailed coming up with policies and programs designed to incorporate a mechanism for intersectoral coordination and collaboration and included interventions on prevention, treatment, care and support. National HIV/AIDS intervention and mitigation strategies encompassing all government ministries, the private sector, faith-based groups and civil society were developed with the objectives to, among others:

- strengthen programs for containing communicable diseases, so that they do not fall short of the scale required to reduce the burden of diseases
- have a secure health system that ensures effective disease control
- ensure capacity for sustainable development of an effective health care delivery system
- empower the people of Zambia to act to improve their own health and to achieve health literacy.

Programs and activities undertaken included the establishment of HIV/AIDS committees, policies and work-plans at places of work. Further, programs and activities aimed at demystifying HIV/AIDS as well as removing the stigma associated with the infection were escalated at all societal levels. The media disseminated information on sexual issues that culturally were considered taboo among the vast majority of the Zambian society. Similarly, schools taught issues related to sex to promote awareness among the school-going population. This helped demystify and to a large extent, destigmatise the disease.

The National AIDS/HIV Council (NAC) was established in 2002 to effectively oversee and manage these interventions. NAC is a broad-based corporate body with representatives from government, the private sector and civil society mandated to coordinate, monitor and evaluate inputs, outputs and the impact of HIV/AIDS programs and interventions. It is supported by a Secretariat whose role is to implement the decisions of the NAC including the development of technical guidelines for the coordination of the multisectoral responses.[5] The NAC reports to the Cabinet Committee responsible for social and human development issues.

Outcome of the HIV/AIDS response

The intervention measures by the Government and its coalition of partners in the fight to combat the HIV/AIDS epidemic have indeed produced dividends as shown below.

1. Drop in HIV/AIDS prevalence rate

The HIV/AIDS prevalence rate has dropped from 16 % in 2005 to 11.6% in 2016 among people aged between 15 and 49.[6] The Government is committed to reducing the prevalence further through strengthened health systems and expanding access to primary health care services.

2 Improvements in quality of life and life expectancy

There has been a noticeable improvement in the quality of life for a significant proportion of the population. According to The World Bank Data, life expectancy improved from 42 years in 1995 to 60.05 in 2014.[7]

Also the Human Development Index registered improvements rising from 0.418 in 1980, to 0.586 in 2014. This is above the Sub-Saharan African countries' average of 0.518.[8]

It should be noted that the Index had dropped to 0.409 in 1985, and to 0.403 in 1990 signifying the challenging socioeconomic conditions that prevailed during that period. It only started rising in year 2000 (at 0.433).[8]

3. Reduction in mother to child transmission

As recently as 2005, nearly 40 % of babies born to HIV positive mothers were infected with the virus. This has now been significantly reduced to below 15 % in 2010 due to compulsory testing and immediate treatment for expecting mothers.[6]

4. Demystification and destigmatisation of the HIV/AIDS disease

Demystification and destigmatisation of the disease has had the overall effect of increasing the use of medication as those infected started breaking their silence and accepting their condition. Before this, many died in silence for fear of the stigma resulting from opening up about their condition.

5. Containment of the disease burden

Through the measures and interventions taken to combat the epidemic, the burden of disease arising from communicable diseases has eased, though more still needs to be done. The emerging challenge is the burden of disease arising from non-communicable diseases such as diabetes.

Challenges to reducing further the burden of disease

The lack of, or slow improvements in some of the social determinants of health pose a significant challenge in reducing the disease burden further. Contributing factors include:

A widening income gap

Despite the decline in the percentage of the population living below the poverty line, from 68% in 2004 to 54% in 2015[9], Zambia is faced with high income-inequality with a Gini coefficient of 0.69 in 2015.[9] This reflects the country's inability to distribute its economic growth fairly across the population. Reducing income inequality is important to improving health outcomes.

Poor nutrition

Zambia is self-sufficient in the production of commodities such as maize, which is the national staple; wheat, soybeans, poultry, beef and meat products from small-ruminants. The country is also self-sufficient in a variety of vegetables and, to a large extent, dairy products. In spite of this, nutrition levels among the citizens are low, even compared to countries whose economic performance is below Zambia's.

The Zambia Demographic and Health Survey 2013-14 showed stunting, wasting and underweight rates at 40 %, 5 % and 25 % respectively in 1992 compared to 40 %, 6 % and 15 % in 2013-14.[10]

Further the World Food Programme's World Hunger Map 2016 categorises Zambia as one of

the countries with chronic undernourishment.[11] From as early as 2003, Zambia's rate of undernourishment has consistently been above 35% of the population, placing the country in the most affected category.

This state of affairs is worrying because poor nutrition is a serious public health threat. Poor nutrition also undermines the very important role that nutrition plays in the management of HIV/AIDS.

Mind-set issues

For lack of a better term, the majority of the Zambian population suffers from 'mind-set issues'. This has had a bearing on the population's ability to create and nurture social and physical environments that promote good health. Among other things, this challenge is manifested in poor health-seeking behavior, poor water and sanitation and poor nutrition.[10]

Opportunity for improving public health

Currently there exists a strong window of opportunity to scale-up the HiAP approach regarding health issues because of:

- Political will
  The political leadership has demonstrated a strong will to address health issues head on. Launching the National Health Week in November, 2016, the Republican President underscored the point that Zambia, from then onwards, was "starting a journey to change our lives towards truly making us a nation of healthy and productive people". The President called on Zambian communities to embrace a radical new approach which will vigorously target promoting good health and preventing disease as key priorities.

  Pledging to provide the necessary leadership, the President called on citizens to make their households the entry point for good health instead of the health facilities. Further, he noted that caring for the environment in which communities lived was part of promoting good health.

  To make this new vision a reality, the President emphasised the importance that all stakeholders including line ministries, the private sector, the civil society, faith-based organisations and leadership at various levels embrace the obligation and responsibility to stimulate wellness in the Zambian society by encouraging individual, family and communities for collective action. Accordingly, and in line with the National Health Policy, a new Division on Health Promotion, Social and Environmental Determinants with a multisectoral approach as a key principle in its operation, was created in 2017.
- Growing economy
  Among the growth sectors in Zambia is agriculture which is a source of livelihood for more than half of the population. Improved agricultural production impacts positively on household income and food security. It therefore plays a catalytic role in scaling up some of the positive social determinants of health.
- Continued improvements in water and sanitation
  According to the Ministry of National Development Planning, the period between 2006 and 2015 registered improvements in some socio-economic indicators, especially in urban areas. The percentage of households with access to improved sources of drinking water significantly improved from 58% in 2006 to 67.7% in 2015. Rural areas in particular registered an increase from 42% in 2006 to 51.6% in 2015. Urban areas registered a marginal increase from 88% in 2006 to 89.2% during the same period. Sanitation in rural areas improved from 11% in 2007 to 19% in 2013-14, reflecting the serious stance taken by some traditional rulers regarding good health.[9]
- Coalition of willing partners
  There are social partners committed to improving some determinants of health. Up-scaling nutrition is one such area where civil society is particularly involved.

Reflections and conclusion

The outcome of the response to the HIV/AIDS epidemic in Zambia is evidence that sustained political, civic, traditional, community and corporate leadership is essential in ensuring an effective and focused multi-sectoral response to issues of public health. It is indeed testimony that sustained improvement in public health "starts in our homes, schools, workplaces, neighbourhoods and communities" as observed in Healthy People 2020.[12] By acting together in ensuring that social and environmental determinants of health are fostered, public health can be significantly improved.

In this regard, Zambia should also rollout this integrated response to nutrition as improvements in the nutrition wellbeing will reinforce improvements in community health.

In relation to strengthening Zambia's policy formulation process using the HiAP approach, there is a need to adequately expose key staff in the PAC Division to best practice in mainstreaming the HiAP approach.

Key contact/s and further information

Mr. Crusivia Hichikumba, Director, Office of the President, Policy Analysis and Coordination Unit, Cabinet office, Zambia
Email: crusivia.hichikumba@cabinet.gov.zm

Dr. Kennedy Malama, Director, Public Health, Ministry of Health, Zambia
Email: malamakennedy@gmail.com

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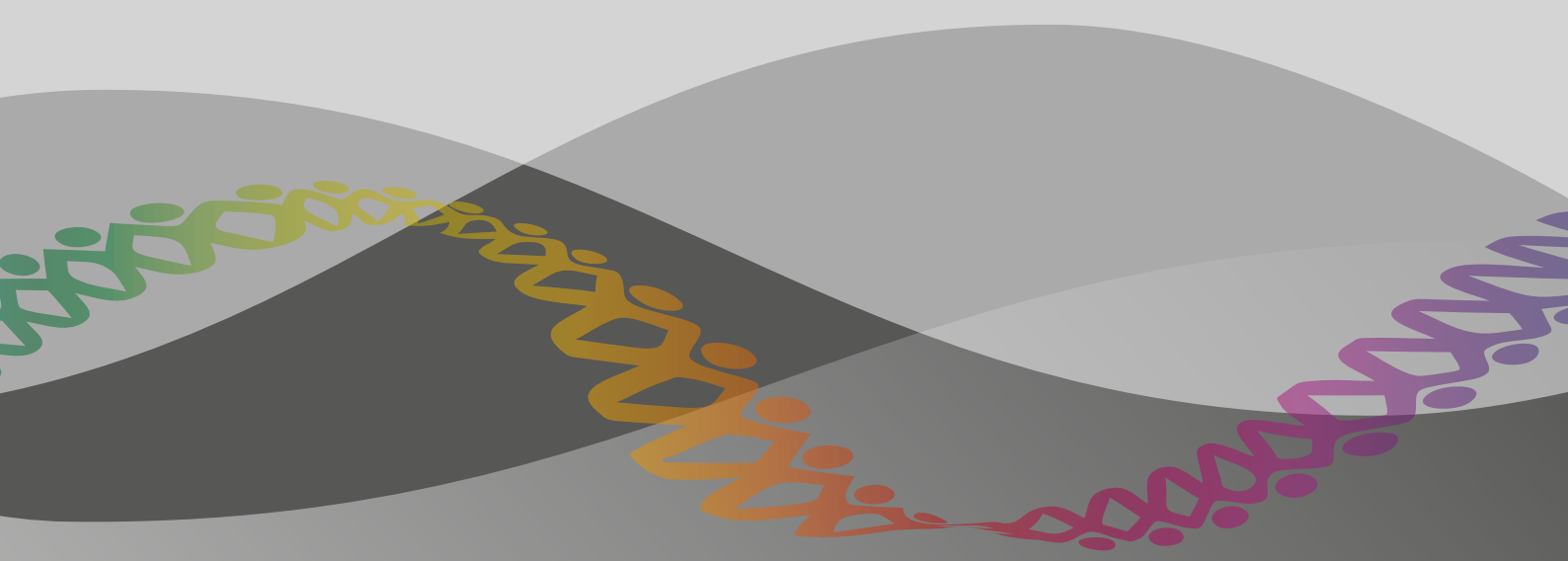

Health in All Policies

Conclusions: an agenda for transformation

Authors

Ilona Kickbusch[A], Vivian Lin[B] and Britta Baer[B]

[A]Graduate Institute of International and Development Studies, Switzerland

[B]World Health Organization, Regional Office for the Western Pacific, Philippines

"[T]oday's complex health challenges can no longer be addressed by the health sector acting alone. Curbing the rise of antimicrobial resistance requires policy support from agriculture. Abundant evidence shows that educated mothers have the healthiest families. Access to clean energy fuels economic growth, but it also reduces millions of deaths from respiratory and cardiovascular disease associated with air pollution." [i]

Former DG Margaret Chan

Introduction

This concluding chapter offers reflections on the lessons from Health in All Policies (HiAP) efforts around the world, and distils the key elements that can be observed in diverse contexts. The contributions in this book show that a new mindset with respect to health and its role in society is emerging in the political arena. The time and opportunity to promote action on the determinants of health through implementing HiAP has never been better. Not only do we have significant evidence that such approaches work for health and provide co-benefits for other sectors, we also know that we will not be able to address the most pressing health challenges if we do not work with a different kind of approach which involves a wide range of stakeholders. This new context challenges the public health actors to venture outside their organisational and professional boundaries and their comfort zones. We are experiencing a move from a linear understanding of policy - reflected in the approach to the Millennium Development Goals (MDGs) - to one that accepts complexity. This validates approaches that prioritise governance for health and wellbeing.[1]

Many Different Pathways

The case studies illustrate many different pathways to HiAP, usually linking strong advocacy from the health sector with health and societal challenges at hand. An analysis shows they all include several, if not all, of the five types of smart governance for health identified by Kickbusch and Gleicher[1] namely governing by: collaborating; engaging citizens; mixing regulation and persuasion; establishing new independent agencies and expert bodies; and proving adaptive and resilient, and engaging in foresight. It is helpful to have both mature and recent examples described. Many 'first generation' HiAP initiatives experienced a long gestation period during which much of the work was to convince other actors of the co-benefits of working together - despite the pressing problems at hand. For example, the California HiAP Task Force has its origin in the high rates of chronic disease, high inequity and challenges related to climate change. It is typical of the kind of parallel structures that have been developed for HiAP.

For 'second generation' HiAP initiatives, the recent adoption of the Sustainable Development Goals (SDGs) leads to new political dynamics driving action not only between sectors and stakeholders but also with the highest level of government. Never before has the promotion of health and wellbeing been placed so clearly at the centre of a global agenda that will transform our world: SDG 3 aims to "ensure healthy lives and promote well-being for all at all ages".

The new SDG context is defined by uncertainty - change happens rapidly, problems don't stand still and solutions often have unintended consequences. In the literature this challenge is often referred to as the realm of "wicked problems".[2] By definition such problems require the involvement of many stakeholders and they are usually politically highly sensitive - think of the wide range of actors affected by a sugar tax as well as the range of political positions that need to be considered. Technical arguments and solutions alone no longer work and straightforward planning processes reach

i Chan M. (2016). The relevance and importance of promoting health in national SDG responses. Keynote address at the 9th Global Conference on Health Promotion in Shanghai, China, 21 November 2016. Geneva: World Health Organization. Available from: http://www.who.int/dg/speeches/2016/shanghai-health-promotion/en/.

Figure 1. Health in the SDG era

Source: WHO infographic available from: http://www.euro.who.int/__data/assets/pdf_file/0007/319804/banner-health-SDG-era.pdf?ua=1

their limits. In a radical departure the SDGs define the problem and the solution space at the same time - as is illustrated for example in the SDG circle the World Health Organization (WHO) has developed for health (Figure 1). This leads to the discovery of new relationships which might otherwise be overlooked - for example the high relevance of SDG 12 on sustainable production and consumption for health - as well as understanding the boundary conditions in relation to responsibilities.

For the more recent HiAP initiatives, and particularly those in developing countries, the SDGs provide a unique rationale for addressing health and its many determinants in an integrated and transformative way. Advocates of HiAP not only have a toolbox at hand, through the SDGs, they also have the benefit of the commitment of all actors required by SDG 16 and 17. Multi-stakeholder approaches are required of all sectors, all are expected to reach out to others to generate co-benefits. Promoting

health is fast becoming a cornerstone of all national SDG implementation plans, and the challenge at hand is to create a new culture of government where health is mainstreamed. The final goal is well described in the case study from Christchurch, New Zealand: "Having health as part of the conversations and having equity as a focus are now business as usual for councils to the point where they no longer recognise these topics as unusual."

Adaptation and reinvention over time

The case studies show how HiAP has been adapted and reinvented over time. Indeed the literature on wicked problems highlights the need for an opportunity-driven approach based on making decisions, doing experiments, launching pilot programs, testing prototypes and so on.[3] First generation HiAP approaches have - over the last 10 years or so - had to be very adaptive, resilient and creative to respond to changing contexts, especially shifting political priorities. It has been easier for those with a clear legal or regulatory base, and reliable funding. Today, as the SDGs provide the vision and the goals for action, we enter a new development phase of HiAP approaches: what might have been seen as the chaotic exception is turning out to be the way things are.

Many of the case studies in this book exemplify how the perspective on HiAP is changing - best documented perhaps by the pioneer country that has been pursuing HiAP since the 1970s. Finland is in the process of developing a new approach which combines health, wellbeing and equity, and is beginning to use the expanded title of Health and Wellbeing in all Policies: HWiAP. This precisely reflects the wording of SDG 3 for which Finland argued consistently during the SDG negotiations and makes it easier to refer to the targets and indicators developed under that SDG. The legitimacy and necessity for action is now drawn from both nationally and globally adopted goals that all countries have agreed to work towards.

This means that the framing of HiAP will need to be revisited in many instances. The Shanghai Declaration points out that HiAP stands for exactly the type of transformative action called for by the 2030 agenda: an approach based on equity, cooperation and empowerment.[4] The focus is on the broader societal transformations that benefit the poorest and can improve the wellbeing of society as a whole. Many of the examples in this book exemplify this reframing and show how HiAP activities are increasingly integral to overall government policy and therefore have the support of high-level decision-makers. As California did early on in its development of HiAP, the challenge is to integrate the promotion of health with overall societal goals such as increasing equity and planetary challenges, thus combining the various pillars of sustainability. As expressed in Figure 2 from Finland, the wellbeing of people can only be achieved if it is firmly grounded in securing the natural environment, and if all sectors of society contribute: the private sector, civil society and governments.

Framing: HiAP as societies for wellbeing and sustainability

Most HiAP work is framed in terms of how investments in health contribute to a more productive society, strengthen resilience and social cohesion, empower people and contribute to social capital, wellbeing and happiness. Health also contributes significantly to the economy - it creates value for business to contribute to healthy communities, overcome gaps in equity, develop new industries around healthy products and services and low carbon. Health is seen as a social and economic development goal requiring action from government, society and the private sector.

The case studies show that this applies to societies at all levels of development:

- In the Healthy China 2030 strategy, health is framed as a top priority to reach "a prosperous society, fulfil the SDGs and modernise society".
- The case study from Finland shows how HiAP has become integral to the Finnish Government program with "promoting wellbeing and health" as one of five overall objectives.

Figure 2. The sustainable well-being framework

Source: Reproduced from Hämäläinen T. (2013). Towards a Sustainable Well-being Society. Building blocks for a new socioeconomic model. Helsinki: Sitra. Available from: http://rritrends.res-agora.eu/uploads/22/Towards_a_Sustainable_Wellbeing_Society.pdf. Page 5 (adapted from Eeva Hellström, Sustainable Economy Forum, not dated).

- The Californian Healthy Community Framework on which the state's HiAP work is based also aims to integrate five priorities which address the key determinants of health: basic needs, environment, economic and social development, equity and social relationships.
- The Quebec Government has recently adopted a whole of government intersectoral Policy for Prevention in Health.
- The examples from Sudan, Surinam, Namibia and Zambia all position health as part of the national development plans.

HiAP strategies all recognise that investments in health can help lift people out of poverty and that the largest population health benefit is achieved by addressing the social determinants of health and ensuring and protecting people's rights - no matter what their position in society, gender, sexual orientation, age or level of disability. More than in the past the combined actions on health and environment are prioritised and the co-benefits between sectors are highlighted.

Transformation through highest level political action

Wicked problems are about people, stakeholders, vested interests and politics - and so are the SDGs. Rather than be understood as a technocratic planning tool, HiAP is rediscovering its political dimension. The case studies reflect that increasingly health and wellbeing are the concern of the highest level of government. In California, an executive order by the Governor established the Health in All Policies Task Force and later legislation established the office of health equity, and in South Australia the support of the Office of the Premier and Cabinet was critical. The case study from Christchurch underlines the same point at the city level. In Quebec HiAP is now supported by the Council of Ministers.

The second generation case studies show that countries are now linking their policy goals to the 2030 agenda and are adopting national visions, strategies and action plans linked to the SDGs. These can run from 5 to 15 years, pushing beyond short-term political gains. They have learned from the more seasoned approaches that highest level political support makes the difference and have the support of the SDG agenda to move in this direction. For example, Namibia has set the goal to adopt a national strategy for Health in All Policies which is coordinated in the Office of the Prime Minister and has strong links to the National Planning Commission.

A transformed Ministry of Health and health department

This SDG related change in perspective of how the promotion of health contributes to other social goals requires a transformed Ministry of Health (MOH) which works relentlessly to integrate investment in health with the logic of other policies and programs. Ministries of health, health agencies and organisations have a key role in advocating, mediating and enabling health. This is reinforced if this work is strengthened by legislation, for example through public health acts. In Québec the act adopted in 2001 required "all government sectors to ensure that their laws and regulations do not cause any negative impact on the population's health". The critical issue of such laws is to establish the legitimacy of the MOH or other health agencies to operate outside of the boundaries of their sector. The implementation of the cross-sectoral and multidisciplinary challenges calls for adaptable and integrative systems capabilities as part of the overall public health system - this has not always been the case as some case studies show. Indeed the South Australian case study indicates an extraordinary story of survival in an environment that cut support to health promotion programs drastically.

Transformation through policy coherence

Problems cannot be treated in silos. The goal of Health in All Policies described in the case studies is increased policy coherence. As Namibia outlines the general goal is that a HiAP approach should systematically take into account the health implications of decisions, seek synergies and avoid harmful health impacts on health and health equity. California's Task Force acts as a "collaborative, multiagency body charged with promoting health, equity and environmental sustainability". This is done in a multitude of creative ways as the case studies show: working groups, platforms, taskforces, committees, tandems and agreements between sectors using the South Australian health lens approach. This diversity underlines how contextually dependent the mechanisms are.

There is in general much lip service being paid to policy coherence. However, this does not always translate into practice. In the end politics may matter more than policy commitments. More efforts are needed to facilitate investment to support implementation of these policies. In the literature it is suggested that these factors be addressed by applying social and organisational modelling. A HiAP strategy would then aim to do three things in the move towards policy coherence: define the contextual environment and the extent to which that can be influenced or changed; define those actions which it can control within its own strategic space; and define the transactional environment where it aims to affect change together with the other actors in the space. It is in the transactional environment where 'out of the box' thinking is developed and where policy coherence is constructed as a dynamic process.[5]

Transformation through participatory governance

Social mobilisation, high levels of health literacy and community participation, especially of vulnerable groups such as indigenous people is one of the most critical governance challenges to implement the SDGs and to ensure sustainability. The case study that has most to offer in this regard is the Thai mechanism of the National Health Assembly. No other HiAP approach is so participatory. Here is probably one of the biggest challenges of HiAP for second generation programs: how to involve not only other sectors but a broader range of stakeholders and representatives of the public at large. The Shanghai Declaration also draws attention to the role of health literacy in empowering individual citizens and enabling their engagement in decision-making. A high level of health literacy of decision-makers also supports their commitment to health impact, co-benefits and effective action on the determinants of health.

Knowledge and data transformation

Reporting and monitoring is critical for HiAP approaches, including routine reporting and health impact assessments. For example, Namibia plans a determinants of health of the nation report every two years. Where HiAP becomes embedded in national policy, such as China, then routine statistical systems will need to incorporate reporting on equity and social determinants of health. Enormous potential lies in sharing knowledge and in using data in new ways to better plan: for public health, for better cities, for better health care services. A new ethics on issues of privacy, confidentiality and ownership is called for in relation to tracking determinants and inequities.

Capacity building to work in new ways

The rapidly changing environment and the increasing need for joined-up policy requires continuous capacity development for staff engaged in health promotion. As governments, businesses and civil society are challenged to work together to achieve the Sustainable Development Agenda and work in HiAP, new skills are required of all actors involved in generating health and wellbeing. The trajectories of the older generations of HiAP clearly point to the need for different skill sets during the 'start up' phase and the 'maintenance phase'. Thinking about, and incorporating practise to support sustainability of HiAP is also required from the outset.

Lessons learned

The case studies in this book show that HiAP efforts need to address similar elements (see appendix) and confirm many of the lessons from the broader literature on partnerships, governance and implementation science. All case studies reiterate that in a complex world, no one actor can solve a problem. Due to growing complexities, traditional alignments between state, market and communities are increasingly questioned. This shifts the discussion to network or nodal governance, where multiple stakeholders coalesce around shared interests.[6]

Kania and Kramer's five conditions for collective success start with the importance of a common agenda.[7] Key factors in the success of partnerships for health encourage reflection on (i) the need for the partnership, (ii) choice of partners, (iii) the workings of partnerships, (iv) planning of collaborative action, (v) implementation, (vi) overcoming barriers to partnerships, and (vii) reflecting on and continuing partnerships.[8] In real life these things usually all need to be done at the same time. Case studies in this book show how a policy document or law can sometimes provide a basis for HiAP – as, for example, an Executive Order in California, a Metropolitan Ordinance in Quito, Ecuador, or a National Health Act in Thailand. In Quebec, years of broadening policy mandates, including a government policy on prevention in health, opened a window for HiAP.

It is widely acknowledged that leaders and champions can play a critical role in instigating and building HiAP, creating vision and establishing trust.[9-11] The growth in actors on health in the SDGs offers new opportunities for

HiAP by potentially expanding the list of partners and champions. Case studies in this book draw attention to incentives set by political leaders, parliamentarians, civil society, and communities. External players, including funders, can sometimes help to create impetus for coming together.[6] This echoes the experience in South Australia, where the "Thinkers in Residence" program acted as a catalyst.[12] Similarly, case studies in Namibia, Sudan and Suriname speak of the added value that external experts can bring when initiating HiAP. In the context of the SDGs, this highlights the positive contribution that international donors and partners can make by convening stakeholders, particularly in low resource settings. It also raises some important questions about how to go beyond the initial dialogue or project. South Australia provides useful experiences of how to sustain momentum, including the central role of a local coalition in driving change. On-going partnership between the external and the local level can facilitate periodic review and reflection, providing opportunities to adapt and re-tune.

Working effectively across stakeholders and sectors means unaccustomed ways of thinking and working for many within and outside government. Once HiAP has been initiated, moving beyond development of a vision or plan requires changes in behaviour. While behaviour change is not a new idea for health, it rarely focuses on decision-makers and implementers. Evidence from behavioural economics, cognitive science and related fields, may offer useful models for the future on how to motivate policy makers in other sectors to cooperate. The case studies in this book highlight that sustaining HiAP requires agility. Agility means considering implementation failure throughout the journey of HiAP. It requires finding champions and building coalitions every step along the way in a dynamic environment of changing interests and incentives. This echoes lessons from the literature on "complex adaptive systems", made up of many intersecting and dynamic parts.[13,14]

Damschroder et al identify five domains critical to thinking through implementation, including the characteristics of the intervention, outer setting (the broad macro environment), inner setting (organisational setting), characteristics of individuals involved, and the process of implementation.[15] Corbin et al identify nine core elements for partnership and stress the need for balance – for example, balancing between different types of participants and resources, between inclusive structures and tight frameworks for production, between maintenance and production tasks, etc.[16] Adaptability and flexibility are core concerns across these domains. This draws attention to the importance of also being flexible about partnerships, and the different interests, inputs and levels of engagement over time. The first generation case studies in this book show an extraordinary amount of skill to have adapted to changes in the broader environment.

Resourcing and institutionalisation

The case studies in this book also reiterate that HiAP relies on appropriate resources and institutions to sustain efforts. In many case studies, a small and dedicated team of HiAP practitioners acted as an engine for moving forward and driving partnerships. For example, the HiAP Task Force in California has played a critical role in engaging stakeholders, establishing a shared vision and updating it as needed over time. Generating evidence and providing analysis and advice to partners has been core to HiAP in South Australia, with a dedicated team able to build and strengthen relationships with other sectors and agencies. Advocacy for budget prioritisation based on win-wins relies on strong evidence illustrating the returns on investment. An important strategy, highlighted by many case studies, has been to aim for policies and projects not to be optional additions, but rather established as a new way of doing business. For example, broad national policy frameworks provided an entry point in China and Sudan. This reiterates the importance of building on existing agendas and making incremental changes. Law can provide a strong basis for institutionalising HiAP, for example

by embedding HiAP as a whole as through the Public Health Act in South Australia, the National Health Act in Thailand, or the Wellbeing of Future Generations Act in Wales, or by mandating specific tools, including health impact assessments, that foster collaboration.

Moving forward

The experience of HiAP can now contribute to support the implementation of the SDGs. The overall global narrative has changed - it now has governance at its very centre. The health narrative has changed as well - it explicitly includes a broad understanding of wellbeing. The SDG approach - as Fukuda Parr explains in her study of the MDGs[17] - is a radical departure in form and substance; it is no longer focused on the end outcome only but includes the debate about the means to get there. The new narrative accepts complexity - indeed it thrives on it. And most importantly development is no longer a project of developing countries but of developed countries as well. This provides a new basis for sharing experiences.

The case studies in this book reflect the diversity of approaches, processes, dimensions and outcomes. There is no simple model or solution that can easily be imported to other countries and settings. The case studies illustrate universal lessons as well as specific applications of HiAP. They stress that success in initiating and sustaining action critically depends on context, and the practitioners' ability to reflect on their own history, culture and system. For example, Thailand has arguably one of the most advanced institutional structures, supported by a culture of using law and public participation. Finland's well-established record on social solidarity and a history of collaboration in Canterbury, New Zealand, presented a fertile ground for HiAP. These and other case studies also show how history and culture interact with politics and agency. Moore speaks of three interrelated dimensions – including defining public value, creating an 'authorising environment' and building operational capacity – that would ideally be aligned.[18,19]

Lastly, the case studies in this book help with building the evidence base for the future. Key questions for further examination might include: How is HiAP adapted and reinvented over time? How can implementation failure be prevented or mitigated? How did HiAP practitioners understand and navigate the intersecting dynamics of politics, systems and culture? These questions and related experiences in countries have never been more relevant than in the context of the SDGs. The SDGs call for a new mindset with respect to health. HiAP is core to this agenda. Success critically depends on our ability to reflect on existing examples and related lessons and entry points. This collection of case studies is a step in this direction.

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Health in All Policies

Appendices

Appendix 1

Adelaide Statement

Outcome Statement from the 2017 International Conference

Health in All Policies: Progressing the Sustainable Development Goals

Implementing the Sustainable Development Agenda through good governance for health and wellbeing: building on the experience of Health in All Policies

Preamble

We - 150 experts and practitioners of Health in All Policies (HiAP) from 21 countries - have come together in Adelaide at the invitation of the Government of South Australia and the World Health Organization, to celebrate ten years of Health in All Policies in South Australia. This meeting, on the traditional lands of the Kaurna people, offered the first major opportunity to explore the recommendations of the Shanghai Declaration in greater depth.

We commit to take forward the mandate of the Shanghai Declaration on Promoting Health in the 2030 Agenda for Sustainable Development and to advancing the equitable achievement of the Sustainable Development Goals (SDGs) through the mechanisms of good governance. In this, we draw on our practical experience of working at different levels of government and in diverse contexts in countries around the world.

Our work has benefited from previous important policy documents such as the 2010 Adelaide and 2013 Helsinki Statements on Health in All Policies, the report of the Commission on the Social Determinants of Health (SDOH) and the Rio Political Declaration on SDOH.

Introduction

Action on the Sustainable Development Goals means acting on the determinants of health and wellbeing. These determinants are frequently shaped by political decisions and public policies - policies which can support health and wellbeing or can fail to take account of their impacts on health and equity.

Health is a political choice. Political decisions can impact on economic and social inequities, including through policies which shape unhealthy living and working environments, or which fail to address inequities of gender, race and ethnicity. Faced with the many complex existing and emerging challenges to health and wellbeing in countries and globally, including rapid urbanisation, climate change, pandemic threats and the proliferation of unhealthy commodities, practical responses are urgently needed.

The SDGs are indivisible and universal. They provide a road map for all countries to societal wellbeing by integrating actions across the social, economic and ecological domains. Within the SDG context good health is a precondition for, an outcome and indicator of, sustainable development. Health is core to the SDGs with their focus on people, planet, peace, prosperity and partnerships.

Transformative strategies for implementing the SDGs. A transformative approach requires joint action and policy coherence. Good governance for health and wellbeing will be a crucial strategy in achieving the SDGs, in line with the emphasis in the Shanghai Declaration.

The SDGs provide new impetus for our work in reaching out across different sectors of government and society. The SDGs require us to be systemic in our thinking; to recognise the commonalities between the health of people, ecosystems and the planet. Health is a societal investment that contributes to wellbeing beyond Gross Domestic Product (GDP).

Health in AII Policies offers us new ways to confront major 21st century challenges to health and wellbeing, including safety and security. We must accelerate and foster the wider adoption of this approach in order to: reduce inequities in health and wellbeing for people of all ages; embrace social innovation such as network models of governance; address the commercial determinants of health; and ensure no one is left behind in social and economic development.

The investment in, and lessons from, the successful experience of HiAP implementation in South Australia and internationally will support us in moving forward. The breadth of experience presented at the conference affirmed that the benefits of a HiAP based approach can be realised at all levels of government - city, regional, state, national - and in different contexts.

Action on determinants

The interconnectedness between the determinants of health will require strong and effective action by governments and societies. Our discussions have put a special focus on the commercial, political and environmental determinants. Our work aims to implement a mutual gain approach but we recognise that persistent marketing of proven unhealthy commodities, enduring inequalities and environmental degradation, can require strengthened legislative, regulatory, and fiscal measures.

Many of the determinants we need to address are at the global level. It is essential that we build international alliances between countries, cities, civil society organisations and citizens to address these determinants.

Action on equity

In acting on determinants we affirm the importance of pursuing equity, fairness and social justice. The mental, physical, and spiritual needs of First Nations peoples must feature strongly, including recognising the impact of colonization.

We acknowledge the contribution of social protection and equitable access to health care services as a determinant of health outcomes, and recognise that universal health coverage is the most effective mechanism to ensure this can be achieved.

We recognise that fiscal responses in the face of economic downturns can have a profound effect on citizens as well as institutional capacities to respond to the needs of the most disadvantaged, and we urge governments to consider the health and wellbeing impacts of such decisions.

Action on shared leadership with Citizens

HiAP requires active engagement of citizens and this can be achieved through mechanisms such as citizens' juries, participatory budgeting, and societal dialogue. The Shanghai Declaration reminds us that health literacy empowers individual citizens and enables their engagement in collective health action. Ensuring a strong civil society underpins this. Transparency in the provision of information fosters citizen engagement and strengthens accountability.

Citizen engagement must respect the rights and needs of displaced persons, refugees, asylum seekers and other marginalized groups, and ensure opportunities for their participation.

Action on evidence

We need to generate an evidence base that can be used by all sectors and citizens. Accountability of HiAP approaches will be strengthened through interdisciplinary research.

Learning from HiAP to implement the Sustainable Development Agenda

HiAP is a practical strategy that can be used to achieve the SDGs. It is implemented in different ways in a variety of contexts and systems but there are common values and aims. HiAP works best when a combination of factors are in place: good governance; development of strong and sound partnerships based on co-design, co-delivery and co-benefits; dedicated capacity and resources; and the use of evidence and evaluation. Together, these factors can and do deliver positive change. The key features of these are set out in Annex 1.

Our commitment

We commit to building on the Health in All Policies approach to advance the Sustainable Development Agenda consistent with the Shanghai Declaration. We recognise that health is a political choice, and we will continue to strongly advocate for health, wellbeing and equity to be considered in all policies.

Annex 1

Experts and practitioners from around the world with experience in implementing Health in All Policies have identified the strengths of HiAP practice and its key features.

Strengths of HiAP	Key Features
Governance	• An authorising environment from the highest levels of government • Political and executive leadership as well as leadership at all levels of the hierarchy and horizontal leadership • Leveraging decision making structures • Creating an environment for cultural change in practices and ways of working • Leadership that looks outwards, provides space to stretch outside of formal structures or boundaries, encourages dialogue, supports experimentation and innovation • Developing a clearly articulated and shared vision
Ways of thinking	• Social innovation • Political acumen • Valuing partnerships • Seeking mutual gain • Citizens and community at the centre • Creative problem solving • Utilising 'champions' or advocates • Outcome focused
Ways of working	• Co-design, co-production and collaboration to achieve shared goals and realise co-benefits • Dialogue and systematic consultation • Diplomacy to build constituencies to support change • Shared measures, reporting and public accountability • Basing action on evidence • Learning-by-doing • Reflecting on practice and responding to changing contexts • Dedicated capacity
Principles	• Joined up approaches • Flexibility and adaptability • Respectful and responsive to partners' needs • Investment in building trust and relationships • Transparent and open communication • Systematise and institutionalize • Build a skilled HiAP workforce • Focus on public value

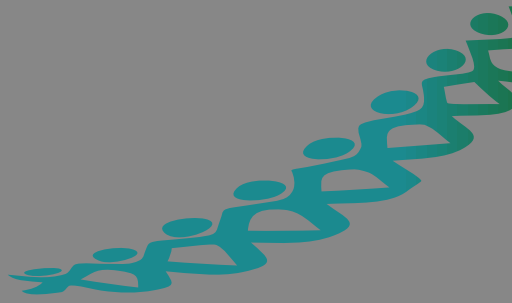
Appendix 2: Overview of case studies

	USA California	Canada Quebec	China	Ecuador City of Quito	Finland	Namibia
Stage of maturity	Mature	Emerging	Emerging	Emerging	Mature	New
Starting point	HiAP task force, created by Executive order (2010) – consistent high-level government leadership support since then	Government policy on prevention in health (2016) – building on years of broadening policy mandates Development of interministerial action plan (by October 2017)	Healthy China 2030 (2016) - first long-term national strategy for health taking a "one health" approach. Means for participation in global health governance and achievement of SDGs	Enabling legal and policy environment Metropolitan Ordinance 0494 (2014)	Long track record on HiAP (since 1972) Government's ten year objectives and key projects (2015)	National consultation workshop to draft HiAP implementation plan – identified 6 entry points for first wave policy action (WHO mission in October 2016)
Pathway to HiAP	Establishing mandate and structure (2009-2010) Engaging stakeholders (2010-2011) Securing commitments (2011-2012) Implementation (2012-2015) Systematisation/ formalisation (2016 onwards) Spread of HiAP in California and the US (2009 to now)	Policy on health and well-being (1992) Public health act (2001) Government action plan to promote healthy lifestyles (2006-2012)	Strong history of Government commitment to health (at highest level) 18th CPC Central Committee decision to promote development of a healthy China (2015), with drafting group established 2016	Joining Healthy Cities movement (2016) Focus on NCDs initially, then broadened to health inequities	Finland's EU position (since 1995) EU presidency (2006) with focus on HiAP 8th Global Conference on Health Promotion (2013)	Aligned with national development plan (NDP5)
Level (National, state, local)	State	Province	National	District/ Municipality	National	National
Partnerships	Task force with broad intersectoral representation from 22 agencies – support by backbone HiAP team key Inputs by external stakeholders (e.g. local and regional governments, advocacy organisations, think tanks)	Firm political anchor in MSSS, with support from other sectors (contributions by 15 ministries and government agencies, modelled against SDGs)	Over 20 ministries participated in working group to draft policy, supported by experts and research	District level Departments (health and others), public corporations, Ministry of Public Health (Ecuador), PAHO, communities	Multiple structures and mechanisms for intersectoral collaboration – natural continuation of existing work	Initially led by Ministry of Health and Social Services with support from WHO Proposed to be led by Office of the Prime Minister with MoH in secretariat role National planning commission to support policy screening

New Zealand Christchurch	Australia South Australia	Sudan	Suriname	Thailand	United Kingdom Wales	Zambia
Mature	Mature	New	Emerging	Mature	Emerging	New
Long history of collaboration Healthy Christchurch charter (2002), signed by high-level city decision makers and modelled after Healthy Cities	Adelaide Thinker in Residence (2007) – HiAP initiated, supported by a high level mandate from central government, an overarching framework which is supportive of a diverse program of work, a commitment to work collaboratively and in partnership across agencies, and a strong evaluation process	National health policy (2007) – 2013 assessment draws attention to intersectoral collaboration HiAP Roadmap (2015) – framed in relation to UHC	Initiated through WHO subregional training workshop (2015), followed by participatory assessment and national consensus workshop High-level commitment through engagement of Chair of parliament, Vice president and ministers Parliament briefing by Michael Marmot (2015)	National Health Act (2007) Broad vision of health facilitates participation by non-health sector including civil society	Wellbeing of future generations act (2015) – provides an enabling framework for thinking and working differently	Government's vision for health in revised national development plan Recognises that broader determinants of health lie outside the health sector – HiAP framed as an approach to tackle these for better health and health equity New division on health promotion, social and environmental determinants (2017) with multisectoral approach as a key principle
Series of health impact assessments (2005 onwards) Canterbury earthquakes (2011) Canterbury HiAP Partnership (2011 onwards)	5 distinct phases have evolved in response to a variety of challenges and opportunities, which in turn informed the HiAP model and practice Proof of concept and practice (2007 – 2008) Establish and apply method (2008-2009) Consolidate and grow (2009-2013) Adapt and renew (2014) Strengthen and systematise (2015-2017)	HiAP preliminary stakeholder assessment (2015) Policy dialogue on HiAP (2015) Development of Roadmap (2015) Series of stakeholder meetings and workshops (2016) – leading to commitments and operational plan (2017)	Establishment of policy working groups and a monitoring steering and strategy (MSS) group, chaired by Vice president's office, with Director of Health as secretariat (2016)	Long history of reform towards whole of society approach	Long-standing commitment to sustainable development at the heart of devolution (since 1998)	Existing experiences and structures to respond to crosscutting concerns e.g. HIV/gender HiAP not yet institutionalised: a strategy has been drafted and approval is in process
District/ Council	State	National	National	National	National	National
Municipal government, District Health Board, a national government department and an Indigenous organisation	HiAP unit (initially 1 Program manager, now unit of up to 6) within the Health department	Ten ministries signed commitments with MoH – another 12 are in development	Buy in through several conferences with VP's office and through VP's office and MoH with cabinet and chief executives	National health commission as an advisory body to the Cabinet, chaired by Prime Minister and covering government, knowledge and people sectors	All public bodies work towards legally binding common purpose (7 statutory wellbeing goals)	Central role of the policy analysis and coordination division in the cabinet office in the Office of the President

	USA California	Canada Quebec	China	Ecuador City of Quito	Finland	Namibia
Engagement process	Task force guided by shared principles/vision, updated over time – clarity of values and principles important Key partnership strategies include: shared vision, shared leadership, benefits to participating agencies, individual relationships, navigating differences	Responds to long-term criticism of lack of coherence between central and local levels of government Long process of policy development (starting with consultations in 2010)	Policy has strong administrative power (reviewed and passed by the Political Bureau of the CPC, and issued by the CPC Central Committee and State Council) Local governments, ministries and agencies expected to put Healthy China on top of the policy agenda – implementation mechanisms currently being set up, including regular and standardised supervision and assessment mechanisms, as well as monitoring and evaluation mechanisms	Setting up mechanisms for social participation/ community leadership Supported by cross-sectoral collaboration around community priorities	7 key projects as pilots, divided into 2 thematic groups – with separate orientation meetings and briefing papers Focus on testing new methods of collaboration and looking for co-benefits	Intersectoral action not new (a range of policies and mechanisms exist) but HiAP an opportunity to strengthen and broaden partnerships
Community engagement/ equity	Commitment to equity in government practices (action plan under development)	Pressure from citizens, organised groups, experts and media important to create political impetus for action	Equity and fairness central to the policy (including emphasis on primary and rural health and UHC)	Citizen & community participation central (e.g. priority setting, developing plans, work teams, certification of spaces)	Often easier to talk about equity with other ministries that health	Involvement of communities seen as critical
Funding sources (including in-kind resources)	Funding through government, private foundations and in kind-support through other state agencies	Financial incentives (new money) important to get other sectors involved	Multiple-sourced financing mechanisms	Municipal government	Not indicated (central government?)	Not indicated (central government?)
Lessons	Change in culture over time Important to be nimble to respond to emerging opportunities Increasingly calls for specialised technical expertise – may exceed existing capacity of team Monitoring and evaluation especially challenging Challenge of ensuring continuity of HiAP in future – given funding constraints and political changes	Process as important as results – including creating appropriate linkages between political, bureaucratic and civil society spheres Presence of a team dedicated to coordinating the project is an asset Other sectors' capacity and commitment to HiAP varies and follows diverse paths	Taking a "one health" approach calls for coordinating efforts, including those of various government ministries and departments, sectors, society and individual actors. Policy is a major milestone – strategically places health on the development agenda. Now needs to be followed by developing key mechanisms, especially national health impact assessment mechanism.	Culture of social participation important but may vary (marginalised groups) Collaboration across sectors takes time and happens step by step	Collaboration is time-consuming and continuous High-level mandate essential, backed by concrete plans Be prepared to defend gains on HiAP Evidence e.g. on co-benefits can help	Policy coherence remains a challenge Many existing mechanisms and policies – but not all functional Weak implementation, budget lines and human resources Opportunities around child welfare, women's health/gender and GBV, informal settlements, remote populations

New Zealand Christchurch	Australia South Australia	Sudan	Suriname	Thailand	United Kingdom Wales	Zambia
Started with ad hoc meetings, increasingly strengthened relationships and trust, supported through joint training, capacity building, working together, electronic portal, joint publications & presentations	Partnerships and collaboration are core to the approach. Practices and processes have strong focus on building and sustaining relationships. Co-design and co-benefit direct effort towards establishing trust, a shared understanding and common purpose amongst partners. 5 key stages: Engage, gather evidence, generate, navigate and evaluate. 4 methods: desktop analysis, 90 day projects, Public Health Partner Authorities, Health Lens Analysis	General consensus that lack of coordination and collaboration was a challenge Series of workshops to improve understanding of SDH and generate buy in	8 intersectoral policy working groups were established and each developed 3 proposals 6 promising proposals selected in first round; another six in second round (previous 6 were peer reviewed) PWGs to be disbanded and replaced by policy implementation teams A national health forum and annual population health report expected at the end of 2017	National Health Assembly meets annually: there have been 9 NHAs with 73 resolutions Process involves agenda setting; policy formation; policy adoption; policy implementation; monitoring and evaluation and revision	Accountability mechanisms built into the legislation including roles for an independent future generations commissioner and the auditor general	Consultation integral to policy development: mechanisms for consultation are in place Interministerial committee of officials
From early on focused engagement of Ngai Tahu (the local tribe), later focus on equity more broadly	Equity part of the vision – but not always at the centre of the approach Equity issues regularly raised and there is growing understanding of equity issues and the need for equity to become a greater focus in future	Equity is one of the core values	Health inequities as well as the SDGs more broadly a key focus of HiAP	Whole of society approach (people one of three sectors involved)	Public engagement contributed to development of act Act established public service boards as mechanism for collaboration at local level – requires partners to work together to develop local well-being assessment and plan	Health equity is a central concern Coalition of willing partners – including communities/civil society
Government (and government funded unit) Participating organisations	Small portion of health budget - relies on HiAP project partners providing in-kind support and contributing limited additional resources where possible	Not indicated	Not indicated (central government?)	Central government	Not indicated	Not indicated
Need for continuous institutionalisation of HiAP; and systematic and coordinated engagement of partners while being able to adapt to changing environments/ partnerships and opportunistic interactions	Two foundational pillars: strong governance and flexible partnership practices and processes including Health Lens Analysis Learning by doing to devise a suitable HiAP model for the given context & innovate and adapt over time Relationships are crucial for success and ensuring that HiAP remains relevant, useful and sustained Continuity of staff and connections invaluable HiAP is not linear - requires balancing the science and technical skills with political Intuition, emotional intelligence and creative insights	High-level commitment has been key – challenges include weak capacity (PHI, MoH and others), lack of coordination and structural barriers Bilateral engagement between MoH and others to develop operational plan Better monitoring and reporting would be beneficial	HiAP institutionalisation constrained by economic downturn HiAP needs not to be framed as a burden – but a vehicle to achieving sustainable development HiAP needs time, commitment and goes through multiple cycles	A broad definition of health has facilitated engagement of partners Important to seize opportunities that arise (may not be named HiAP) Success requires a mindset change NHC as the driving force for HiAP	Ministerial support an important enabler for the development of the Act, framed as a model for how SDGs can be translated to the subnational level Organisational and cultural change is an iterative process – emphasis to be placed more on "difference required"	Political will for HiAP: President as a champion Growing economy provides opportunities Need for more staff exposure/training on HiAP



For further information

Department for Health and Ageing
Prevention and Population Health Branch
Health Determinants and Policy Unit
PO Box 6
Rundle Mall, Adelaide
South Australia 5000
Email: HealthHiAP@sa.gov.au
http://www.sahealth.sa.gov.au/healthinallpolicies

World Health Organization
Social Determinants of Health
Email: hiap@who.int or actionsdh@who.int

www.ausgoal.gov.au/creative-commons

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