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HEALTH IN ALL POLICIES AS A STRATEGIC POLICY RESPONSE TO NCDs

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Health, Nutrition, and Population (HNP) Discussion Paper

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Health, Nutrition, and Population (HNP) Discussion Paper

Health in All Policies as a Strategic Policy Response to NCDs

Vivian Lin,[a] Catherine Jones, [b] Shiyong Wang,[c] and Enis Barış[d]

[a] La Trobe University, Melbourne, Australia
[b] University of Montreal, Canada
[c] Health, Nutrition, and Population, Human Development Network, the World Bank
[d] Health, Nutrition, and Population, Human Development, Middle East and North Africa Region, the World Bank

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Abstract: The aim of HiAP is to bring diverse sectors together to find shared solutions; it focuses on identifying "win-win" or "cobenefits" such that policy measures contribute not only to improved health outcomes but also to outcomes desired by other sectors, such as education, environment, welfare, agriculture, and transportation. HiAP can be applied to NCD prevention and control from three different entry points: risk factors or conditions, population groups (including life course), and sectors. Health in All Policies (HiAP) is a relatively new concept and policy practice that attempts to incorporate consideration into the policy decision-making process of how public policies and programs affect community health and well-being. It represents a way of working across sectors that aims to find solutions for complex, interrelated, and persistent problems. With the global epidemic in non-communicable diseases (NCDs), HiAP offers a potential approach and a pathway to secure coordinated action on social determinants of health that relate to NCDs and result in health inequalities. Promising examples can be seen globally for action on both specific NCD risk factors as well as in a more systemic approach to policy decision making.

Keywords: Non-communicable diseases, Health in All Policies, Mutisectroal Approach

Correspondence Details: Shiyong Wang, 1818 H Street, NW, Washington, DC, USA; telephone: 1-202-473-4532; fax: 1-202-522-3234; e-mail: swang1@worldbank.org.

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PREFACE

According to the Global Burden of Disease Study (GBD 2010), between 1990 and 2010, in terms of disability-adjusted life years (DALYs), non-communicable diseases increased and caused increasing disabilities in most of the countries in the Middle East and North Africa Region. For instance, the share of disease burden caused by NCDs in Egypt rose from 46.2 percent in 1990 to 72.5 percent in 2010. On the other hand, despite improved awareness and political commitment, countries in the region are still searching for ways to implement effective responses to the escalating scourge from NCDs.

To facilitate this pursuit, the World Bank (the Middle East and North Africa Region — MENA) and the World Health Organization (the Regional Office for the Eastern Mediterranean — EMRO) agreed to develop a joint report on NCDs in the region. The objectives of the joint report are (a) to document NCD epidemiology and country responses in the region, (b) to canvass policy options available for NCD prevention and control based on global experiences, (c) to further improve political commitment to actionable national NCD plans/programs for the implementation of the UN Declaration on NCDs, and (d) to suggest a roadmap for advancing an NCD prevention and control agenda in the region.

To prepare the report, six background papers have been commissioned. They include the following:

- Social Economic Impacts of NCDs in EMRO/MENA Region
- Epidemiological Analysis of NCDs in EMRO/MENA
- Assessment on Health in All Policies for NCDs in EMRO/MENA
- Development of Sub-Account for NCDs in Selected Countries
- Toward Harmonization of Generic Drugs Policy in EMRO/MENA
- Development of Pro-Health Workforce Development in EMRO/MENA

This review is one of the six background papers for the joint World Bank and WHO regional report on NCDs. Health in All Policies (HiAP) represents the up-to-date philosophy and practice of pro-health development. Similar approaches include multi-sectoral action for health, healthy public policies, and the whole-of-government approach. HiAP requires development policies and practices to be assessed for their impact on people's health. In case they cause negative impact, be it in the short or long term, mitigation measures must be designed and implemented. HiAP has been mandated by the European Community and increasingly practiced around the World. However, HiAP-related practices have not been systematically analyzed and documented in the MENA Region.

This paper reviews recent developments in the global understanding of HiAP recognizing that the literature is still limited. It also proposes tools to document HiAP experiences in addressing NCD prevention and control (Annex 2) and to collect information related to policy initiatives and intersectoral mechanisms and partnerships that address the key risk factors and social determinants of NCD prevalence (Annex 3), building on existing tools that WHO (EMRO) has developed to assess health promotion projects and gauge

intersectoral action capacity in ministries of health. It is hoped by the authors that this document can improve the understanding among the relevant policy makers and academics in the region of HiAP approaches for better health outcomes and help generate more evidence on HiAP for NCDs through structured assessments by the member states.

INTRODUCTION

1. Many determinants of non-communicable diseases (NCDs) lie outside the service delivery remit of the health care system. The theory and practice of health promotion, as articulated in the Ottawa Charter for Health Promotion (WHO 1986), point to the importance of action on public policy and environmental influences as well as of action to support change at community and individual levels. Prevention of NCDs, therefore, requires collaboration from multiple sectors, at both the policy level and the community levels. The clustering of key NCD risk factors in lower socioeconomic groups further suggests that the determinants of NCDs are similar to the determinants of social and health inequities in general. This further reinforces the importance of intersectoral collaboration as a strategy to achieve health gain and to close the health equity gap (McQueen et al. 2012). The role of those within the health sector is often to provide analytical and evidential support for defining potential interventions.

2. The term Health in All Policies (HiAP) was coined in the late 1990s, although its roots can be traced back to the early history of public health when the importance of social determinants of health was recognized by the Greeks and Romans (Ibid.). During the Finnish EU presidency in 2006, this approach to policy making was explored through a resolution that called for member states to undertake health impact assessment (HIA) of major policy initiatives, with specific attention to policy impact on equity and to consider the added value of cooperation between government sectors, social partners, private sector, and non-government organizations in formulating and implementing national policies (Council of the European Union 2006). More recently, Finland hosted the WHO's 8th Global Conference on Health Promotion, which took stock of global lessons to date.

3. HiAP has been applied to a myriad of public health concerns to address the non-health sector influences on health outcomes. The purpose of this paper is to consider how HiAP may be adopted as a strategy for addressing NCDs. This paper will not review evidence about the relationship between social determinants of health and NCDs, or health equity. This paper will define HiAP, discuss how it works and how it applies to NCDs, review case studies that have been documented across the world, and consider key lessons for adoption of the HiAP approach as part of a national response to NCDs.

WHAT IS HIAP?

4. The early European interest in HiAP was formulated by experiences with intersectoral collaboration from a number of large-scale NCD prevention and control projects, notably Heartbeat Wales in the United Kingdom and the North Karelia Project in Finland (Kickbusch and Buckett 2010). As these projects demonstrated the value of intersectoral collaboration, the challenge was to go beyond projects and create systemic change. The Finnish government led the way with integration of optimal population health and its fair distribution as targets of public policy when it recognized health as a basic contributor to the welfare of the country. As the EU president in 2006, Finland called upon governments across Europe to ensure that health considerations were included in all government policies.

5. Simply put, HiAP is a collaborative approach to improving the health of all people by incorporating health considerations into policy decision making across sectors (Rudolph et al. 2013). From the public policy perspective, it has variously been linked to other terms such as joined-up government, horizontal governance, policy coherence, partnerships, and whole-of-government, as well as whole-of-society approach. From a public health perspective, it also reflects the "one health" approach, which addresses diseases arising from the human and animal interface, and requires close cooperation between the health, animal, and agricultural sectors. From a health-promotion perspective, the HiAP concept and practice builds on earlier and closely related concepts of healthy public policy and intersectoral action.

6. There have been a variety of definitions of HiAP. The 2006 European Observatory publication considers HiAP "a horizontal, complementary policy-related strategy with a high potential to contributing to population health. The core of HiAP is to examine determinants of health, which can be influenced to improve health but are mainly controlled by policies of sectors other than health" (Sihto, Ollia, and Koivusalo, 2006). By 2010, the Adelaide Statement on Health in All Policies described HiAP as another approach to governance, highlighting such features as systematic engagement across government to address the health and well-being dimensions of the activities of various sectors, the need for institutionalized processes that value cross-sector problem solving, providing leadership, mandates, incentives, budgetary commitments, and sustainable mechanisms to support government agencies to work collaboratively on integrated solutions (WHO 2010 b). Reflecting on these discourses, the 2012 European Observatory study considered HiAP a policy principle as well as a policy practice that includes, integrates, or internalizes health in other policies that shape or influence the social determinants of health (Lin et al. 2012).

Box 1 DEFINITION of HiAP

Health in All Policies is an inter-sectoral approach to public policies that systematically takes into account the health and health systems implications of decisions, seeks synergies, and avoids harmful health impacts to improve population and health equity.

Source: WHO 2013c.

7. As the aim of HiAP is to bring diverse sectors together to find shared solutions, it has a focus on identifying "win-win" or "cobenefits" such that policy measures contribute not only to improved health outcomes but also to outcomes desired by other sectors, such as education, environment, welfare, agriculture, and transportation. As such, HiAP has been suggested as an approach to 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 (Kickbusch and Buckett 2010). The call for, and attempt to implement, joined-up government in the United Kingdom and Scandinavia in the 1990s was motivated by the need for new strategies to address persistent social and health challenges. In the WHO Asia-Pacific Region (Rani et al. 2012), more utilitarian frameworks informed the establishment of intersectoral commissions for public health (in Mongolia), health- promoting environment (in Malaysia), and NCDs (in Fiji and the Philippines).

8. By 2010, these whole-of-government HiAP approaches have been reported from 16 countries and regions around the world, including developing countries: Australia, Brazil, Cuba, England, Finland, Iran, Malaysia, New Zealand, Northern Ireland, Norway, Quebec, Scotland, Sri Lanka, Sweden, Thailand, and Wales. In each instance, the formal adoption of HiAP was preceded by the emergence of ad hoc intersectoral initiatives to address health equity — informed by a government vision for health, which was broader than health care delivery and recognized the role of social determinants. Nearly all countries undertook a mixture of universal and targeted approaches in their attempt to improve health for all and to address the health equity and needs of vulnerable population groups.

APPLYING HIAP TO NCD PREVENTION AND CONTROL

9. The importance of public policy measures to control NCD risk factors has been well established and forms the basis of the WHO's recommended "NCD's Best Buys" (WHO 2011a). The most advanced practices are in tobacco control, with lessons increasingly applied to alcohol, nutrition, physical activity, and mental health. Exemplar elements of tobacco control include banning of advertising, enlargement of tobacco warning labels and use of graphic warnings, and banning of cigarette sales to minors (WHO 2005). While these policy measures are specifically directed to reduce tobacco consumption, they have also brought shared benefits (or co-benefits) to the health sector and other areas of public policy. For instance, increased tax on tobacco products raised both the price signal for smokers as well as revenue for the government, while the smoking ban in worksites and public spaces helps to prevent exposure to second-hand smoke as well as to enhance productivity and amenities.

10. Adopting the HiAP approach for NCD prevention was recognized at the UN High-Level Meeting on NCDs in New York in October 2011, following from the First Global Ministerial Conference on Healthy Lifestyles and NCDs Control in Moscow in 2011, which identified the potential impact for fiscal policies and various regulatory measures.

11. HiAP can be applied to NCD prevention and control from three different entry points: risk factors or conditions, population groups (including life course), and sectors. The WHO's Best Buys for NCD prevention are largely policy measures, as seen in the box below, and are directed at the major risk factors.

Box 2 NCD BEST BUYS

Tobacco use
- Tobacco tax increase
- Legislation for smoke-free indoor worksites and for smoke-free public places
- Health information and warnings on packets
- Bans on tobacco advertising, promotion, and sponsorship

Harmful alcohol use
- Increase taxes on alcohol
- Restrict access to retailed alcohol
- Bans on alcohol advertising

Unhealthy diet and physical inactivity
- Reduce salt content of manufactured and prepared foods
- Replace trans fat with polyunsaturated fat
- Mass media campaign to raise awareness on diet and physical activity

Source: WHO 2011a.

12. There are a number of public policy measures, which are in place in many countries related to nutrition (for example, labeling of ingredients) and to alcohol (blood alcohol limits for drivers, banning of advertising, limited hours for bars) (ANPHA 2012; WHO 2012). While the evidence is still accumulating, incentives that increase the availability and affordability of fruits and vegetables, and other economic interventions to promote availability and access to healthy foods, have been recognized as important policy issues. Targeting disadvantaged communities or vulnerable population groups can be part and parcel of these approaches.

13. As NCDs often have their origins in intrauterine and early childhood environments, adopting a life-course approach is important for NCD prevention. Opportunities also exist across the lifespan for lifestyle modification, but reorienting risk factors at the population level is more feasible within a conducive economic and legal environment. Policy opportunities through the life course can be seen in the table below.

Table 1 Life-Course Approach for NCD Prevention

Stage of life	Policy opportunities
Foetal development and maternal environment	Subsidy for healthy food, targeted at women of low social economic segments
Infancy and early childhood	Subsidy for healthy food, targeted at low SES families Early childhood development programs Policies to support exclusive breastfeeding (e.g., breastfeeding rooms)
Adolescence	Regulating food advertising School lunch programs Banning of alcohol and tobacco sales to minors
Adulthood	Health insurance incentives for keeping physically active Active transport
Aging and older people	Age-friendly cities
All stages	Safe communities Banning smoking in public spaces and worksites

Source: World Bank 2011.

14. Population-based early childhood development programs have been demonstrated to be particularly important in reducing social and health inequities in the long term (WHO 2008). Given the vulnerability of children, controls on advertising — of tobacco, unhealthy food, alcohol — aimed at children has become another priority for NCD prevention.

HiAP action on SDH relevant to NCDs

15. As public policy measures intervene at the population level, their impact is bigger than individual-level interventions. When targeted, they can also be effective in reducing social and health inequities through action on broader social determinants of health. Areas that have been identified as promising interventions for NCD prevention that can also address broader social determinants of health are urban planning, taxation (incentives or disincentives), pricing and subsidies (incentives or disincentives), production and marketing of goods, health-promotion financing, and legislative mandates (UN 2011; World Bank 2011).

16. Urban development polices (such as targeting housing density, public transportation, green space) can encourage active transport and walkable cities. Availability of safe environments for walking and recreational activities can be important in influencing individual behavior. Economic incentives can be used to increase use of public transportation and, hence, incidental physical activity. All these policies can be targeted to favor disadvantaged localities or vulnerable population groups.

17. Regulatory and fiscal measures are increasingly used in many countries, states, and cities. Former New York mayor Michael Bloomberg's track record is most notable in adopting such measures for smoking, restaurants, food supply, and cars, for instance. While evidence in a well-established area such as smoking is strong, there is limited experience and therefore evidence for the effectiveness of such measures for tackling more complex issues such as obesity.

18. Regulatory and fiscal policies are not necessarily sufficient for prevention. Policy intent is achieved through a combination of legislative enforcement, community education, policies at micro settings, and the development of alternative products. Healthy settings, created through intersectoral collaboration, can create policy environments at the micro-level that reinforce healthy living. For instance, policies can offer incentives for health-promotion programs at the worksite. Health-promoting schools can also be adopted on a system wide basis. Incentives and subsidies can be used to target settings in particular localities or specific population groups. Partnerships between government agencies, civil society, and the private sector at local and national levels are integral to the NCD prevention effort and complement government policies. Such partnerships create enabling environments for individuals to exercise choice in managing potential risks to health.

19. In an analysis of the NCD challenges for China, the World Bank suggested a range of public policy interventions for NCD prevention and control, as seen in the table below. These are relevant to developed and developing countries alike (Table 2).

20. While there are numerous possibilities for policy alignment to address the NCD challenge, the starting point is often identifying the co-benefits for the different sectors. For instance, improving scholastic outcomes while improving health of children, or increased production of fruits and vegetables with improved consumption of fruits and vegetables in populations, or having green cities that are attractive to tourism while encouraging greater physical activity.

Table 2 Examples of HiAP for NCD Prevention and Control

Sector	Policy opportunity
Finance	• Subsidy for healthy food production • Increasing prices for tobacco, alcohol, oils • Removal of subsidies for harmful products, such as tobacco and sugar
Agriculture, food	• Salt reduction in processed food • Reduction of trans fats in food • Crop substitution for tobacco • Maintaining adequate land for agriculture and local food system development
Environment	• Enforcement of environmental pollution standards • Green spaces and physical activity facilities as part of housing development
Infrastructure, transportation	• Better public transportation • Road planning to facilitate cycling and walking • Safe communities
Education	• School breakfast/lunch programs • Sun protection measures
Social protection	• Single payer system • Funding for care planning and coordination
Law enforcement	• Penalties for violating smoke-free environment, excessive drinking, and occupational and environmental pollution
Media	• Ban inclusion of smoking and alcohol in TV and films • Ban advertising of cigarettes and alcohol
Private sector	• Incentives for worksite-based programs

Source: World Bank 2011.

HOW HIAP IS OPERATIONALIZED

21. While the concept of intersectoral action for health gain is well recognized, the challenge for many governments is how best to operationalize it. Some of the practical challenges experienced by European governments have included lack of simple solutions, limited understanding of causal pathways, lack of available stratified and small area data, length of time needed to achieve results, need for multiple sectors to work in concert, levers at different levels of government, and competing policy agendas (Exworthy and Hunter 2011). Nonetheless, the experiences around the world to date identify a variety of tools being used to implement the HiAP approach. Notably, these include (European Observatory on Health Systems and Policies 2006, Government of South Australia 2010; Shankardass et al. 2011; McQueen et al. 2012):

i. Governance structures (such as inter-ministerial and interdepartmental committees, cross-sector action teams, partnership forums, integrated budgets and accounting)

ii. Shared activities (joint workforce development, information and evaluation systems, community consultations, integrated reporting)
iii. Analytical tools (health lens, health impact assessment)

GOVERNANCE

22. Governance structures provide a practical mechanism and reflect the mandate for joint work across sectors of government, and for engagement with stakeholders in the policy process. Such structures can be established at the political level, the bureaucratic level, and through partnership arrangements with non-state actors. Case studies reviewed by the European Observatory found such mechanisms as (McQueen et al. 2012):

- Parliament (for example, inquiry, committee)
- Government (cabinet committee, coordinating minister)
- Ministry (interdepartmental committee, joint task force)
- Statutory agency (delegated financing, service delivery, regulation)
- Civil society (consultative forum, funded project)
- Public-private partnership (joint venture, consultation)

23. The European case studies found these governance structures were used for a wide range of governance actions and through different phases of the policy cycle. Commonly, these structures accomplished the following:

- Provided evidence in support of HiAP
- Advocated for HiAP
- Helped set policy goals and targets
- Coordinated policy development and implementation
- Offered policy guidance
- Negotiated or provided financial support
- Provided a legal mandate
- Oversaw implementation and management of programs
- Ensured monitoring and evaluation

24. While governments ultimately take responsibility for policy decision making, there were also case studies that demonstrated the importance of engagement with non-state actors, both with civil society and private sector organizations. Participatory processes have been important for policy agenda setting as well as for generating and testing acceptability of various policy options.

25. These European case studies showed that different governance structures were useful for different purposes. Many were important for agenda setting and selection of policy options as much as for negotiating policy goals, engaging stakeholders, monitoring

implementation, and evaluating policy impacts. Table 1.3 summarizes the main governance actions associated with particular governance structures.

Table 3 Overview of How Structures May Address Action to Support Health in All Policies

			Governance actions								
			Evidence support	Setting goals & targets	Coordination	Advocacy	Monitoring & evaluation	Policy guidance	Financial support	Providing legal mandate	Implementation & management
Inter-sectoral governance structures	*Government level*	Ministerial linkages		√	√		√			√	
		Cabinet committees and secretaries		√	√	√					
	Parliament level	Parliamentary committees	√			√	√	√		√	
	Bureaucratic level / (civil service)	Interdepartmental committees and units	√		√	√	√	√			√
		Mega ministries and mergers			√						√
	Managing funding arrangements	Joint budgeting			√				√		√
		Delegated financing			√	√			√	√	√
	Engagement beyond government	Public engagement	√	√		√		√			
		Stakeholder engagement				√		√	√	√	
		Industry engagement			√				√		

Source: Lin et al. 2012.

PROCESSES AND TOOLS

26. Immediate success is not always assured, however. Any type of partnership takes time to establish — to develop workable business rules, to understand the other's imperatives, and to agree on common goals and strategies. In all instances of HiAP, a particular problem was identified and acted upon through one or more interventions. These entry points for HiAP point to the specific sector to be involved as well as demonstrate the role that the health sector plays. Having shared activities that mutually satisfy each other's core business needs is one way to foster strong partnerships. Analytical and capacity building work are good starting points for dialogue and cooperation between different sectors.

27. Using shared analytical tools helps to reach common understanding of the policy problem to be addressed. Health impact assessments (HIAs) have been recognized as one of the most promising tools and are increasingly used to bring communities and government agencies together around proposed development (Kemm et al. 2004). HIA is defined as "a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population" (National Research Council 2011). Wales has adopted the use of health equity impact assessment as a rapid policy analysis tool, which includes community participation. In Norway, HIAP is used as a policy instrument to promote intersectoral action.

28. The core stages of an HIA include (1) screening to determine whether an HIA is warranted and would be useful in the decision-making process; (2) scoping to determine which health impacts to evaluate, the methods for analysis, and the work plan for undertaking the assessment; (3) assessment through gathering data on existing conditions and predicting future health impacts; (4) making recommendations to reduce negative health outcomes while promoting positive health outcomes; (5) communicating findings; and (6) monitoring and evaluating the impact of the HIA on the decision and on process outcomes (Rudolph et al. 2013).

29. Engagement is a process, although informed by analytical work. The South Australia Health Lens process is a five-step approach that particularly stresses the application in early stages of the policy-development process: (1) engage (for example, joint working group to agree on policy focus); (2) gather evidence (quantitative and qualitative research, critical appraisal); (3) generate advice (report and recommendations); (4) navigate policy decision making (output approved by lead agency and health sector); and (5) evaluate (process and impact). Having the central agency (that is, Department of the Premier and Cabinet) as coordinator of interdepartmental processes can be important in providing a strong authorizing environment.

30. The South Australian approach is comparable to the health-promotion lens developed by Pan American Health Organization (PAHO), which attempts to incorporate an understanding of the social, cultural, political, environmental, and economic conditions and structures that affect the lives and health of individuals and communities (PAHO 2008). The aim is to build on the strengths and assets of the communities and their institutions, and incorporate them into all aspects of program planning.

31. While these tools have different names, they have similar aims: (1) provide a method for considering health issues related to policies in other sectors, and (2) point to the importance of analytical work as well as engagement with stakeholders.

32. With structures and processes in place, the sharing of quantitative and qualitative data across sectors provides another mechanism for developing a common understanding of the problems and potential solutions. Experiences suggest the importance of using data from a variety of sectors to expand the collective understanding of the relationship between health and physical, social, and economic environments (Rudolph et al. 2013).

IMPLEMENTING HIAP: INTERNATIONAL CASE EXAMPLES

33. Although HiAP is a relatively new development in public policy, there are experiences of HiAP in both developed and developing countries, and these examples are applied to specific issues of relevance to NCDs and to a systems approach to policy development. They are also applied at national and subnational levels. The most notable example of an HiAP approach applied internationally for NCD prevention and control is the Framework Convention on Tobacco Control (FCTC), which is being implemented in both developed and developing countries. These policy measures have brought shared benefits (or co-benefits) to the health sector as well as to other arenas of public policy, such as raising government revenue and enhancing worksite productivity and public space amenities. Increasingly, HiAP is being adopted to address other NCD risk factors such as alcohol use and obesity (for example, food, physical activity, active transport).

34. In terms of a system-wide approach, healthy cities have been exemplary in adopting an HiAP approach at the local level. Since the late 1980s, in both developed and developing countries, a variety of models have evolved that bring together municipal decision making with citizen participation that address locally identified priority actions to improve health for the community. The focus and form of healthy cities vary widely depending on the framework for local municipal administration, but healthy cities have been widely established in Europe, Latin America, and Asia. Variously, these efforts have tackled public transportation, safe drinking water, food supply, affordable housing, quality recreational environments, social services and educational opportunities, physical activity facilities, cultural amenities, crime and violence, pollution, and traffic safety. They are conceived more as social movements than as public health interventions. For instance, in Asia, the Alliance for Healthy Cities is a network of mayors who promote the approach and facilitate mutual learning. The challenge in moving from these local efforts to a national approach is the complexity of issues and the number of actors at the national level.

35. While Michael Bloomberg was the mayor of New York City, comprehensive regulatory measures were adopted to reduce exposure to NCD risk factors and to promote health, but the actions were not enunciated as part of a “healthy cities” framework. Although the now infamous attempt to ban large-size soda bottles ultimately failed, the ban on trans fats affected the industry well beyond the city, given the size of the New York market. The threat of bans also had a larger community impact in stimulating debates across the country, if not globally.

36. The Pan American Health Organization has suggested some criteria that can be used to determine whether a policy activity can be classified as HiAP. These are (1) political support at the highest level, (2) formal intersectoral structure, (3) a specific budget allocation, (4) explicit commitment from other sectors, (5) explicit commitment to reduce inequity in health, (6) scientific evidence on the impact, and (7) mechanisms for participation and empowerment that enhance ownership and sustainability of programs (PAHO 2013). Some notable examples are illustrated in the table below.

Table 4 Global Examples of HiAP

	Developed countries	Developing countries
NCD risk factors	FCTC Health-promotion foundations — Victoria Alcohol control policy — Australia Healthy Transportation Compact in Massachusetts Comprehensive regulatory measures — New York (see case study)	FCTC Health-promotion foundations/ boards — Thailand (see case study), Singapore Conditional cash transfer for maternal child health (MCH) — Mexico (see case study) National Agreement for Healthy Food — Mexico Alcohol policy — Thailand, Chile Sao Paulo Green and Healthy Environment Program Argentine "Less Salt, More Life" Intersectoral commissions for NCDs — Philippines, Fiji
System-wide policy strategy	Healthy cities King County Equity and Social Justice Ordinance Quebec Strategic Meeting on Health South Australia HiAP California HiAP Task Force (see case study) US National Prevention, Health Promotion, and Public Health Council Finland HiAP (see case study) Health Targets in Austria	Healthy cities Inter-American Faces, Voices, and Places (FVP) Ecuador National Plan for Good Living (see case study) El Salvador Intersectoral Health Commission First Wealth is Health in Bihar, India Thai National Health Assembly Thailand Health Impact Assessment Mongolia Intersectoral Commission for Public Health

Source: Authors assessment

37. For the policies and programs that focus on key NCD risk factors, whether at the national or subnational level, there is a general approach of adopting multilevel and multi-sectoral interventions, consistent with the Ottawa Charter for Health Promotion (WHO 1986). Typically, there would be policy interventions to regulate unhealthy products or create environments that support behavior change, alongside the targeting of population groups (such as children) or particular communities for communication, education, and action. This has been seen in the Argentine salt-reduction program, the Mexican national agreement for food health, and alcohol control in Thailand and Chile.

38. The adoption of an intersectoral governance mechanism to work across a wide range of social determinants is a newer application of the HiAP approach. Finland has the most established and longstanding approach dated to the 1970s, when it was recognized that the health of the population was closely connected with the social and

economic well-being of the nation (Leppo et al. 2013). Targets were set for health improvement and have been successively updated, with legislative requirement for reporting since the 1990s. Constitutional reform placed responsibility for health promotion with public authorities, and health impact assessment has contributed to improved understanding of health by other sectors. More recently, a pragmatic approach has been adopted in South Australia (SA) (Government of South Australia 2010). With the State Strategic Plan providing the entry point, joint policy initiatives were identified for relevant sectors based on the intersection of interest between health and other sectors. Health lens was used as the analytical tool to identify these co-benefits, while policy coordination was facilitated from the Department of the Premier and Cabinet. Like Finland, SA used targets, administrative structures, and analytical tools. Unlike Finland, SA did not take a comprehensive approach, but worked selectively as priorities and opportunities emerged.

39. Similar strategies are being adopted in developing countries. The National Plan for Good Living in Ecuador is a program that flows from the National Development Plan, which aims to reduce economic and social inequality gaps and address basic needs of communities. It resulted from a constitutional reform and is coordinated by the National Secretariat for Planning and Development, with the participation of all sectors and levels of government. Between 2006 and 2011, social investments were more than doubled, credits for agriculture were doubled, rural homes with access to waste collection increased from 22 to 37 percent, and access to public health services also increased (PAHO 2013).

40. A more comprehensive approach has been adopted in Thailand in terms of creating sustainable financing and institutions. Since the early 2000s, Thailand has seen the implementation of a surcharge on tobacco and alcohol sales to establish the Thai Health Promotion Foundation (ThaiHealth) that works with different sectors and communities to tackle a variety of health issues, with NCD risk factors as a priority. By the mid-2000s, HIAs were constitutionally required, and public hearings were established to allow views of interested parties to be aired. At the same time, a National Health Assembly has been legislated as an instrument as well as part of a learning process at local and national levels to develop participatory public policies on health. Examples of issues considered in the 2012 National Health Assembly include food safety, air pollution, systems to support walking and cycling, children and IT, health workforce education, among others.

41. The Thai approach is also distinctive in creating an autonomous statutory body in the form of ThaiHealth, building on state-level development in Australia with the creation of the Victorian Health Promotion Foundation (VicHealth). As both organizations are outside the Ministry and Department of Health, they are able to work across sectors with greater ease, including in building partnerships, mobilizing community organizations, and advocating for healthy public policies. The funding of such organizations from tobacco and alcohol tax has now been replicated in a number of countries, prompted in part by the FCTC — including Mongolia, Malaysia, Tonga, Vietnam, and the Lao People's Democratic Republic — although some have funding via a budget allocation as well.

42. In all instances, the entry points for HiAP and the structures for intersectoral governance were different. The level at which action was taken also varied, with state-level policy action more important in federalist systems. This speaks to the context-specific nature of policy making as well as to the complexities of a country's constitution. It is thus difficult for a country to replicate exactly the model in another country, but it is possible for countries to consider the conditions under which different models were adopted.

43. In many countries, the HiAP approach has been embedded in the national strategies for HIV prevention and control as well as in strategies for road safety. While they have not been labeled as "HiAP," countries can learn lessons from their HIV- and injury-prevention work and apply them to NCD prevention and control efforts.

LESSONS FROM HIAP EXPERIENCES

44. Joined-up government can be effected in different ways (Mulgan 2010). Top-down reliance on government authority is effective but dependent on the commitment of leaders. Cooperation between departments and agencies based on shared conviction for the need to change may be more sustainable, but requires a supportive, authorizing environment. Bottom-up collaboration from the community can focus on real problem-solving, but scaling-up can be more difficult. Legislative provision for cross-cutting ways of working is an effective approach to embed new governance practices, but its form and achievement are dependent on the political climate.

45. There have been limited evaluations of horizontal governance. Earlier studies in intersectoral action suggest that there are pre-conditions for effective collaboration (Kickbusch and Buckett 2010). These include a need to work together to achieve shared goals, opportunities to work together, organizational capacity (resources, skills, knowledge to take action), well-conceived plans, and a relationship between the parties.

More recent case studies collected by the European Observatory on Health Systems and Policies noted that several building blocks were needed for success in HiAP (Lin et al. 2012). These include the following:

- Leadership
- Political commitment/government mandate
- Human resources
- Financial resources
- Information and research
- Policy analysis tools
- Partnership management
- Stakeholder engagement

46. Once governance structures are established (that is, building blocks are in place), certain features in the governance process help create and sustain trust in the partnership and provide for accountability and transparency. Key among these are the following:

- Clear terms of reference
- A process for identifying shared priorities
- Transparency in decision making, including resolution of disagreements
- A process for engaging multiple stakeholders within and outside government
- Available multisectoral policy and action plan
- A budget or funding mechanisms for joint programs and activities
- A budget or funding mechanisms for relevant programs for each ministry
- Monitoring and evaluation mechanism or tools
- Regular communication and reporting tools or mechanism with the general public (for example, TV, journals, radio, special communiqué)

47. Finally, lessons from the European case studies point to some key factors for success (Lin et al. 2012):

- Political will — presence of political support or interest
- Partnership and constituents' interests — support from stakeholders outside government as well as across portfolios or departments
- Political importance of the specific health issues identified — expectation that a policy solution will be found
- Immediacy of the problem — time-limited response expected
- Leadership — political or bureaucratic
- Context appropriate — suitable to the situational and political landscape
- Resources available — governance structures and actions require human and financial resources

- Implementation practicalities — solutions must be feasible and workable

48. While these general lessons are important, the key to getting started — even when there is political will to establish a coordinating structure and drive cross-sectoral cooperation — is finding the appropriate entry points. Structures and policy statements are not necessarily effective in themselves. Taking action may be a matter of being opportunistic. For instance, piggybacking on existing political imperatives to deliver results (such as tobacco control in China for the 2008 Olympics and 2010 Shanghai Expo), or building on shared interests (such as early childhood education to deliver outcomes for both education and health sectors in South Australia).

49. These lessons about preconditions for collaboration, effective governance structures, and successful intersectoral policy making reinforce the four key actions stated at the 2011 Rio Political Declaration on Social Determinants of Health, which are also observed in the recent review of Australian case studies on action on social determinants of health (Lin 2013):

- Governance — the importance of interagency partnerships (for policy alignment, program funding), engagement of cabinet committees, use of intergovernmental agreements, and value of legislation
- Participation — civil society coalitions play critical roles, and stakeholder engagement accompanies ongoing consultative mechanisms
- Health sector role — health departments provide analytical support for other sectors, advocate for policy development on the basis of evidence, and ensure the health sector also delivers related health programs
- Monitoring and evaluation — ongoing accountability reporting is crucial, being able to commission evaluation is even more helpful in generating evidence of effectiveness

50. These conditions must be present regardless of the nature of political administration or health system. They can be applied across a range of partnership models. A variety of models for interaction between health and other sectors have been seen in countries that implement the HiAP approach. These range across a continuum of relationships, from strong partnerships to softer forms of cooperation, as seen in the table below.

Table 5 Models of Inter-sectoral Interaction

Information	Cooperation	Cooperation and coordination	Coordination	Coordination and integration	Integration
Many countries	Brazil New Zealand	England Sri Lanka Wales	Malaysia N. Ireland Quebec Scotland S. Australia Sweden	Cuba Finland Thailand	Iran, Islamic Rep. Norway

Source: National Collaborating Centre for Determinants of Health 2012.

51. All models rely on building strong relationships between individuals and agencies. Trust, reciprocity, and mutuality are the three essential elements of collaborative relationships (Rudolph et al. 2013). They require participants in the HiAP process to understand the political and organizational contexts for various partners, to share information and ideas, to take a long-term strategic view, and to be flexible and pragmatic in the short term.

52. Experiences in diverse countries suggest that the health sector has multiple roles to play to facilitate HiAP — depending on context — which can result in different models of intersectoral interaction. These roles can include the following:

- Provide health and population data
- Provide research and analysis of health impact
- Advocate for policy attention
- Propose policy strategies
- Draft policy documents
- Negotiate budgets
- Provide technical guidance on policy implementation
- Develop performance-monitoring indicators
- Provide monitoring and evaluation data
- Provide capacity building for other sectors

53. The global experiences suggest that HiAP involves the articulation of a strategy or intervention as well as a process for effective relationship management. They also reinforce the need to take a longer-term perspective in assessing possible health and social outcomes. This is likely to require the adoption of an action-learning orientation to ensure the process stays on track and the interventions are adapted to the changing environment. As such, capacity building within government, and a reorientation of public administration, may well be required.

54. The challenges and failures of HiAP attempts are not well documented, but can be assumed to be the converse of the success factors. Industry resistance can be anticipated when its interests might be adversely affected by regulatory and fiscal measures. Strong policy analysis skills are therefore needed. Some investments are inevitably required even if policy measures are not costly. Decentralized systems may pose structural challenges if policy levers rest at different levels of government.

55. The biggest challenge for horizontal governance, however, is likely in its ongoing implementation, so that policy practice and program delivery all reflect joined-up thinking (Hyde 2008). While governments and ministers have responsibilities for strategies, it is the senior level of public service that must support policy and program development, the mid-level bureaucrats who implement protocols and guidelines, and the service managers who ensure local service delivery. This reflects whole-of-government outcomes. Thus policy coherence has to work not only across agencies, but also across all levels of the system. St. Pierre and Gauvin (2010) suggest that organizational culture is also a key condition for effective intersectoral governance, and the mechanisms and strategies needed for culture change include collective learning, reshaping of values, and capacity building.

56. The 2013 WHO 8th Global Conference on Health Promotion in Helsinki identified a range of actions needed by governments to progress to the HiAP approach, as seen in the box below.

Box 3 What Government Actions Are Needed

- Health and health equity as political priority — adopt HiAP principles and act on SDH
- Effective structures, processes, and resources to enable implementation
- Capacity of the Ministry of Health (MOH) to engage other sectors of government through leadership, partnership, advocacy, and mediation
- Institutional capacity and skills for implementation and evidence on determinants and responses
- Transparent audit and accountability mechanisms for health and equity impact
- Conflict-of-interest measures as safeguards against distortion by vested interests
- Involvement of communities, social movements, and civil society

*Source***:** WHO 2013C.

MOVING FORWARD

57. Being clear about possible effective action may be a prelude to establishing a multisectoral structure or plan. The WHO's Best Buys is a useful starting point for assessing a realistic entry point for HiAP. The global evidence, as seen in the table below, suggests the policy interventions are not costly and are feasible. However, the specific contexts and costs for each country need to be assessed. The choice of entry points would determine which ministries should be at the intersectoral policy table.

Table 6 Cost and Feasibility of NCD Best Buys

Intervention	Cost-effectiveness	Implementation cost	Feasibility
Tobacco - Taxation - Smoke-free environments - Warning labels - Advertising ban Other: Counseling	Very cost-effective Quite cost-effective	Very low cost Quite low cost	Highly feasible, with FCTC as framework Primary care
Alcohol - Taxation - Restrict access - Advertising ban Other: Breath testing Counseling	Very cost-effective Quite cost-effective	Very low cost Quite low cost	Highly feasible Police Primary care
Diet and physical activity - Reduce salt - Replace trans fats	Very cost-effective	Very low cost	Highly feasible

Intervention	Cost-effectiveness	Implementation cost	Feasibility
- Promote awareness Other: Counseling Worksite and schools	Quite cost-effective Less cost-effective	Higher cost Higher cost	Primary care Settings

Source: Adapted from NCD Roadmap Report. 2014.

58. The multisectoral structure, if it is result-oriented, is likely to be dependent on priority areas for action. The assignment of responsibilities should be clear; table 1.7 suggests issues for further consideration in context.

Table 7 Allocation of Responsibilities under HiAP for NCD Prevention and Control

Ministry responsible	Proposed action	Intended benefit in reducing NCD	Likely cost / revenue implications	Feasibility and obstacles to implementation	Political implications (e.g., winners and losers)
Prime Minister's Office	Establish and chair multisectoral taskforce on NCDs	Oversee policy adoption and implementation	Low cost, potential revenue increase through taxation; potential administrative efficiencies	Easily feasible but implementation needs monitoring	Some industry opposition can be expected
Ministry of Finance	Increase excise duty on tobacco and alcohol	Reduce consumption of harmful products	Increase revenue, with some administrative costs	Requires good analysis, and taxation collection and monitoring systems	Resistance from industry
Attorney-General	Coordinate legislation reform	Policy coherence facilitates implementation	Avoid legal and compensation costs if laws are sound	Easily feasible	Credibility of government
Ministry of Health	Scale up core service package of essential NCD (PEN) interventions to national coverage	Early detection, improved management, decrease hospitalization	Increase funding for primary and secondary prevention	Requires good data and workforce training	Improved health and productivity

Ministry of Communication	Ban or restrict advertising	Promote knowledge; counter marketing of unhealthy products	Some costs to monitor compliance; some revenue from fines related to breaches	Need to monitor alternative advertising vehicles	Reduced revenue for advertising industry; opposition from industries with bans
Ministries of Industry and Agriculture	Promote production of healthy products	Expand access to healthy products	Some costs to support farmers and industry to transition	Requires good negotiations and possible technical support	Support from local producers; resistance from manufacturers
Ministry of Planning	Plan for active transport, recreational spaces	Reduce exposure to obesogenic environments	Low cost for planning; infrastructure investment may be public or private	Coordination across jurisdictions and private sector can mean delays	Community support for improved urban environment; some resistance from developers
Ministries of Education and Labor	Institute programs in settings	Support behavior change	Set up costs	Need good communications and reliable suppliers	Community support

Source: Authors adaptation from NCD Roadmap Report 2014.

CONCLUSIONS

59. The evidence base pointing to the importance of policy interventions for NCD prevention and control, along with the global experiences with HiAP to date, create an imperative for governments to take an inter-sectoral approach to address the social determinants of health underlying the high prevalence of NCDs and associated health inequalities. HiAP can be applied to NCD prevention and control from three different entry points: risk factors or conditions, population groups (including life course), and sectors.

60. Governments may start with intersectoral governance structures that tackle the key risk factor, where the evidence and business case are well established and are supported by social norms. In some countries, tobacco may be such an entry point, with the FCTC as an accepted international framework and clarity that the tobacco industry is the clear target for policy development. In other countries, with rapid urbanization and government attention focused on planning, reducing exposure to an obesogenic environment may be both an urgent public health concern as well as an issue aligned with government priorities. In any case, civil society support and priority attention to the health agenda are important.

61. A focus on health inequalities can be built in through efforts to target vulnerable groups, through extra resources or incentives, or through appropriate adaptation of

strategies for the general population. Such intersectoral structures may evolve into a more systematic approach to policy making across other risk factors, and may address health equity concerns more generally.

62. Although HiAP is a relatively new form of policy practice, to date, in all instances around the world, the entry points for HiAP and the structures for intersectoral governance were different. Nonetheless, there are some shared lessons. The recent guide to Health in All Policies published by the American Public Health Association (Rudolph et al. 2013) summarizes the key elements of HiAP: (1) promotes health equity and sustainability in specific policies, programs, and processes, and embeds these considerations into government decision-making processes; (2) supports inter-sectoral collaboration with partners who shape the economic, physical, and social environments; (3) simultaneously addresses the policy and programmatic goals of public health and other agencies by finding co-benefits, or win-wins, for multiple partners; (4) engages stakeholders at all levels in identifying policy and systems changes necessary to create health improvements and to ensure work is responsive to community needs; and (5) institutionalizes the approach by making changes in the structures for intersectoral collaboration in government, and in mechanisms to ensure a health lens is applied in decision-making processes. Capacity building and analytical work are useful starting points for cooperation across sectors.

63. There is a need to understand better how to effect and secure HiAP. There are lessons to be learned internationally about how the public agenda for health is set, how policies are formulated, how HiAP is effectively implemented and appropriately evaluated, and what policy interventions have been effective. The variety and effectiveness of governance actions, and their relationship to the variety and effectiveness of governance structures and processes, are at the core of knowledge gaps.

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ANNEX 1: CASE STUDIES

A Comprehensive Local Approach: New York City

Mayor of New York Michael Bloomberg has attracted international attention for his public health policy reforms, which have taken the form of healthy public policy. These policy measures address smoking, food supply, traffic, environment, and general quality of urban living through various bans and include the following:

2003 Smoking in commercial establishments (bars and restaurants)
2009 Sale of flavored tobacco products
2011 Smoking in public places
2013 Cigarette sales to people under age 21
2013 Cigarette in-store display
2006 Trans fats in restaurants
2008 Chain restaurants' menus without calorie count
2007 Nonfuel efficient cabs
2007 Cars driving in newly created bike lanes
2009 Cars in Time Square
2013 Speeding in residential "slow zones"
2005 Government buildings not LEED-certified
2007 Greenhouse emissions
2013 Styrofoam packaging in single-service food items
2013 Commercial music louder than 45 decibels
2013 Construction cranes more than 25 years old
2005 Less than 2:1 ratio of female-to-male restrooms in public buildings

In addition, there have been a number of suggested or voluntary bans:

2006 Illegal guns
2009 Black roofs
2010 Sodium level in processed foods
2013 Organic food waste from landfills
2013 Loud headphones

In 2012, his now infamous ban on soda bottles larger than 16 ounces was overruled.

These policy measures were supported by research, including appraisal of published studies, granular and long-term local prevalence data, field studies in the community context, research collaboration across sectors, and dissemination of research through a variety of media. In other words, these policy measures were not based solely on the mayor's personal views or a result only of his strong political leadership, but arose from a well-orchestrated policy process. (Laugesen and Isett 2013) Opponents did raise concerns, for instance, about stigmatizing the poor with anti-obesity policies as well as about the strength of evidence related to the anti-obesity policies.

Source: Laugesen and Isett 2013.

Comprehensive National Plan: Ecuador National Plan for Good Living (NPGL)

The NPGL is an example of the whole-of-government approach, where health is one of many areas tackled by the policy. The plan redefines the role of the state in social policy and establishes equity and redistribution goals from a rights-based approach. The commitment of the legislature was necessary to adopt a new constitution for the country that set the grounds for this plan. Public institutions were redesigned to reflect this vision and coordinating ministries were created. Active civil society is promoted; the plan provides spaces for dialogue that ensure adaptation to local needs and enable ownership from stakeholders.

The NPGL is present in all central, regional, and local state structures. The National Planning Council, a collegial and intersectoral body, functions as the technical secretariat, while the National Plan is coordinated by the National Secretariat for Planning and Development. All sectors and levels of government are involved. National budget is allocated to each institution involved. The sectoral-specific work plans have to be consistent with the National Plan. The work of the health sector is guided by the principle of social determinants of health approach.

Citizenry accountability processes exist at both central and local levels. Active social participation is mandated for development, construction, design, implementation, and evaluation of the program. Focal groups, consultations, and consensus-building activities provide the vehicle for community representatives to give input.

Source: PAHO 2013.

Targeted Population-Based Intersectoral Public Policies: Mexico

Human Development Program Oportunidades (Progresa prior to 2002)

Oportunidades is a supported and integrated approach to tackling the health and educational needs of the poor. Conditional cash transfers provide financial incentives to parents to increase school attendance and retention, improve the use of preventative and other medical services, and improve nutrition. The program was created in 1997 on the basis of a strong body of evidence from both social and health sciences developed over two decades that emphasized the links between food intake, nutrition, health, and education. Food subsidies had been in place at the time but were inadequate because a large share of the benefits was received by the non-poor, and targeted programs had very limited coverage in rural areas.

Oportunidades is based on the idea that there is a synergistic, mutually reinforcing effect of improvements in education, health, and nutrition. The program is therefore credited with transcending notions, which underpin silo programs in the social sector. Accumulated empirical evidence and economic arguments were considered important in achieving legal mandates. The success of the original program led to expansion from rural to urban settings. The provision of monetary incentives is considered unconventional, these are equivalent to a 25 percent increase in family income and are given to the mother of the family. This is an intentional strategy designed to target funds within the household to improve children's education and nutrition. A further condition of the cash transfer payments is that all family members including adults accept preventative health services. The services are aimed at the most common health problems as well as the most significant opportunities for prevention such as family planning, prevention and

treatment of respiratory infections, and accident prevention.

Presidential leadership has been essential to the implementation of the program, which occurs across sectors, involving the ministries of social development, health, education, and finance. The various sectors involved share common goals and performance indicators, which are published yearly and monitored regularly by a technical committee created specifically for this purpose, as well as by Congress and the Ministry of Finance.

Evaluation involving independent national and international academic researchers has played a key role in the continuity of the program. Demonstrated improvements in health include improved access to primary care, both preventive and curative and in rural and urban areas, reduced maternal and infant mortality, reduced illness in children age 0 to 5 years in rural areas, and improved health in adults. Achievements of the program in relation to education include higher middle-school enrollment rates, improved retention rates for 15 to 19 year olds in rural areas, and reduced dropout rates among 16 to 19 year olds in urban areas. The success of the Progresa/Oportunidades program has led to expansion of this sort of multisectoral approach to other parts of Latin America.

Challenges identified for the program in the long term include linking achievements in improved living conditions of the very poor with economic policies that allow beneficiaries to join the labor force and improve their lifetime income. Improvements in the quality of health and education are seen as essential in achieving such outcomes. Improvements in early childhood development programs that develop physical, linguistic, cognitive, and socioemotional skills were identified as a cost-effective strategy to improve middle-school retention rates, which would contribute to subsequent improvements in employment outcomes in the future.

Sources: WHO 2010, 2013a.

Policy Agenda-Setting Focused on Cobenefits: California's Health in All Policies Task Force

Established in 2010, California's Health in All Policies Task Force is a collaboration between the Public Health Institute (PHI), the California Department of Public Health (CDPH), and the California Strategic Growth Council (SGC). The task force comprises 19 designated agencies and departments, and is the first formal use of HiAP by a US state governmental panel.

By harnessing the power that state agencies and departments can bring through their varied areas of expertise the HiAP Task Force identifies priority programs, policies, and strategies with the overall goal of improving the health of Californian people.

While advancing the existing SGC goals of improving air and water quality, protecting natural resources and agricultural lands, increasing the availability of affordable housing, improving infrastructure systems, promoting public health, planning sustainable communities, and meeting the state’s climate change goals, the particular goals of the HiAP Task Force include the following:

- All California residents have the option to safely walk, bicycle, or take public transit to school,

work, and essential destinations
- All California residents live in safe, healthy, and affordable housing
- All California residents have access to places to be active, including parks, green space, and healthy tree canopy
- All California residents are able to live and be active in their communities without fear of violence or crime
- All California residents have access to healthy, affordable foods at school, at work, and in their neighborhoods
- California's decision makers are informed about the health consequences of various policy options during the policy development process (Strategic Growth Council undated).

The approach adopted focused on co-benefits and win-win strategies. Over an eight-month period, representatives from the 19 participating executive branch entities came together in individual and group task force meetings, held public input workshops, and received written comments from a diverse array of stakeholders. These state leaders developed a broad-ranging set of recommendations geared to improve the efficiency, cost-effectiveness, and collaborative nature of state government, while promoting health and sustainability.

The HiAP Task Force's recommendations addressed two strategic directions:
1. Building healthy and safe communities with opportunities for active transportation; safe, healthy, affordable housing; places to be active, including parks, green space, and healthy tree canopy; the ability to be active without fear of violence or crime; and access to healthy, affordable foods; and
2. Finding opportunities to apply a health lens during public policy and program development.

The recommendations range from one-time actions by a single agency to ongoing opportunities for all agencies to consider health when making decisions. Many of the recommendations can be implemented through administrative action, while others require legislation. Examples of recommendations include removing barriers to institutional acquisition of locally grown produce, adding a health lens to transportation and city planning guidance documents, and assessing tools that might be used to project long-term costs and benefits of proposed legislation.

Source: Greer 2012.

Intersectoral Policy Advocacy Through Autonomous Statutory Body: Thai Health Promotion Foundation

Established in 2001 and funded by a surcharge on alcohol and tobacco, Thai Health Promotion Foundation (ThaiHealth) addresses major health risk factors including tobacco and alcohol, unsafe driving, physical inactivity, and junk food, as well as child, youth, and family health; healthy organizations; health service system; and specific population groups. ThaiHealth recognizes policy advocacy as one of three key strategies in a comprehensive approach to health promotion. Together with knowledge and social participation, the power of policy is recognized as a necessary element in achieving sustainable improvement in health status for the nation. Working with a wide range of multisectorial implementation partners ThaiHealth emphasizes

health-promoting public policies as well as issue-based programs and holistic approaches, while targeting the social determinants of health. Policy is developed at the national, provincial, district, and subdistrict levels. ThaiHealth also works with organizations and networks of organizations advocating that they move toward developing healthy, safe, and supportive environments in their local communities.

Since the establishment of ThaiHealth, significant reductions in health risk factors have been achieved. By 2009 high smoking rates in Thailand recorded in 1991 had reduced by more than half, down to 20.7 percent of the population. Policies related to tobacco consumption influenced by ThaiHealth include cigarette pack warnings, bans on tobacco advertisements, bans on smoking in public places and government buildings and hospitals, media and social antismoking campaigns, movie ratings in relation to tobacco smoking content, and support services for giving up smoking.

Alcohol consumption is of concern in Thailand, rates had nearly doubled during the 1990s; however, alcohol consumption rates have since decreased overall including the percentage of people consuming alcohol at a harmful level. The number of national alcohol-related policies has increased. Road accident rates and traffic injury rates are falling dramatically, traffic accident related death rates are also falling. Alcohol control policies implemented include taxation measures, limitations on advertising and sales, abstinence campaigns such as "No alcohol during Buddhist Lent," and public warning messages.

The use of policy as a mechanism for achieving health is a clear goal, not only of all plans and actions, but also of the range of health-promotion methods and approaches undertaken by the foundation, including advocacy, social marketing, community development, partnerships, and grants. The ThaiHealth Ten-Year Review reports that the organization has catalyzed policy development in every part of government and across many settings at the local and provincial levels, making a significant contribution to the development of government policies, many of which would otherwise still be in development or would never have been developed at all.

ThaiHealth takes a particular approach to social marketing, which, rather than aiming only at increasing awareness with the purpose of behavior change, has the more important goal of mobilizing the community to act in ways conducive to health by changing society's preparedness to accept and advocate for major policy reform that will promote health. With this goal in mind social marketing is used by ThaiHealth with the double aim of contributing to the reduction of risk behavior, while at the same time enabling all levels of government, communities, and organizations to develop health-promoting policies.

ThaiHealth recognizes the importance to the implementation of health in all policies of maintaining good relationships with government, especially with health departments. To this end ThaiHealth established a unit to liaise with members of Parliament, providing them with updates about health promotion and ThaiHealth priorities and activities, arranging for health checks, and running programs about healthy work environments. Of high priority is fostering understanding among members of Parliament of the various dimensions of health promotion and also about the importance of the social determinants of health (Galbally et al. 2012).

Source: Galbally et al, 2012

A National Approach: Health in All Policies in Finland

Over the last few decades the standard of health among Finns has improved greatly, and the country's infant mortality rates have settled at among the best in the world. Since the 1970s, life expectancy has increased almost 11 years for men and 9 years for women, functional capacity of the elderly has improved dramatically, while health care expenditure has remained under control at an average level for OECD countries.

Health became a political priority in the 1970s, with the recognition that the health of the population depended less on the provision of health care services and more on social factors. Development of a new health policy began with work carried out by the Economic Council of Finland. Targets were set to improve the health of the population, beginning with prevention of road accidents, work-related diseases and accidents, and smoking-related diseases. Coronary heart disease rates among males of working age in Finland were among the highest in the world. In 1972, after much debate about what action needed to be taken, a project commenced in the hardest hit province of North Karelia, to address the risk factors of heart disease: poor diet, smoking, and high blood pressure. The project aimed to influence people's lifestyles through a series of broad-based local measures. At the same time new legislation supported reform of primary health care, and municipalities took responsibility for health centers and coordination of care, with a focus on preventative work. The establishment of health centers within municipal organizations provided a new framework for intersectoral cooperation for health.

HiAP policy has developed as national policy over the last few decades. National health policies are drafted by the Ministry of Social Affairs and Health (MSAH), which has also been primarily responsible for strategic development of policy. Developments at the local level have been due largely to guidance and direction from MSAH, policy making and development by local authorities has also been important. The private sector and other organizations that are influential in society in promoting health have also played an important role.

In 1985 the Finnish Parliament approved targets and policies for health, even in sectors outside health care. The content was discussed at ministerial level with the result that the government was committed to every aspect of the program, and the scope of the report was broadened and established as a national Health for All Program. Subsequent evaluation of the program found that debate of the report and endorsement of policies formulated from it had facilitated intersectoral activities in those areas where it had been previously difficult. Importantly, the process had involved health sector and other sectoral planners sitting around the same table discussing broad-based health-related aims. The program was praised for its policies; however, weaknesses in implementation were identified. Recommendations made as a result of the evaluation in relation to improvements in infrastructure and research were subsequently incorporated into a revised program. Formal processes for intersectoral cooperation were set up and the National Public Health Committee was established. Research into health inequalities among population groups was developed by universities and research institutes, funded by the Academy of Finland, the government scientific research agency within the Ministry of Education, Science and Culture.

The introduction of legislation in Finland in the 1990s, requiring all administrative sectors to report on their work in the area of health, was important in making visible the responsibility of all sectors for improving public health. A major step was constitutional reform, which placed responsibility for health promotion with public authorities and resulted in the creation of

administrative structures with management systems at both state and local authority levels. As a result, the legal and administrative framework now in place is considered to be adequate, and the report proposes that in future there is a need to focus on the content of work and action. Although the methods needed for a comprehensive health policy have been developed, and the use of health impact assessment (HIA) has improved understanding of health in other administrative sectors, the report recognizes that HIA is not implemented sufficiently and that the resources available for it are meagre.

The WHO evaluations of Finnish health policy concluded that HiAP is an effective way to improve public health and that policy measures in the various sectors can be implemented in most cases with a positive economic and financial impact on society. The report noted, however, that the achievement of practical results using the HiAP approach requires continuous determined work and made recommendations in six areas in relation to the challenges for Finland:

- Health-promotion actors must exploit critical stages in policy development such as negotiating for government health services in a climate of privatization; more effective efforts need to be made to include health on the agendas of municipal boards as well as of the whole of government. The information on society's scope for civic participation can be utilized to ensure transparency of policies and enable assessment of all the effects of different measures and decisions before they are made.
- Pursue international cooperation as it is increasingly important due to economic globalization. Challenges and solutions will be more similar across countries, so continued coworking with WHO will be important, as will be networking within the EU on the drafting of international economic and other agreements.
- Increase the use of HIA by insisting on the use of this process when the EU Commission drafts its decisions.
- Highlight the importance of health as a production factor in the development of economic policy by promoting more effective analysis of health impacts, such as the long-term financial losses sustained as a result of the poor health of low socioeconomic groups.
- Reduce inequality in society through further research as well as increased political will, for example, by using HIA to promote better working conditions for groups with poor socioeconomic status to extend working lives.
- Work with the EU and internationally to address obesity and alcohol, to strike a new balance between economic objectives and health targets, promote understanding between the public and private sector on the value of health as a resource for economic activity and also as an ethical goal for the whole of society.

Source: Melkas 2013.

ANNEX 2: EZ DOCUMENTATION TOOL TEMPLATE

Background and instructions for filling out the HiAP for NCDs EZ-Documentation Template

What is HiAP?

Health in All Policies (HiAP) is a policy practice used by government and nongovernment actors to address factors outside of the health system and in policy sectors other than health that influence the social determinants of health (such as transport, housing, tax, and agricultural policies). These two broad categories of actors aim to include the range of government actors (elected officials and civil servants) and nongovernmental actors (professionals, NGOs, civil society, industry, and other stakeholders) who participate in HiAP. HiAP builds on the health-promotion and public health strategies of healthy public policy and intersectoral collaboration, but it uses a more systemic (whole-of-government) approach to focus on action in the policy arena related to the achievement of health and well-being goals rather than using a single health–issue approach.[1] HiAP may be adopted by policy and decision makers who wish to integrate a consideration of health, well-being, and equity in the development, implementation, and evaluation of policies.[2]

Purpose of documentation

The objective of this template is to provide a tool for documenting HiAP experiences in addressing noncommunicable disease prevention and control in the countries of the WHO Eastern Mediterranean Region. HiAP has been identified as important for the prevention and control of NCDs because many of the determinants of NCDs are outside the direct responsibility of the health sector. As HiAP[3] is a relatively new development, there is limited documentation on its processes and a lack of evidence on outcomes. Policy learning relies on understanding the context and processes of making particular policy choices.

Instructions for the use of this documentation template

Section 1: It is recommended that one person be identified as the contact person for the purpose of documentation to streamline the collection and documentation of information on the policy process. Consultation with other stakeholders and partners is necessary to cover a range of perspectives. This may be done with one-on-one discussion or in small group meetings.

Section 2: This section aims to outline the policy issue and its context for development. The documentation should include the problem to be addressed by the policy, the policy

1. Lin et al. 2012, 23–55.

2. McQueen et al. 2012, 3-21.

3. The term "HiAP" was first introduced in 2006 within the context of the priorities of the Finnish presidency of the European Union.

instruments to be used for implementation (including specific measures), and the monitoring indicators for these. The context is intended to capture the leadership, participation, structure, and evidence that supported the policy's development. Users may wish to refer to their country profile data on NCDs and country capacity at http://www.who.int/nmh/countries/en/index.html.

Section 3: This section is the most substantial. The background section aims to document the policy development and implementation actors, resources, and processes. The policy analysis section proposes questions to help analyze the policy development process and the way implementation was carried out. This section contains detailed questions to encourage reflection on lessons to be learned. This section would benefit from discussion with those closely involved with policy development and implementation to generate a range of reflections for policy learning.

HiAP for NCDs EZ-Documentation Template

Section 1: CONTACT INFORMATION

Please provide complete information for the contact person responsible for coordinating the documentation of this policy.

- Name:
- Position:
- Organization:
- Address:
- City, Country, Postal code:
- Telephone:
- Fax:
- E-mail:
- Relationship to the policy being documented:

Section 2: POLICY SUMMARY

Please provide a brief overview of the policy and its development.

2.1 Policy Overview

Name of policy:_____
When was the policy adopted? Month_____Year_____
What is the NCD condition, risk factor, or associated social determinant of health that the policy addresses?
Policy measure(s) (for example, specific applications of such policy instruments as taxation, legislation, program, subsidy, information/education, incentives):
Target population/location/setting or industry/product/service (for example, food, transportation):
Monitoring indicators used (if any):

2.2 Policy Development Background

- What were the policy's aims or objectives (short term and long term, if available)?
- Who were the intended beneficiaries of the policy?
- Does the policy make any particular considerations for vulnerable groups/populations? Was there an overall objective to reduce inequalities in health?
- What was the information and evidence base (for example, epidemiological, economic, community attitude, stakeholder support) to support the development of the policy?
- Who were the key leaders in advocating for policy development; what organizations/sectors did they come from; and what roles did they play?

Leaders	Organization/sector	Leadership role played

- Which agencies were involved?

Policy phase	Agencies involved
Policy development	
Policy implementation	
Policy oversight & monitoring	
Policy evaluation	

- What funding was available for policy implementation?

Funding purpose	Amount (and conditions, if any)
Overall	
Specific activity / program	
Specific activity / program	

- What policy instruments were used for implementation (for example, legislation and regulation, service delivery, financial subsidies, financial incentives, education, organizational change, joint budgeting)?
- What is the monitoring and evaluation arrangement for the policy? Are there any results to report?

2.3 Policy Governance

- What structure[4] (for example, commission, task force, committee, alliance) was established as the responsible governance body for this policy area (or which existing body was designated)?
- What are its main terms of reference?
- Who participates in that structure (what departments, organizations, policy makers, stakeholders)? Describe their involvement.

4. If more than one governance structure is established for this policy area, repeat the questions in section 2.2 for each.

Participants	Participants' organizational role(s)	How were they involved?

Section 3: POLICY ANALYSIS AND REFLECTION

Please describe the process of policy development and explore reflections on the lessons learned.

3.1 Policy Analysis

Policy and political environment

- Why was the policy needed?
- How did it get started? Describe the political importance of the policy issue. Was there a sense of urgency for action? If yes, why? What were the political drivers for the policy issue?
- How did the policy get on the political agenda?
- How have any aspects of the political, economic, social, and/or cultural environment influenced the policy issue or proposed policy change?
- Was there demonstrable political will for tackling the policy issue? From whom/at which level? How was it manifested? How was it recognized and utilized by HiAP and other key policy proponents?
- Was there substantial debate about the policy? What were the main points of difference or compromises made?
- Was there anything in the international environment that facilitated or hindered the process?

Policy actors

- How actively involved were actors within and outside government in developing the policy?
- What opposition was there, and how was it manifested?
- How well were constituent interests represented or addressed in the policy development? What compromises and negotiations were necessary?
- How were beneficiaries involved in the planning, implementation, or evaluation of the policy?

Policy content, instruments, and activities

- How were the final choices made regarding instruments considered for policy implementation? How were the specific measures to apply these instruments developed, or adapted if they were piloted first?
- How were monitoring arrangements (for example, indicators, reporting) decided?
- What activities were implemented under the policy?
    - What activities worked well? How do you know they worked well?
    - What activities did not work well? How do you know they did not work well?

3.2 Reflection

On objectives and outcomes

- Was the policy able to achieve its objectives (and how is achievement measured)? Why or why not?
- What were the main or proudest achievements/outcomes of the policy?
- What were the unintended or unexpected consequences (either positive or negative) of the policy?
- Was the policy able to address the systematic differences in health outcomes or the differential impacts of the determinants of health across the population?

On policy governance and the policy cycle

Please use the grid below to explore issues for reflection with regard to various phases in the policy cycle.

(1) How effective were the structure and processes for policy development?
(2) How effective were the structure and processes for oversight of policy implementation?
(3) What role did interagency partnership play in policy planning, implementation, and evaluation?
(4) What role did nongovernment actors play in policy planning, implementation, and evaluation?
(5) What were the main challenges and impediments faced in the policy planning, implementation, and evaluation?
(6) What were the facilitating factors that enabled successful development and implementation of the policy?

	Policy development/planning	**Policy implementation**	**Policy oversight & monitoring**	**Policy evaluation**
Effectiveness of governance structures & processes				
Role of interagency partnership				
Role of nongovernment actors				
Challenges & impediments (factors that hindered)				
Facilitating factors				

On policy learning

- What are the lessons learned from this project that can be shared with others?
- What changes would you suggest to policy makers as a result of policy implementation so far?

If you were to start again on developing this policy, what would you change?

ANNEX 3: HEALTH IN ALL POLICIES FOR NCD PREVENTION AND CONTROL-COUNTRY ASSESSMENT TOOL

BACKGROUND

This assessment tool is part of the joint effort of the World Bank and the WHO Regional Office for the Eastern Mediterranean (EMRO) to promote the Health in All Policies (HiAP) approach in prevention and control of non-communicable diseases (NCDs). While a relatively new term for integrated action on factors outside the health sector affecting health outcomes, HiAP is a policy practice that builds on earlier constructs of intersectoral or multisectoral action and healthy public policy, and uses a more systematic (or whole-of-government) approach, rather than policy action on single policy sectoral issues.

This assessment exercise seeks to collect information from the countries of MENA/EMR related to policy initiatives and intersectoral mechanisms, including partnerships with civil society and the private sector, that address the key risk factors and the social determinants of NCD prevalence. Most of the multisectoral collaboration between MOH and non-health sectors will be at national and subnational levels, depending on the degree of decentralization within a country.

EXPECTED OUTCOMES

The result of this assessment will help identify progress and gaps, so that actions to enhance national capacities or to advocate for policy actions can be identified. The result should also serve as a basis for cross-country learning.

TARGET RESPONDENTS

The MOH focal point responsible for NCDs is the recommended coordinator for responding to this assessment. It is expected that the focal point will need to complete the assessment with input from relevant people from other sectors as well as from various areas within the MOH. Depending on the policy coordination mechanism within a country, it may be appropriate for this assessment to be completed by the NCD Commission, or by the secretariat of a whole-of-government structure that supports the HiAP approach.

STRUCTURE OF ASSESSMENT

HiAP is a relatively new policy approach and practice, although it is closely related to earlier concepts such as healthy public policy or intersectoral/multisectoral action. As such, this tool will be focused on assessing progress, identifying facilitating factors and challenges, and adopting this approach for NCD prevention and control. The questions are organized around the following key elements:

1. Experience of governance structures and actions for HiAP

2. Extent of implementation of WHO's recommended Best Buys for NCD interventions and other relevant policy actions on related social determinants of NCDs
3. Capacities and resources for HiAP
4. Reflections

METHODOLOGY

The information will be collected through three types of questions:

1. Structured closed-ended questions (yes, no, I don't know/unsure)
2. Open-ended questions (needing description/ evidences)
3. Rank-order scaling questions from 1 to 6 as follows:

Status of policy decision implementation	**Scale**	**Criteria**
Fully implemented	6	At least 5 of the 6 indicators below are met: ***a)*** Policy/program fully funded and implemented for targeted issues or in targeted communities ***b)*** Legislation/regulation is adopted and enforced ***c)*** Voluntary agreement, such as a memorandum of understanding (MOU), is implemented ***d)*** Implementation support unit in place and provides technical guidance for implementation and monitoring ***e)*** Sustainability mechanism is considered or already approved and disseminated by high-level authorities and incorporated in national health and other development policies ***f)*** At least one report has already been issued
Partially implemented	5	Implementation arrangements for policy decision are in place; stakeholders are aware; funding allocated; monitoring mechanism developed.
Actioned	4	A policy decision has been publicly announced, involving two or more sectors, with specific policy instruments adopted, for example, financing, legislation, program delivery, targets.
Under development	3	Action for policy development has commenced — for example, national or subnational policy/project team has been formed, relevant research and data analysis is being undertaken, consultation is being developed, intersectoral governance mechanism is in place.
Being considered	2	There is a verbal or written commitment from high-level policy makers to initiate action, but no action has been undertaken for policy

		development.
Not currently actioned	1	The policy has either not been considered or has been rejected.

The assessment can be administered in two ways:

1. The focal point canvasses the questions and compiles the responses with all relevant individuals and/or agencies in a country;
2. The MOH conducts a one-day workshop with relevant individuals/agencies to collectively generate the responses.

The latter approach may be helpful in supporting a multisectoral conversation about HiAP and NCDs, thereby helping to identify areas for potential action or priority attention. It may also be more efficient than pursuing individual responses.

INFORMATION ABOUT THE ASSESSMENT RESPONDENT(S)

Please provide complete information for the **focal point** for the completion of this assessment.

Name:
Position:
Organization:

Address:
City, Country, Postal code:
Telephone:
Fax:
E-mail:

Please provide information on the **other respondents who participated** in/contributed to the assessment. Where individuals are reluctant to be identified, please indicate the organization they represent.

Organization	Name	Position	E-mail

SECTION 1: EXPERIENCE OF GOVERNANCE STRUCTURES AND ACTIONS FOR HIAP

1.1 Availability of Experiences on HiAP

Q1-1 Is there an explicit government commitment to joined-up government (or whole-of-government approach or multisectoral action)?

Yes **No** **I don't know** **Unsure**

Q1-2 To what extent is the government moving toward joined-up government (or whole-of-government approach or multisectoral action)?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

Q1-3 Is there a formal, agreed government process that is implemented, whereby the Ministry of Health (MOH) gives input to policy making in other ministries?

Yes **No** **I don't know** **Unsure**

If yes or unsure, please specify:

……

Q1-4 Is there a designated mechanism to ensure that health priorities are integrated in existing national/subnational plans and policy documents of other nonhealth sectors?

Yes **No** **I don't know** **Unsure**

If yes or unsure, please specify:

……

Q1-5 is there formal collaboration between health and nonhealth entities for joint activities that improve health outcomes?

Entities	National or subnational government				Civil society				Private sector (business)			
	Yes	No	Don't know	Unsure	Yes	No	Don't know	Unsure	Yes	No	Don't know	Unsure
National or subnational government												
Civil society												
Private sector (business)												
Government-civil society-private sector (joint all three)	Yes			No			Don't know			Unsure		

If yes, please indicate what policy or program areas have formal collaboration or joint activities:

_____

_____

Q1-6 Please characterize the main forms of engagement that MOH adopts with each of the following groups:

	Communication (information provision)	Consultation (obtain feedback)	Cooperation (shared resources)	Coordination (aligned work)	Collaboration (joint work)
Community at large					
Beneficiaries					
Service providers					
Government agencies					

1.2 National or Subnational Mechanisms for HIAP

Q1-7 Is there a structure for intersectoral policy governance for health, either in general or for specific health issues? If yes, please specify name of mechanism. Please answer all items.

	Yes — specify name of mechanism	No	I don't know	Unsure
Parliament (inquiry, committee)				
Government (cabinet committee, coordinating minister)				
Ministry (interdepartmental committee, joint task force)				
Statutory agency (delegated financing, service delivery, regulation)				
Civil society (consultative forum, funded project)				
Public-private partnership (joint venture, consultation)				

If no structures exist, please go to **Q2.1**

Q1-8 For each of the governance structures named above, please specify what governance actions it is concerned with. Please answer all that apply.

Name of mechanism	**Agenda-setting and preference formation**		**Policy development and bargaining**		**Policy design an tool development**	**Implementation and oversight**	
	Evidence support	Advocacy	Set goals and targets	Develop plans and guidance	Specify tools: legislation, financing, programs, information	Delivery or enforcement	M&E
Parliament							
Government							
Ministry							
Statutory agency							
Civil society							
Public-private partners HIP							

Q1-9 For each of the structures named above, how well is the structure supported in relation to the following building blocks? (In case there are more than two structures, please enlarge matrix).

Structure:_____

Building block	**No support**	**Weak support**	**Moderate support**	**Good support**	**Very strong support**	**Don't know**
Leadership						
Political commitment / government mandate						
Human resources						
Financial resources						
Information and research						
Policy analysis						

tools						
Partnership management						
Stakeholder engagement						

Structure:_____

Building block	**No support**	**Weak support**	**Moderate support**	**Good support**	**Very strong support**	**Don't know**
Leadership						
Political commitment / government mandate						
Human resources						
Financial resources						
Information and research						
Policy analysis tools						
Partnership management						
Stakeholder engagement						

Q1-10 How effective are these structures in performing the different phases of the policy process?

Phase of policy process	**Ineffective**	**Somewhat ineffective**	**Somewhat effective**	**Quite effective**	**Very effective**	**Don't know**
Agenda setting						
Policy development						
Policy tool selection						
Policy implementation oversight						
Policy evaluation						

Q1-11 What role has the Ministry of Health (MOH) played in these structures? Tick a maximum of the five that apply. Please indicate the structure if there is more than one. Please enlarge matrix in case there are more than two structures.

Structure:_____

_____Provide health and population data
_____Provide research and analysis of health impact
_____Advocate for policy attention
_____Propose policy strategies
_____Draft policy documents
_____Negotiate budgets
_____Provide technical guidance on policy implementation
_____Develop performance-monitoring indicators
_____Provide monitoring and evaluation data
_____Provide capacity building for other sectors
_____Other. Please specify:_____

Structure:_____

_____Provide health and population data
_____Provide research and analysis of health impact
_____Advocate for policy attention
_____Propose policy strategies
_____Draft policy documents
_____Negotiate budgets
_____Provide technical guidance on policy implementation
_____Develop performance-monitoring indicators
_____Provide monitoring and evaluation data
_____Provide capacity building for other sectors
_____Other. Please specify_____

1.3 Accountability Frameworks

Q1-12 (a) If relevant, what are the key performance expectations and outputs from the HiAP mechanism?

_____
_____
_____
_____

Q1-12 (b) Is there a system in place for tracking or reporting on them? If yes, please specify.

_____
_____
_____

Q1-13 Are there any mechanisms to document, track, and/or report the progress and/or achievements of national and subnational plans/activities that are jointly developed or carried out by two or more sectors?

Yes **No** **I don't know**

If yes, please specify:

_____
_____
_____
_____

Q1-14 Is there any requirement to report on achievements of joint activities to higher authorities such as an annual reporting to the Parliament, Council of Ministers, or others?

Yes **No** **I don't know**

If yes, please specify:

_____
_____
_____
_____

Q1-15 Is there a process for ministries to come together, and with nongovernment partners, to review progress, reflect on lessons learned, and revise policy strategies?

Yes **No** **I don't know**

If yes, please specify:

_____
_____
_____
_____

SECTION 2: EXTENT OF IMPLEMENTATION OF WHO'S BEST BUYS FOR NCD INTERVENTIONS AND POLICY ACTION ON SOCIAL DETERMINANTS OF NCDS

2.1 Best Buy NCD Interventions

Risk Factor: Tobacco use

Has your country increased taxes on tobacco?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**
Date					

Have smoke-free indoor worksites been introduced (that is, legislated and enforced)?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

Have smoke-free public places been introduced (that is, legislated and enforced)?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

Are health information and warnings available on the packet (of tobacco products)?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**
Type of warning					

Are bans on tobacco advertising, promotion, and sponsorship in place?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

Risk Factor: Harmful alcohol use

Has your country increased taxes on alcohol?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**
Date					

Has access to retailed alcohol been restricted?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**
Type of restriction					

Are bans on alcohol advertising in place?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**
Type of ban					

Risk Factor: Unhealthy diet and physical inactivity

Have policy measures been adopted to reduce salt content of manufactured and prepared foods?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

Have policy measures been adopted to require replacement of trans fat with polyunsaturated fat?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

Have comprehensive communication measures been undertaken, in a variety of settings and through the mass media, to raise awareness on diet and physical activity?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**
Key issues addressed					

To what extent do the communication interventions target disadvantaged localities or vulnerable population groups?

1	2	3	4	5	6
Unsure	**Not at all**	**Being considered**	**Under development**	**Some targeting**	**Well targeted**

Disease Management: Cardiovascular disease and diabetes

Has government reduced financial barriers to multidrug therapy (for example, through subsidies) for people with a high risk of developing heart attacks and strokes?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

To what extent do the affordability interventions target vulnerable population groups?

1	2	3	4	5	6
Unsure	**Not at all**	**Being considered**	**Under development**	**Some targeting**	**Well targeted**

Disease Prevention: Cancer

Have financial and service-delivery provisions, including outreach to disadvantaged target communities, been made for scaling-up of hepatitis B immunization to prevent liver cancer?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

Have financial and service-delivery provisions, including outreach to disadvantaged target communities, been made for screening and treatment of precancerous lesions to prevent cervical cancer?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

2.2 Policy Actions on Other Relevant Social Determinants of Health

Have urban development polices (such as housing density, public transportation, green space) been adopted to encourage active transport and walkable cities?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

If relevant, to what extent do these urban development policies that promote good health and safe environments target disadvantaged localities?

1	2	3	4	5	6
Unsure	**Not at all**	**Under consideration**	**Being developed**	**Partially implemented**	**Fully implemented**

Do these policies that offer incentives for healthy lifestyle programs exist at the worksite?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**
Type of incentive					

If relevant, to what extent do the worksite incentive policies target vulnerable population groups?

1	2	3	4	5	6
Unsure	**Not at all**	**Under consideration**	**Being developed**	**Limited targeting**	**Well targeted**

Has availability of safe environments for walking and recreational activities increased in your major cities?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

If relevant, to what extent do the safer environment policies target disadvantaged localities?

1	2	3	4	5	6
Unsure	**Not at all**	**Under consideration**	**Being developed**	**Partially implemented**	**Fully implemented**

Are there economic incentives in place to increase use of public transportation and other incidental physical activity?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**
Type of incentive					

If relevant, to what extent do the incentives for physical activity target disadvantaged localities or vulnerable population groups?

1	2	3	4	5	6
Unsure	**Not at all**	**Under consideration**	**Being developed**	**Some targeting**	**Well targeted**

Are there population-based early childhood development programs?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

Have health-promoting schools been instituted as a matter of policy?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

Are there controls on advertising of unhealthy food aimed at children?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

Are there incentives in place to increase availability and affordability of fruits and vegetables?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**
Type of incentives					

If relevant, to what extent do the policies to increase healthy food affordability target disadvantaged communities or vulnerable population groups?

1	2	3	4	5	6
Unsure	**Not at all**	**Under consideration**	**Being developed**	**Some targeting**	**Well targeted**

Are there economic interventions in place to promote availability and access of healthy foods?

1	2	3	4	5	6
No action	**Being considered**	**Under development**	**Actioned**	**Partially implemented**	**Fully implemented**

If relevant, to what extent do the healthy food–promotion policies target disadvantaged localities or vulnerable population groups?

1	2	3	4	5	6
Unsure	**Not at all**	**Under consideration**	**Being developed**	**Partially implemented**	**Fully implemented**

2.3 National or Subnational Mechanisms for NCDs

Q2-1 Is there any high-level body such as a council/commission/committee bringing representatives from different sectors to work together on NCDs?

Yes **No** **I don't know** **Unsure**

If the answer is **YES**, please specify the nonhealth sectors, nongovernmental, and private sector organizations represented in each, and answer the subsequent question. If the answer is **NO,** please move to section 3.

Name of the high-level body (1):	
Nonhealth sectors included:	**Nongovernmental & private sector organizations included:**
Name of the high-level body (2):	
Nonhealth sectors included:	**Nongovernmental & private sector organizations included:**
Name of the high- level body (3):	
Nonhealth sectors included:	**Nongovernmental & private sector organizations included:**

Q2-2 Has the high-level body (bodies) developed and priorities/decisions shared with stakeholders?

	Yes	**No**	**I don't know**
Clear terms of reference			
A process for identifying shared priorities			
Transparency in decision-making, including resolution of disagreements			
A process for engaging multiple stakeholders within and outside government			
Available multisectoral policy and action plan			
A budget or funding mechanism for joint programs and activities			
A budget or funding mechanism for relevant programs for each ministry			

Monitoring and evaluation mechanism/ tools			
Regular communication and reporting tools/ mechanism with the general public (e.g., TV, journals, radio, special communiqué)?			

2.4 Accountability Frameworks

Q2-3 If relevant, what are the key performance expectations and outputs from the NCD Commission?_____
_____
_____

Q2-4 Are there any mechanisms to document, track, and/or report the progress and/or achievements of joint NCD plans/activities at the national and subnational levels?

Yes **No** **I don't know**

If yes, please specify:
_____
_____
_____

Q2-5 Is there any requirement to report on achievements of joint activities to higher authorities, such as an annual NCD reporting to the Parliament, Council of Ministers, or others?

Yes **No** **I don't know**

If yes, please specify:

_____
_____
_____

Q2-6 Is there a process for ministries to come together, and with nongovernment partners, to review progress, reflect on lessons learned, and revise policy strategies?

Yes **No** **I don't know**

If yes, please specify:

_____
_____
_____

SECTION 3: ORGANIZATIONAL CAPACITY AND RESOURCES FOR HIAP

Q3-1 To what extent does the government expect the MOH to collaborate with other sectors as part of the routine work in policy development and implementation?

Too much **As needed** **Not enough** **Not all** **Unsure**

Q3-2 How effective is the MOH in performing the following health sector roles in support of HiAP? Tick whichever applies for each role.

Role	Unable to do	Seldom done	Periodically done	Often done	Consistently done	Don't know
Provide health and population data						
Provide research and analysis of health impact of other sectors' policies						
Advocate for policy attention						
Propose evidence-informed policy strategies						
Draft policy documents						
Negotiate budgets						
Provide technical						

guidance on policy implementation						
Develop performance-monitoring indicators						
Provide monitoring and evaluation data						
Capacity building for other sectors						

Q3-3 How effectively does the MOH provide the following policy functions? Tick whichever applies for each competency

Competency	**Ineffective**	**Somewhat ineffective**	**Somewhat effective**	**Quite effective**	**Very effective**	**Don't know**
Using information and evidence						
Managing stakeholder relations						
Managing intraportfolio, cross-portfolio, and intergovernmental relations						
Policy implementation						
Policy evaluation and monitoring						
Managing the policy process						

Q3-4 Is there a need to enhance the organizational systems of the MOH to work with other sectors?

Yes **No** **I don't know** **Unsure**

If yes, what are the organizational systems and competencies that require further development?

_____

_____

_____

SECTION 4: REFLECTIONS ON EXISTING AND EFFECTIVE EXPERIENCES RELATED TO HIAP

Q4-1 In your opinion, what were the factors/circumstances that initiated/supported HiAP? (Please circle one or more answers and provide an example):

(1) Importance of burden of disease

(2) Community advocacy

(3) Interest in joined-up government and multisectoral collaboration

(4) Decision by the highest authority at the national or subnational level, for example, presidential decree

(5) Clear mutual benefit for various ministries

(6) Commitment to a global agenda, such as the MDGs, social determinants of health (SDH)

(7) Request from a funding agency

(8) Request from other sectors

(9) Resources available

(10) Others, please specify below

……

……

Q4-2 What are the main challenges when working with sectors or with civil society outside health? How did you handle those challenges? Please describe briefly:

……

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……..……
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……..……
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……..……
……..……

Q4-3 What kind of mechanisms can be set-up to improve collaboration between MOH and other sectors and civil society in your country? Please describe briefly:

……
……..……
……
……..……
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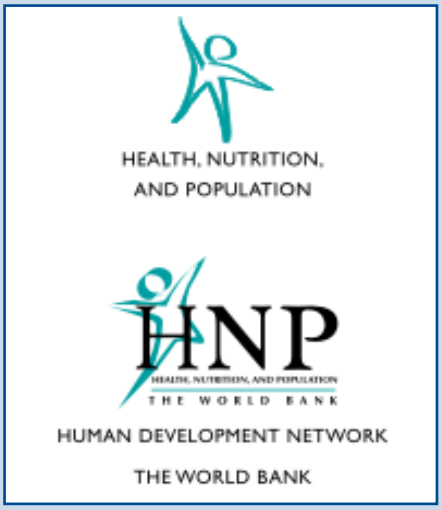
……..……
……

Thank you very much for participating in this assessment.



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THE WORLD BANK

1818 H Street, NW
Washington, DC USA 20433
Telephone: 202 473 1000
Facsimile: 202 477 6391
Internet: www.worldbank.org
E-mail: feedback@worldbank.org