MOVING TOWARDS HEALTH IN ALL POLICIES: A COMPILATION OF EXPERIENCES FROM AFRICA, SOUTH-EAST ASIA AND THE WESTERN PACIFIC
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This specific component of the project reviews regional practices on intersectoral/multisectoral action and HiAP to support assessments of the opportunities for and learning from practice on how to implement HiAP. This report was developed using the Analytical Framework for HiAP and was based on the case studies prepared by the following consultants: Suniti Acharya (nutrition in Nepal); Mary Amuzu-Nyamongo (nutrition in Kenya); Karen J. Hofman (tobacco control and salt use in South Africa); J. Gasherebuka, J. Humuza, J. Mukunzi, L. Rugema and J. Shema (health financing in Rwanda); Doris Kirigia (fishing in Kenya); Rene Loewenson (microfinance in Ghana; mental health in Kenya; health services provision (HSP) in South Africa); Anushree Mishra (intersectoral action in implementing the WHO Framework Convention for Tobacco Control in India); Shilpa Pandav (intersectoral action in Timor Leste); Dorji Penjore (happiness in Bhutan); Tipicha Posayanonda, Orapan Srisookwatana and Nattaya Thaennin (HiAP, Thailand); Sonam Rinchen (tobacco control in Bhutan); Sarah Simpson, Deborah Wildgoose and Carmel Williams (mobility of Aboriginal people in South Australia); Sarah Simpson (noncommunicable diseases in Palau and helmet law in Viet Nam); Anuradhani Kasturiratne and A. Wickremasinghe (the Alawwa Project and local innovation in Colombo, Sri Lanka).

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Rosana Martinelli (consultant) wrote the report, with key contributions from Nicole Valentine – specifically on the introductory sections, and from the other WHO project team members, including the WHO interns. The useful comments received from the external reviewers, William Muhwava and Sarah Simpson are gratefully acknowledged. This document was modelled on the Pan American Health Organization report, *Health in All Policies: summary of the experiences of the Americas* (PAHO, 2013), and the project team would, therefore, like to thank Sophia Leticia Morales and Ana Lucia Ruggiero, in particular, and Eugenio Villar (Coordinator, Social Determinants of Health), for their suggestions and insights in this regard.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CBHI</td>
<td>Community Based Health Insurance initiative (Rwanda)</td>
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<td>ESP</td>
<td>Economic Stimulus Programme (Kenya)</td>
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<tr>
<td>FTCT</td>
<td>WHO Framework Convention on Tobacco Control</td>
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<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>GNH</td>
<td>Gross National Happiness (Bhutan)</td>
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<tr>
<td>GNHC</td>
<td>Gross National Happiness Commission (Bhutan)</td>
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<td>HiAP</td>
<td>Health in All Policies</td>
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<tr>
<td>HIV/AIDS/STI</td>
<td>Human immunodeficiency virus/acquired immunodeficiency syndrome/sexually transmitted infection</td>
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<tr>
<td>HLA</td>
<td>Health Lens Analysis (South Australia)</td>
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<td>HPS</td>
<td>Health Promoting Schools (South Africa)</td>
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<tr>
<td>MCUDP</td>
<td>Metro Colombo Urban Development Project (Sri Lanka)</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MFI</td>
<td>Microfinance institution (Ghana)</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MoDUD</td>
<td>Ministry of Defence and Urban Development (Sri Lanka)</td>
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<tr>
<td>MSNP</td>
<td>Multisectoral Nutrition Program (Nepal)</td>
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<tr>
<td>NCD</td>
<td>Noncommunicable disease</td>
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<tr>
<td>NDoH</td>
<td>National Department of Health (South Africa)</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<tr>
<td>NHA</td>
<td>National Health Assembly (Thailand)</td>
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<tr>
<td>NHC</td>
<td>National Health Commission (Thailand)</td>
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<tr>
<td>NICK</td>
<td>Nutritional Improvement for Children in Urban Chile and Kenya (Kenya)</td>
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<tr>
<td>NPC</td>
<td>National Planning Commission (Nepal)</td>
</tr>
<tr>
<td>NTCC</td>
<td>National Tobacco Control Cell (India)</td>
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<tr>
<td>PHC</td>
<td>Primary health care</td>
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<tr>
<td>PIHOA</td>
<td>Pacific Islands health Officers Association</td>
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<tr>
<td>SASP</td>
<td>South Australia Strategic Plan</td>
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<tr>
<td>SPMC</td>
<td>Stimulus Project Management Committee (Kenya)</td>
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<tr>
<td>UNWG</td>
<td>Urban Nutrition Working Group (Kenya)</td>
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<td>WHO</td>
<td>World Health Organization</td>
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ANALYSING INTERSECTORAL EXPERIENCES: APPLICATION OF A HEALTH IN ALL POLICIES ANALYTIC FRAMEWORK

BACKGROUND TO THE ANALYTIC FRAMEWORK AND GATHERING COUNTRY EXPERIENCES

Health issues have diffused boundaries and health determinants have deep societal roots, which are largely outside the direct influence of the health sector. This leads to the obvious conclusion that health problems can hardly be solved by the exclusive actions of the health sector, or by any other sector alone, and that they require intersectoral action. The “Health in All Policies” (HiAP) approach refers to the practice of intersectoral actions as they touch health through the determinants, with a particular focus on the full policy-making cycle.

Many countries have been practising intersectoral work for years, in particular since its notable mention in the famous Alma Ata Declaration in 1978, which focused on the effective functioning of health services and systems, and in the Healthy Public Policies pronouncements from the 1st Global Conference on Health Promotion in Ottawa in 1986, while focusing on the health promotion role of the health sector. Yet, while this is the case, when identifying and comparing examples and experiences of intersectoral work (whether at service or policy process levels) across countries, there is a notable lack of common concepts and understanding of the different aspects involved in addressing health or its determinants.

Therefore, in recent years, WHO has built on the previous work it produced on intersectoral process guidance with expert groups in the 1980s and 1990s and for the Commission on Social Determinants of Health between 2005 and 2008, through further experts meetings and papers, including the 7th Global Conference on Health Promotion (Nairobi) and the Adelaide International Meeting on Health in All Policies.

Specifically, between 2012 and 2013, a more intensive effort was made to update literature reviews, expert papers, case studies, meetings and debates that was driven forward as part of the preparations for the 8th Global Conference on Health in All Policies (Helsinki) in June 2013, where the focus was to galvanize greater international support for and knowledge on HiAP implementation.

As part of this body of work, WHO supported the documentation of case studies of country experiences on intersectoral action for health in order to provide different insights into the best way to move forward in implementing HiAP. WHO also supported the testing of an analytic
framework that was designed to summarize cases in a way that facilitates learning. Learning between countries and experiences are indispensable in guiding and supporting country implementation.

Using the analytic framework to describe each case, this report provides a compilation of 19 of the country experiences across three WHO regions of Africa, South-East Asia and the Western Pacific, which were produced for the Helsinki meeting.

THE ANALYTIC FRAMEWORK

The analytic framework has four main components that have been used to summarize the 19 country experiences. Each of the four components is described below. They are based on a descriptive analysis of what can be generally termed “the intersectoral action” literature, and specific referencing on the source of the various ideas from the literature can be found in other publications, starting with Demonstrating a Health in All Policies analytic framework for learning from experiences: based on reviews from Africa, South-East Asia and the Western Pacific (WHO, 2013).

A. OPPORTUNITIES FOR INITIATION

This component refers to the socioeconomic and historical context, and the potential it provides to develop HiAP actions. It emphasizes two key domains. First, the policy change window (national or local context) wherein domestic political will and leadership is critical, as well as the context of the organizational structure of government facilitating intersectoral dialogue and structural potential for intersectoral actions. Secondly, it refers to the role that is played by international influences, which are important as they include the spread of policy ideas from one political setting to another.

B. KEY DRIVERS OF IMPLEMENTATION

Analysing this component helps to identify the capacity and limitations to implementing HiAP and how the vision of health and society frames and shapes the relationships within or between governmental and nongovernmental partners. A vision of health can be described by two ends of a continuum: whether it is centred in the absence of disease (focusing on curative health-care actions); or centred beyond the absence of disease (requiring actions from other sectors and social policies). Related to this vision, is the role that society plays in health – whether health is viewed as a human right or individual choice. Another aspect of this component is to understand how the policy priority is framed as this can change the approach when implementing the intervention. A policy priority focusing on determinants is one type of entry point. On the one hand, the policy priority for health may be less at the centre of the policy, although the impacts on health and health equity may still be large. On the other hand, the policy priority may be a health issue, in which case HiAP starts from the health sector, which then needs to find ways of engaging with policy processes in other sectors.

The relationships within or between governmental and nongovernmental partners are also important. A range of relationships between the different public sector actors can be typified in the way information and budgets are used, and how much autonomy there is in decision-making. Public sector actors who engage in information sharing typically have less investment in sharing the viewpoint of the problem and the solution. Relationships that centre on cooperation imply less sectoral autonomy, while a relationship typified by “coordination” involves loss of sectoral autonomy, and, in addition, budget sharing. Finally, the integration of strategies, policies and programmes within a common concept of the problem and theory of change may result in greater autonomy again in the context of redefined roles. Government relationships across the levels of administration involved are also important contextual features that may explain the type of relationships that emerge between different government agencies.

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1 The framework is based on earlier work presented by Solar, Valentine, Rice and Albrecht (2009) for the 7th Global Conference on Health Promotion and summarized in the report of the Meeting of the WHO Policy Maker Resource Group on Social Determinants of Health, Intersectoral Action to Tackle the Social Determinants of Health and the Role of Evaluation (WHO/ETH/10.1 2010). Additions and modifications were made to the framework (i.e. pieces were added, removed and re-organized) by Orielle Solar, Ketan Shankardass and Patricia O’Campo during the realist informed scoping review of the literature to the Ontario Ministry of Health and long term care with Centre for Research on Inner City Health, Toronto, Ontario (Shankardass et al. (2012) A scoping review of intersectoral action for health equity involving governments. International Journal of Public Health 57(1): 25-33).
At the same time, the vision of health can facilitate or limit the arrangements of civil society or public participation. Relationships between civil society and government can range from being solely informative to being truly empowering where decision-making is concerned. This aspect of relationships between governmental and nongovernmental partners is referred to as social participation in the analytic framework and, currently, the framework focuses on characterizing the relationship of the public sector with civil society rather than with the for-profit private sector.

C. KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS

Key domains of an equity lens in policies and interventions are highly relevant in any analysis given that this analytic framework focuses on understanding HiAP’s role in addressing health inequities, and not merely in improving the average level of health. When analysing whether the intersectoral action that has been developed will have or has had an impact on reducing inequities, it is important to be clear on the entry point within the framework of the social determinants of health equity. This framework assumes a hierarchy in social determinants (from differential access and exposure to structural factors affecting social position that importantly affects health), then it is important to assess whether intermediate or structural social determinants of health are the focus of the HiAP actions. The focus of the intervention may be on: reducing health-care impacts or the numbers seeking care, which would otherwise result in greater inequities in social position; reducing particular groups’ risks or exposures or behaviours; or reforming governance and social policy pertaining to changing mechanisms for redistributing power, resources and opportunities.

The second important issue for health equity is the universality of the approach. Policies tend to follow a spectrum of universal to targeted approaches. This relates to the coverage of the programme or policy, namely, its so-called universalism, defined as, “…the entire population is the beneficiary of social benefits as a basic right.” Universal policies that target equity gaps are also considered part of an approach to reduce inequalities.

Thirdly, explicitly stated goals to address equity or not can be observed, as well as whether the goal is equity as a gap or gradient. Some case studies have identified actions geared at addressing equity gaps or gradients, although interpretation of these concepts may have been generous with regards to the intent of the policies analysed. A final issue of relevance is the role of the health sector in the policy process. At what point does health play leadership (knowledge of effective measures and some means of control), negotiator (knowledge of effective measures, but no means of control), or partner roles (knowledge of impacts only, no knowledge of effective measures, no means of control)?

D. KEY DRIVERS OF SUSTAINABILITY

The final component describes how to analyse key drivers for sustaining intersectoral action in the context of HiAP approaches. This includes: formal mechanisms to influence relationships between different sectors and to finance implementation; decision support tools for assessing impacts and evaluating the progress of specific intersectoral work; and capacity building to support the knowledge and skills of stakeholders to build HiAP.

SUMMARY

These components of the analytic framework for HiAP come together to create an overview of key characteristics of intersectoral work that lend themselves to the HiAP ideal, based on the emerging concept of what it is and means in practice, with particular emphasis on addressing health inequities. In summary, the intersectoral experiences that are closer to these characteristics are where:

› there is high political will for intersectoral work;
› there is positive international support for intersectoral work;
› the vision of health used by the health sector, and across government, is closer to social indicators of health and well-being rather than the absence of disease;
› relationships between government partners (formal and informal) are based on at least cooperation (requiring some reduction in sectoral autonomy), and not solely information sharing;
different levels of the government administration are aligned;

social participation is present in a way that influences decision-making;

policy changes/interventions focus on addressing inequities in social position related to health;

coverage approaches combine universalism and targeting;

goals for addressing equity or another expression of social justice are made explicit;

equity goals go beyond solely targeting vulnerable groups;

mandates and pooled or integrated budgets are given to structures or organizations;

a solid evidence base linking social determinants of health and health equity is available;

impact assessments are used;

personnel have the appropriate public health training and negotiating skills, and good knowledge of the public policy-making system.
The discussion of HIAP in Helsinki centred on contextualizing implementation in a series of cross-cutting themes:

› global policy-making
› political will and processes
› health promotion and health equity (and primary health care)
› economics
› social change
› capacity building.

There are several cross-cutting linkages between the conference themes and the analytic framework. Each description of an experience tries to draw out these linkages, in addition to describing the case in terms of the components of the analytic framework but it is worthwhile identifying several of the more obvious linkages. Foremost, all of the above-mentioned components of the framework are designed with a health equity lens that considers how different dimensions are likely to impact on health equity. The global context and how this links to political will and organizational mandates are key elements in seizing windows of opportunity and sustaining action. The power of economic systems and incentives as a motivation for action, and therefore an important evaluation result, as well as an important area for addressing social inequities in health, is also recognized in the sections of the framework dealing with social determinants that are addressed by policies in other sectors. Social change is important to consider as the vision of health is not constant, but shifting and influenced by science, politics, business interests and popular opinion. Capacity building is a clear issue underpinning all areas of public health. Clearly, assessments by the authors of the cases, and assessments more generally during regional meetings and literature reviews, continue to highlight that this area requires strengthening.
STRUCTURE OF THE COMPILATION

In the chapters that follow, the cases, or experiences, are ordered by region and then in alphabetical order by country name. In addition to analysing the cases using the HiAP analytic framework, the following chapters also describe the relevance of the Helsinki Conference themes to each of the cases. For ease of reference, preceding each regional compilation there is also a table that classifies whether the themes from the 8th Global Conference on Health Promotion are addressed in the particular case or experience. In addition, the summaries have been designed to illuminate barriers experienced by health services in addressing the social determinants of health, which is so important in advancing Universal Health Coverage.

1 As with the Pan American Health Organization publication on which this report is modelled, references are not provided but can be found in other project documentation and in particular in the in-depth case studies, several of which WHO also aims to publish in the long form.
EXPERIENCES OF INTERSECTORAL ACTION BY WHO REGION: AFRICA
# CASE STUDIES

## THEMES ADDRESSED BY THE 8TH GLOBAL CONFERENCE ON HEALTH PROMOTION (HELSINKI)

<table>
<thead>
<tr>
<th>In-depth case study topic</th>
<th>Global policy making</th>
<th>Political will and processes</th>
<th>Health promotion, health equity (and PHC)</th>
<th>Economics</th>
<th>Social change</th>
<th>Capacity building</th>
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<tr>
<td>Microfinance as a vehicle for promoting health and intersectoral action on health: a case from Ghana*</td>
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<td>Learning from holistic thinking in mental health programmes in Kenya*</td>
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<td>Addressing determinants of health through intersectoral collaboration: fish farming project in South Imenti constituency in Meru County, Kenya</td>
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<td>Improving health through intersectoral actions: lessons from health financing in Rwanda</td>
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<td>The healthy schools programme in South Africa*</td>
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<td>Successful sodium regulation in South Africa</td>
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<td>Successful tobacco legislation in South Africa</td>
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*Not determined.

a Funded by WHO Regional Office for Africa and WHO Ethics and Social Determinants of Health Department through Rockefeller Foundation Grant for Supporting Regional Positions on Health in All Policies.
This example showcases how health issues can be included in two microfinance programmes in Ghana: the Freedom from Hunger MFI (initiated in 2006) and Grameen Ghana Microfinance Institutions (MFI) (initiated in 2003). Support for participants’ health is enhanced through the improvement of low-income women’s social and economic situations, health literacy and service uptake. This is achieved by integrating inputs from finance, health, agriculture and other economic sectors, showcasing an example of embedding health in a wider economic policy and economic activity. Both schemes integrate health education and identification by women of actions to improve their health and that of their households and communities, or to strengthen service access. Grameen Ghana has added Mobile Technology for Community Health (MOTECH), as a way of tracking the delivery of services and providing information to beneficiaries.

This case is an example of intersectoral information exchange, where the health sector is a partner in this microfinance initiative, providing information, training and education to poor rural women. This example fulfils some of the criteria established through the analytic HiAP framework, as shown below.

**OPPORTUNITIES FOR INITIATION**

- **Policy change window.** The political will for HiAP is high and evidenced by Ghana’s commitment to the universal coverage of key social services and the solid legal framework that establishes and regulates the role of MFIs. They also have presidential support, as some microcredit and small loans schemes are directly inaugurated by the Head of State.
- **International influences.** Even though there is no international mandate for this endeavour, the MFI model is a globally expanded practice, where over 3500 microfinance institutions (MFIs) provide microcredit and financial services to more than 155 million households. Both schemes in Ghana were initiated by international nongovernmental organizations (NGOs) working with national partners.

**KEY DRIVERS OF IMPLEMENTATION**

- **Vision of health.** The absence of disease is at the centre of these cases and, hence, the focus is predominantly on promoting access to curative health care and technologies. There is also a belief that change in individual circumstances can improve a community’s health and well-being by bridging the gap between women and their families, and the available health services.
- **Relationships within governmental partners.** There are various significant relationships within and between governmental partners, predominantly through exchange of information processes. The schemes involved the finance sectors (Lower Pra Rural Bank and Grameen Ghana), their regulators, and the health and education sectors, as well as sectors involved in rural production and markets such as ministries of agriculture. The work was led by the MFIs while the international NGOs (Grameen Ghana and Freedom From Hunger) initiated the process, provided training and worked with local actors who led the implementation. Grameen Ghana also built more direct cooperation with the health sector and local telecommunication services. The programmes were implemented at local level.
Levels of administration of government involved. Although central government is involved, through coordination with international NGOs, implementation occurs through highly decentralized local self-governing credit associations with support from local field agents.

Relationships between governmental and nongovernmental actors. Within the Freedom From Hunger credit, which includes solidarity groups and credit associations independently run by an elected body of women, local health services are involved to provide information at their health sessions. The women and the field agent select the areas covered. They include diarrhoea management and prevention, breastfeeding, infant and child feeding, family planning, immunization, HIV/AIDS prevention and care, women’s health, integrated management of childhood illnesses (IMCI), and malaria prevention and treatment. Similarly, Grameen Ghana uses local field personnel and women’s local associations and networks, and applies participatory approaches to strengthen collective discussion and reflection on the health component. The institution has built closer and more active links with the health sector, particularly the Ministry of Health (MoH) at national level and Community Health Workers, midwives and district managers at local and district level. The Grameen field team also engages local health providers, other NGOs working in the same geographical area, and community leaders, such as village chiefs.

KEY DRIVERS OF SUSTAINABILITY

Mandates of structures, organization and budget. There are no strong mandates or structures that can enable or sustain intersectoral cooperation. Increased access to resources through MFI schemes increase the chances of improving health and, hence, the reason for the partnership which is not structurally formalized. The projects, especially their health component, depend on external grants and funds, and have no secured budget, making them economically fragile. Loans and credits are managed through local small financial associations.

Tools and mechanisms to strengthen the interchange between sectors. There is no evidence of the existence of tools and mechanisms that can strengthen the interchange between sectors, as neither have formally evaluated the MFI impacts on health. Nonetheless, a preliminary evaluation of one of the MFIs found improved incomes and health behaviours compared to the control groups. In general, MFIs were found to strengthen women’s self-esteem and confidence, and to support health-care uptake. Positive features were found to be the field agents and community health workers who connect women to local systems, create links with health...
services, encourage participatory health literacy processes amongst MFI members, and clear partnership agreements on roles and accountability. Yet, MFIs need to integrate measures that generate social advocacy on gender norms, target structural determinants of women’s health, and build service delivery accountability. Business expansion entails longer working hours and limited time with the family. The pressure not to default on loans leads to stress, asset depletion and wider debt in some MFIs. There is also evidence that MFI programmes divert both women’s attention from other more effective empowerment strategies and resources from more effective means of alleviating poverty.

**Knowledge and skills of stakeholders.** Both schemes have a strong component of informing, training and raising women’s awareness of health issues through information meetings, thematic learning sessions on priorities as established by the women – building collective interaction and self-esteem. There was no report on the extent to which Grameen Ghana’s rights-based framework had generated health services advocacy or social demand.

**FINAL REFLECTIONS**

- This case shows alliances among non-traditional sectors, where women’s involvement in micro-finance opportunities provides them with health information and skills to strengthen their human capital.
- Although no new structures have been created, there are innovative and effective means of engaging and working with existing MFIs, to promote healthier lifestyles. In this case, health plays a partnership role, does not take the lead, but benefits from the active participation generated by micro-loans and credits in the targeted communities.
- The commitment of international NGOs is crucial and requires the development of more sustainable mechanisms should they cease to collaborate.
- The experiences base their success on the expectation that women’s behaviours will change with regard to their health, but calls for no structural changes.
- Overall, it seems that greater attention needs to be given to the real-time monitoring of MFIs that integrates health goals and processes, and that women should have a stronger voice in MFI design.
INTERSECTORAL COLLABORATION ON CHILD NUTRITION IN INFORMAL SETTLEMENTS IN MOMBASA: A KENYAN CASE STUDY

The Nutritional Improvement for Children in Urban Chile and Kenya (NICK) is being implemented in Chaani, one of Mombasa’s informal settlements. It aims to reduce child malnutrition by changing the social determinants through the establishment of intersectoral action research groups at municipal level, facilitating three cycles of action and reflection, and evaluating the impact on child malnutrition using an experimental design. The project seeks to respond to the hypothesis that child malnutrition amongst families living in poverty in informal settlements and slum communities in Mombasa can be reduced by broadening the participation of communities and stakeholders in changing the social determinants of malnutrition. This study helps the cities of Mombasa in Kenya and Valparaiso in Chile reduce child malnutrition using participatory action research to broaden stakeholder participation at municipal level to change the social determinants.

This case is an example of intersectoral cooperation and even integration at local level, where health is a partner in multisectoral action that is implemented at local level and could potentially be raised to the national level. It fulfils many of the criteria established through the analytic HiAP framework, as described below.

KEY DRIVERS OF IMPLEMENTATION

› Vision of health. It is understood that changes in behaviours, and personal and communal actions can affect children’s malnutrition.

› Relationships with governmental partners. NICK supported the formation of a municipal level intersectoral Urban Nutrition Working Group (UNWG) to implement action plans developed on the basis of evidence and existing theories. The UNWG members represent the Office of the President, the MoH, the Municipality of Mombasa, areas of gender, children and social development, education, and agriculture, water and local development. It also has civil society representation and semi-autonomous government agencies.

› Levels of administration of the government involved. The implementation of this initiative is realized at local level. The municipality was considered to be the level that is best positioned to understand, develop and implement locally appropriate action plans, produce an evidence base to influence policy upstream and downstream. Nonetheless, some national representation is active within its intersectoral structure.
Relationships between governmental and nongovernmental actors. Civil society is represented within the UNWG. Civil society is predominantly active at the implementation phase, receiving training and support to address the specific determinants of health identified.

KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS

Entry points of social determinants of health. Intermediate social determinants of health are addressed. The focus of the project is to empower and train community members, to change individual, household and groups’ behaviours towards food and nutrition. Training includes balcony farming for limited spaces of land, production and use of energy saving devices, psychosocial support, mitigation of domestic violence, income generation, and waste management, among others.

Coverage approach. Universal, within the community served in the area of Mombasa.

Equity as an explicit target outcome of HiAP. Equity is an explicit target outcome as the case addresses the conditions of extreme poverty of Mombasa’s urban informal settlements and slums exclusively.

Main approach to addressing equity. It focuses on vulnerable groups. Children from resource poor settings are especially at risk of malnutrition and other forms of deprivation, and interventions that tackle single determinants of poor child health have little chance of long-term impact.

Role of health in the policy project. The health sector is a member of the UNWG. Additionally, the MoH will review and evaluate the possible incorporation of this model into its national nutrition plans. It has also formed at national level an intersectoral coordination committee to guide actions in specific divisions including health promotion and noncommunicable diseases (NCDs). Health promotion action is therefore likely to succeed in an environment that already has supportive policies or that is amenable to evidence-based change.

KEY DRIVERS OF SUSTAINABILITY

Mandates of structures, organization and budget. There are formal structures that can potentially enable and sustain intersectoral work. For example, two UNWG group members also participated in the formulation and completion of the draft National Nutrition Action Plan/Policy in September 2012. Additionally, the UNWG could be handed over to the government through the MoH in September 2013, thus increasing the potential for sustainability and making Mombasa the first county to have a formal government-linked nutrition-working group. The budget for the NICK study is ensured until the end of this project in 2013. It is a three-year study that started in October 2010 with funding from the UK Government Department for International Development (DFID) and the Economic and Social Research Council (ESRC). No mention is made on whether or not there will be funding to continue the effort and scale it up.

Tools and mechanisms to strengthen interchange between sectors. The NICK project closes in September 2013 and quantitative pre- and post-intervention results will be ready by end of 2013. Monitoring of the project activities is carried out at community and UNWG levels. At the community level, monitoring is done by the membership of the UNWG who have each been tasked with responsibility for a specific action point in the developed action plans. UNWG-level monitoring is the responsibility of the group as well as the NICK researchers. The UNWG has also been holding monthly progress meetings to review the implementation process as well as plan for any remedial interventions between the six monthly cycles of review, reflection and action.

Knowledge and skills of stakeholders. There is an effort to strengthen stakeholders’ knowledge and skills. Three groups have been identified within the community to receive orientation and training aimed at tackling the determinants of poor child health and nutrition including financial capacity building, strengthening food availability, and improving living conditions. Training also included the production and use of energy saving devices. The
NICK project has been supportive of the UNWG even as it now prepares to transform into a county-level working group and this has helped in individual and group growth and stability. Finally, the NICK project has witnessed the development of personal skills and growth in both the working group and the community groups. It is, therefore, important that issues related to skill development and personal growth be factored in when planning on supporting long-term intersectoral actions.

**FINAL REFLECTIONS**

- Local experiences can provide inputs to the dialogue on HiAP. This experience effectively realizes intersectoral actions and fulfils most of the criteria established as a HiAP case.
- The commitment and active involvement of the community is strong and key to the success of the project, which has the potential to be scaled up to national level.
- The fact that the UNWG exists and is permanent at a local level, as well as its potential to be institutionalized, is the strength of this case. Compared to other areas in the informal settlements where the UNWG is active, sanitation and waste disposal in Chaani has been improved although there are many other challenges including poor drainage and sewerage.
- The NICK project has witnessed the development of personal skills and growth in both the working group and the community groups, which are key aspects of successful intersectoral interventions.
LEARNING FROM HOLISTIC THINKING
IN MENTAL HEALTH PROGRAMMES IN KENYA

This case study describes three levels of intervention on mental health in Kenya that reflect a paradigm shift towards more holistic community centred thinking on mental health: (i) multi-faceted and intersectoral process for national policy development and implementation on mental health; (ii) a coordinated district programme operating in nine districts with high poverty levels; and (iii) locally driven social action at community level. It is a decentralized, comprehensive and community centred approach, where mental health issues are linked to socioeconomic circumstances. It recognizes the ‘vicious cycle’ of poverty and mental ill-health that call for measures that address the disorders themselves, their determinants and the social exclusion they generate – calling for coordinated medical, psychosocial, economic and, for stigmatized conditions, rights-based support to the health sector.

This case represents an example of intersectoral cooperation, where the health sector leads the multisectoral actions on mental health. It fulfils many of the criteria established through the analytic HiAP framework, as described below.

OPPORTUNITIES FOR INITIATION

➤ **Policy change window.** The political will for HiAP seems to be present at national level through the development of a National Mental Health Strategic Plan (2004) that raised the profile of mental health needs, yet no leading political figure or body has been identified as leading this action. The 2007 Mental Health Act recognized some elements of the intersectoral nature of mental health, including the establishment of a multisectoral Board of Mental Health. In 2013, a new Mental Health Bill was drafted.

➤ **International influences.** The case does not follow specific international mandates or influences on this subject matter.

KEY DRIVERS OF IMPLEMENTATION

➤ **Vision of health.** The government established a strong legal and policy basis for the right to health and health care, and for equity in health in Kenya. The BasicNeeds mental health and development model that was designed comprises five separate but interlinked modules, namely: capacity building; community mental health; sustainable livelihoods; research; and management and administration. The programme aims to improve the mental health of participants and reduce their deprivation and exclusion.

➤ **Relationships within governmental partners.** There are various degrees of cooperation between and within governmental levels and partners. At national level, the sectors involved in policy dialogue and operationalizing policy included the police, prisons, schools, child protection agencies, and social welfare services. The district and community level approaches also included the departments of livestock and agriculture, gender and social, and children and youth.

➤ **Levels of administration of the government involved.** All levels of government are involved in the regions affected by these actions, led by the MoH at national level – in charge of policy designed – and in alliance with non-state actors for implementation at local level.

➤ **Relationships between governmental and nongovernmental actors.** At local level, a multidisciplinary team including community members in schools, religious leaders and health workers, carried out public education, set up an additional community clinic point and self-help groups, negotiated actions with local authorities to minimize risks and with local NGOs to extend community centres to provide support to children with mental disabilities.
Organizational and operational interventions were designed in collaboration with stakeholders through consultation workshops. The district and local-level processes set up links with economic actors and social services to strengthen the social inclusion, incomes and well-being of people with mental ill-health as well as that of their households. These economic actors may need more profile in national level policies.

**KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS**

- **Entry points to identify social determinants of health.** Structural and intermediate social determinants of health are addressed. Structural issues are tackled mainly through national regulations. People living in poverty are at increased risk of developing mental health problems through the stress of living in conditions of deprivation, increased risk of trauma and other negative life events, increased obstetric risks, social exclusion and food insecurity. Mental disorders have, in turn, been associated with increased health expenditure, loss of employment, reduced productivity, stigma and a drift into poverty.

- **Coverage approach.** The new regulations affect all not just universal and national levels, but all communities at district and local levels and they should be invited to participate.

- **Equity as an explicit target outcome of HiAP.** Equity is not an explicit target outcome of this HiAP case, although the initiatives described are implemented in marginal and vulnerable communities, as mental ill-health is understood to be both a driver and a consequence of deprivation and exclusion, and thus an important equity concern.

- **Main approach to addressing equity.** Focus placed on vulnerable groups, acting in poor districts of the country to implement the national policy.

- **Role of health in the policy process.** The MoH is leading the initiative. In the 2000s, the MoH was leading comprehensive, intersectoral and decentralized approaches in national policy, district programming and community-centred action on mental health in Kenya.

**KEY DRIVERS OF SUSTAINABILITY**

- **Mandates of structure, organization and budget.** There are formal structures that can enable and sustain intersectoral work, such as the establishment at national level of the Kenya Board of Mental Health in 2007, which included health personnel, and representatives from education, social services and local governments. A national policy process using various forums for dialogue and operational tools supported the integration of mental health into health management systems, and guided intersectoral action and liaison with police, prisons, schools and public education. At district and local levels, intersectoral actions seem to have a more informal arrangement. There is limited budget for these initiatives. Nonetheless, the implementation was integrated within the Kenyan system through the MoH and other relevant ministries making it sustainable without external funding. Local activities depended on local budget.

- **Tools and mechanisms to strengthen interchange between sectors.** There is no evidence of the existence of tools and mechanisms that can strengthen interchange between sectors, as there are no formal evaluation and monitoring mechanisms described, or formal health impact assessments developed. It is stated though that sustainability requires communication across actors, support by people with the capacity to facilitate such communication, and has to be embedded in existing systems and structures or to strengthen such structures (such as networks of people with mental illness).

- **Knowledge and skills of stakeholders.** There is an effort to strengthen the knowledge and skills of stakeholders. The training of 3000 primary care health workers supported the integration of mental health into primary care. Some courses were also run for other sectors, such as for prison nurses. Advocacy was promoted to prioritize mental health in the targeted districts. Efforts to strengthen capacities to organize and implement intersectoral action for mental health were undertaken. Capacity building workshops were held to establish and strengthen district mental health coordination and to ensure the inclusion of mental health in annual district operational planning.
The national process has demonstrated positive use of a multi-faceted and comprehensive approach to policy dialogue and development as an input to sustainable system change and to encourage intersectoral liaison. The district and community level processes show how the same context has also driven bottom up intersectoral approaches to address mental ill-health centred around networks of individuals and their carers, linking services and resources within and beyond the health sector and facilitated by local actors.

All elements described in this case study recognized the ‘vicious cycle’ of poverty and mental ill-health that call for measures that address the disorders themselves, their determinants and the social exclusion they generate. There was shared recognition of the need for coordinated medical, psychosocial, economic and, for stigmatized conditions, rights-based support.

The case study provides consistent evidence across three different levels that intersectoral policy, service and community responses to mental health need to be driven by communication across actors, supported by people with the capacity to facilitate such communication, and to be embedded in existing systems and structures or to strengthen such structures (such as networks of people with mental illness) for the effectiveness and sustainability of the response.
ADDRESSING DETERMINANTS OF HEALTH THROUGH INTERSECTORAL COLLABORATION: FISH FARMING PROJECT IN SOUTH IMENTI CONSTITUENCY IN MERU COUNTY, KENYA

The Government of Kenya implemented a set of programmes and strategies to support opportunities for sustainable development for its citizens’ well-being. Among them, the intersectoral Economic Stimulus Programme (ESP) was launched to address food insecurity and mitigate the effects of the 2007 post-elections violence, and the global economic and financial crisis. The Programme called for the development of intersectoral projects geared at providing citizens with services. Among the numerous intersectoral programmes introduced was fish farming or aquaculture. The focus of fish farming (aquaculture) was to improve food and nutrition and create over 120 000 employment and income-generating opportunities. ESP’s key objectives included: boosting the country’s economic recovery and returning it to the envisioned medium-term growth plan; investing in long-term solutions to challenges of food security; expanding economic opportunities in rural areas for employment creation; and promoting regional development of equity and social stability. Some of the activities covered under ESP included: expanding irrigation-based agriculture, and building wholesale and fresh produce markets, and fish ponds. The findings of the study showed increased food security and improved nutrition. The fish-farming project also created employment and generated income for the participating households. Other findings revealed strengthened intersectoral collaboration and public-private partnerships in food security initiatives. One of the constituencies to benefit from these programmes was Imenti South, Meru County, upon which this case study is based.

This case represents an example of intersectoral cooperation, where health is a partner in multisectoral action mandated at national level and implemented at local level. It fulfils many of the criteria established through the analytic HiAP framework, as described below.

OPPORTUNITIES FOR INITIATION

› **Policy change window.** The Government of Kenya introduced the ESP, with the Ministry of Finance acting as the lead, which shows high political will for this initiative.

› **International influences.** The case does not follow an international mandate or influence.

**KEY DRIVERS OF IMPLEMENTATION**

› **Vision of health.** The vision of health is closer to social indicators, as this initiative seeks, among other things, to change eating habits by promoting fish as a source of nutritional food and by minimizing food insecurity. In so doing, it promotes a healthier life style and reduces the chances of health problems.

› **Relationships with governmental partners.** The Ministry of Finance and Ministry of Fisheries provided governance and leadership of the ESP, coordinating their actions to ensure effective implementation of the project.

› **Levels of administration of the government involved.** The implementation of this initiative required national
and local government involvement. Intersectoral and stakeholders meetings were held twice a month at national (coordination and monitoring) and constituency (implementation) level. At local level, ESP projects were managed by the District Infrastructure and the Stimulus Project Management Committee (SPMC), whose responsibility was to identify the appropriate project location, recommend payments in consultation with relevant and technical ministries, and monitor implementation of the projects. The intersectoral SPMC team consisted of a Member of Parliament (team leader), the District Commissioner, District Development Officer, District Public Works Officer, Community Development Fund Committee (CDFC) Chairperson, Secretary and Treasurer, District Accountant, heads of all departments, nongovernmental and religious organizations’ representatives, two men and women representatives from the constituency, two youth representatives, the CDFC Fund Account Manager, the Constituency Projects Technical Committee (CPTC), and the Kenya Private Sector Alliance.

- **Relationships between governmental and nongovernmental actors.** The government adopted a strategy to expedite commercial fish farming (aquaculture) growth through a collaborative and participatory approach involving public-private sector partnerships. In particular, the ESP ensured maximum intersectoral stakeholder and community participation to guarantee that: projects were identified and implemented in an transparent way; funds were managed accountably; and projects were completed and governed effectively, and benefited the targeted communities. This collaboration increased the quantity of fish produced in the country, which has registered a 5.8% increase since 2010, and a 6.2% increase in fresh water fish.

**KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS**

- **Entry points of social determinants of health.** Intermediate social determinants of health are addressed. The aim of the project was to address the broader determinants of health related to nutrition, food security, employment, household income-generating activities.
- **Coverage approach.** Universal, within the communities served.

- **Equity as an explicit target outcome of HiAP.** Equity is an explicit target outcome as the case seeks to secure the livelihood of Kenyans, and address the challenges of regional and inter-generational inequity.

- **Main approach to addressing equity.** It focuses on vulnerable groups, addressing the needs of populations at risk of food insecurity.

- **Role of health in the policy project.** The role of the MoH, in collaboration with other stakeholders, was to promote the benefits of fish consumption through local health facilities and outreach activities particularly during market days.

**KEY DRIVERS OF SUSTAINABILITY**

- **Mandates of structures, organization and budget.** Local intersectoral SPMC were established to ensure the best allocation of resources and its transparent use. Additionally, the Ministry of Finance provided the necessary resources for the successful implementation of this initiative.

- **Tools and mechanisms to strengthen interchange between sectors.** No mechanisms were reported.

- **Knowledge and skills of stakeholders.** The farmers were empowered with the relevant technical information and educated on which fish species were best suited to their sites and how to care for the fingerlings to ensure fish farming was a sustainable venture in the region. They received continuous support on fish marketing channels, improving infrastructure and accessing information.
• This is a case of HiAP where multiple positive outcomes result from cooperation among sectors, as there is a demonstrated impact on food security, employment and healthier eating habits.

• There is need to increase funding to the agriculture and fisheries industries as these were initially short-term initiatives but seem to be becoming more long-term processes.

• It is important that interventions utilize participatory and community-based approaches to improve the nutrition and food security of the poorest and most vulnerable population groups within the context of securing sustainable livelihoods.
This case study examines how intersectoral actions have contributed to improving health insurance financing and universal health protection in Rwanda. The case study covers the period 2005–2012, when key health financing policy innovations were adopted, such as the Community Based Health Insurance (CBHI) initiative, and others were scaled up to cover the whole country through the decentralization policy. The effort to expand the health protection coverage policy was gradual, and required political and broader consultative mechanisms to ensure that formal and informal sectors of the economy were covered. For the formal sector, the Rwandaise Assurance Maladie (RAMA) plan was established in 2001 to cover public servants and their dependents and private sectors (but not individuals). Through Ministry of Defence (MoD) and MoH, the Military Medical Insurance (MMI) was established to cover the military and their civilian dependents. There are several other private health insurances covering a minor segment of the population, mostly those working in the banking sector. For the informal sector, the CBHI was first formally introduced in 1998 in three of the 30 districts in the country. The policy aimed at addressing or improving the quality and quantity of health services offered by health workers as well as strengthening the capacity of institutions in terms accountability and governance. In 10 years, 92% of Rwanda’s population of 11 million was insured and protected from catastrophic health-care expenditures. This in turn had an impact on health outcomes, especially with regards to achieving MDG 4: Reduce Child Mortality throughout the country. Nonetheless, whereas the achievements have been outstanding, their sustainability remains a big challenge for both the government and donors.

This case represents an example of intersectoral collaboration, where the health sector partners with financial institutions and NGOs to increase a population’s health insurance coverage. It fulfils many of the criteria established through the analytic HiAP framework, as described below.

**OPPORTUNITIES FOR INITIATION**

› **Policy change window.** This initiative has high-level political leadership support, through the President’s Office, the Ministry of Local Government, and the Ministry of Finance and Economic Planning. The president himself signs performance contracts with District Mayors to enhance service delivery and improve the health and well-being of the population. One of the critical activities under the performance contracts is universal health protection through improved CBHI enrolment rates, and the president has made this one of his political top priorities.

› **International influences.** Organizations such as the U.S. Agency for International Development (USAID) provided technical support during the design of the policy, and financially and technically supported evaluation studies to inform the policy-maker, especially during the scaling up phase of the programme. Some in the international community consider Rwanda as a model for low- and middle-income countries in terms of attaining universal health coverage and improving service delivery. This effort also follows a commitment made in 2001 by the African Heads of State to allocate annual budgets to improve the health sector (The
Abuja Declaration. In May 2005, the Fifty-eighth World Health Assembly adopted a resolution urging Member States to ensure that health-financing systems included a method for prepaying financial contributions for health care, with the aim of promoting risk sharing. Finally, the world health reports for 2008 and 2010, and resolutions on *Primary health care and strengthening health systems* of the Sixty-second World Health Assembly, 2009 (WHA62.12) and on *Sustainable health financing structures and universal coverage* of the Sixty-fourth World Health Assembly, 2011 (WHA64.9), highlighted universal health coverage as one of the four keys pillars of primary health care and services through patient-centred care.

**KEY DRIVERS OF IMPLEMENTATION**

› **Vision of health.** This case predominantly addresses health coverage by focusing on the absence of disease.

› **Relationships within governmental partners.** Intersectoral collaboration was vital. The Ministry of Economy and Finance has been increasing its budget share to health for years and provided some funding for the insurance programme. The Ministry of Local Government has strengthened governance structures at all levels to ensure that strong administrative structures are in place to support implementation processes for most government programmes, including those for health. With structures in place, the implementation of various health innovations was possible.

› **Levels of administration of the government involved.** This is in an example of an whole-of-government approach, where each level has a specific responsibility. Most of the implementation took place at district level through presidential mandates. First, the district leaders work with the lowest administrative units (sectors, cells and villages, through Community Health Workers) to mobilize the population on the advantages of enrolling in the CBHI. Secondly, the president signs contracts with District Mayors setting health performance targets. Thirdly, the district officials work with the local banks to offer soft loans to the local population who wish to borrow money and pay to a CBHI scheme in order to be enrolled. The mayors have the mandate to hire and fire health workers (doctors, nurses, laboratory technicians, etc.) from district hospitals and health centres. The District Mayor coordinates implementation of policies including those of health. Finally, the President’s Office carries out external evaluations on district performance contracts, and mayors who are below certain performance levels are removed from their position.

› **Relationships between governmental and nongovernmental actors.** In addition to the 15 government ministries, the health sector is supported by several development partners, faith-based organizations and NGOs. Different cadres with varying qualifications provide services at different levels of the health-care system. Many NGOs play an important role in improving health through intersectoral action on health financing. For the church (public, confessional, private-for-profit and NGOs) are directly involved in supporting the community to provide care and covering annual premiums subscriptions for the poorest category of the population. The development partners at the district level are also responsible for supporting the efforts to implement various policies including health financing.

**KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS**

› **Entry points to addressing social determinants of health.** This example focuses predominantly on access to and financing of health services, so it does not provide answers to structural or intermediate social determinants of health.

› **Coverage approach.** This represents an example of mixed approach. While the focus is to achieve universal health coverage, the government has implemented targeted programmes that would support the most vulnerable populations to ensure their coverage. The Ministry of Local Government has established clear criteria that rank the population according their wealth where the “poorest” are protected from out-of-pocket health expenditures.
› **Equity as an explicit target outcome of HiAP.** Even though equity is not an explicit goal, it is imbedded in the government’s targeted action, in support of the most vulnerable populations.

› **Main approach to addressing equity.** The focus is on addressing the needs of the poorest sectors of the population. The government, through health financing policy, introduced a system of co-financing the CBHI whereby other insurances covering the formal sector make an annual contribution (about 1% of their annual collection) to the CBHI to cover the deficits. In addition, the government contributes to the CBHI fund to further boost pooling in an effort to cover the deficit. For the poorest, who have to prove they cannot afford the premiums, the government and partners (including faith-based organizations) pay their premium. Additionally, the health financing policy takes seriously the inclusion of the informal sector (about 85%) in mainstream health financing. The formal sector’s health insurance covers less than 15% of the population.

› **Roles of health in the policy process.** Through a broader consultative processes with partners and relevant sectors, the MoH developed a comprehensive health financing policy framework based on national and global health-care financing best practices, to respond to the financial accessibility problems. The health-financing policy is built on the core principal that the country needs to protect all individuals and families in both formal and informal sectors of the economy from out-of-pocket health-care expenditures.

**KEY DRIVERS OF SUSTAINABILITY**

› **Mandates of structures, organization and budget.** The Ministry of Local Government has strengthened governance structures at all levels to ensure that strong administrative structures are in place to support implementation processes for most government programmes, including health. With structures in place, the implementation of various health innovations was possible.

With the support of other sectors and development partners, Rwanda has recorded high revenue mobilization from domestic sources, mainly organized in CBHI schemes and other private insurances, and increased public funds (from tax-based funding). As a result of good governance and using donor funding more efficiently, coupled with relatively low levels of corruption, there has been sustained increased external funding. Nonetheless, Rwanda’s critical challenge remains its sustainability, as a large share of funding comes from the development partners. However, Rwanda is striving to keep the strategy by: increasing the allocation of resources to performance-based financing from internally generated revenues, mobilizing more internal resources, and using part of the insurance to finance a performance-based financing programme.

› **Tools and mechanisms to strengthen interchange between sectors.** Through a performance-based financing programme, the model remunerated health facilities and health workers (doctors and nurses) for improvements in the quality and quantity of maternal and child health indicators. About five years after it was first implemented, a standard impact evaluation (treatment-control comparison) was conducted which showed that health facilities that had joined the programme had improved these indicators. In 2006, with the support of partners, the health financing policy was scaled up countrywide. Additionally, the President’s Office carried out external evaluation on district performance contracts, and mayors who are below certain performance levels are removed from their position.

› **Knowledge and skills of stakeholders.** There does not seem to be a strategy to train and increase stakeholders’ understanding of the system in general and the programme in particular.
The success of this case is based on the strong political commitment and funding from both governmental and nongovernmental sources.

It could be strengthened by also tacking cost control actions for health services.

Even though it does not have a social determinants approach, it acknowledges the existing inequalities in access to services and develops a programme subsidizing health costs for poor communities.

Insurance coverage is also directly related to more routine visits to health providers, and could lead to the earlier detection of diseases that could both save lives and reduce the costs of health.
THE HEALTHY SCHOOLS PROGRAMME IN SOUTH AFRICA

This case study describes the Health Promoting Schools (HPS) programme in South Africa from 1995 to date. The school provides a setting for across sectoral work between education, health and other sectors to prevent factors that place learners at risk, such as poverty, violence, substance abuse and HIV/AIDS. It is a national level policy and programme, with further exploration of evidence from a rural primary school site in Western Cape initiated in 1996. This programme was initiated as a response to shared policy actions across health and education sectors and with support from WHO, to address these concerns based on international experience. The issues addressed in South Africa were many, including road safety, personal hygiene, substance abuse, HIV and nutrition, with processes such as teenage clubs, after-care programmes for cultural activities, outdoor educational activities such as camps, and support groups for teachers’ health promotion. The case study shows the role of provincial departments, local authorities, technical support teams and community actors in taking the national concept to local level.

This case represents an example of intersectoral cooperation and coordination, among traditional partner sectors, where health and education work jointly (as co-leaders) in the school setting. It fulfils many of the criteria established through the analytic HiAP framework.

OPPORTUNITIES FOR INITIATION

› **Policy change window.** There seems to be the political will for HiAP between the health and education sectors, and local authorities, as both sectors saw the benefit of the HPS approach to their own domain of work, and the value of collaboration and integration of processes to their own desired outcomes. Thus, while the HPS was initiated with full international and national support, its uptake in the provinces depended on local contexts.

› **International influences.** The case does not follow an international mandate, but is based on and informed by one, as HPS is a WHO initiative that supports the concept in Africa as one way of building intersectoral collaboration, drawing on the Ottawa Charter for Health Promotion and the Jakarta Declaration for Promoting Health. The support from WHO was used to sensitize administrative and school authorities, and inform policies, services, curricula or extra curricula schedules on areas such as HIV/AIDS/STI prevention, violence, and drug and tobacco prevention. From 1997, the WHO Regional Office for Africa supported the initiation and implementation of HPS in about 32 African countries and, by 2007, approximately 300 schools reported HPS to be “fully operational”.

KEY DRIVERS OF IMPLEMENTATION

› **Vision of health.** Health is tackled from different perspectives and addresses issues such as poverty, substance abuse, nutrition, care, etc. Awareness of the impact of racial and gender discrimination in health inequalities also informed the programme.

› **Relationships within governmental partners.** There is coordination between and within governmental levels and partners. The National Department of Health established a Health Promoting Schools Committee with representatives from health and education. Both health and education departments had policies and mechanisms to support their role and made inputs to the HPS programme. These intersectoral mechanisms were replicated within the provinces.
Levels of administration of the government involved. All levels of government are involved. The application of the programme was flexible in order to facilitate local ownership and initiative, with support from provincial technical teams and schools’ management levels.

Relationships between governmental and nongovernmental actors. Partnerships were built between different government departments, NGOs, higher education institutions, as well as with the media. Partnerships with various business organizations were noted to be particularly prominent in the provincial initiatives.

Entry points to addressing social determinants of health. Intermediate social determinants of health are addressed, as this case focuses on the school as a setting for community-based prevention of factors that place students at risk. The HPS framework was recognized as a strategic, holistic, comprehensive response to these factors. An HPS is one that: constantly strengthens its capacity as a healthy setting for living, learning and working; fosters health and learning with all measures at its disposal; engages health and education officials, teachers, teachers’ unions, students, parents, health providers and community leaders to make schools a healthy place; integrates broad health promotion and education services, promotes individual and social well-being and the health of school personnel, families and community members and pupils; and works with community leaders to understand their role in both health and education. Hence, it does not go as far as to address more structural social determinants of health, but rather focuses on changing lifestyle, housing and school conditions.

Coverage approach. Universal, as it affects all school populations and participants.

Equity as an explicit target outcome of HiAP. Equity is not an explicit target outcome of this HiAP case. Nonetheless, in its focus on overcoming barriers to learning (such as violence, poor health and unhealthy environments), equity is addressed given that interventions would support learning in more disadvantaged groups exposed to these risks. Studied in greater detail, the case is situated in a semi-rural town outside of Cape Town that has high levels of unemployment, crime, substance abuse, gangsterism and teenage commercial sex work.

Main approach to addressing equity. The main approach to addressing equity is to focus on vulnerable groups, as it seeks to improve the situation of vulnerable groups rather than reducing equity gaps among groups.

Roles of health in the policy process. The health sector partners with education and actively participates in policy development and implementation.

Mandates of structures, organization and budget. There are formal structures that can enable and sustain intersectoral work. Following increasing demand for processes to support institutionalization, including guidelines on roles and responsibilities, consistent training, budget support and formal tools for monitoring and evaluation, the policy and programme was progressively institutionalized and integrated between 1994 and 2000. In 2000, the National Committee for Education Support Services recommended that all aspects of the HPS strategy be adopted to ensure the development of healthy school policies, supportive learning environments, strong community links, personal skills development and the provision of appropriate education support services. Additionally, the National Directorate of Health Promotion included the HPS in their five-year plans, and provided support through provincial structures. At local level, for example, Western Cape set up an intersectoral provincial reference group comprising members of the departments of health and welfare and education, community-based organizations, volunteers and members of the private sector to introduce, implement and sustain the HPS concept in schools. In all cases, health and education departments seemed to be co-leaders. There also seems to be a limited budget for the implementation of this
initiative. Although core personnel are covered in regular budgets, resource constraints were noted in meeting the level of demand for health promotion, and there seems to be no integrated budget allocation from health and education. Thus, businesses may have helped to implement programmes not covered by budget resources.

- **Tools and mechanisms to strengthen interchange between sectors.** There are no formal evaluations of HPS in Africa. The evaluations utilizing a quasi-experimental approach with comparison schools reported better performances in the intervention schools for certain areas, but no differences in others.

- **Knowledge and skills of stakeholders.** Teachers were trained to deal with a wide range of problems experienced by students. Teachers were gaining new skills and, as a result, were more enthusiastic about their work. The pooling of personnel through intersectoral collaboration was identified as a cost-effective way of tackling the shared policy concerns on the lack of health promotion capacities in the provinces, and the limited health promotion personnel in the health sector, which enabled groups with high need and limited resources to be reached.

**FINAL REFLECTIONS**

- The case study demonstrates a significant change in the process of integrating the institutional cultures, systems and goals of two sectors (health and education) to overcome barriers to learning that exist particularly in disadvantaged communities. It highlights the possibility of building a national programme while allowing for local diversity of practice. This increases the potential for sustainability and a more embedded intersectoral action.

- Even though local creativity and development were highly valued and important, those involved called for more support from national guidelines and instruments, and tools for evaluating and monitoring the development of HPS, as well as training for health workers and post-graduate studies on health promotion.

- The views of parents and pupils need to be further explored, and their voice to be stronger for the effectiveness, sustainability and equity of the initiative.
SUCCESSFUL SODIUM REGULATION IN SOUTH AFRICA

In 2013, South Africa passed legislation regulating the amount of sodium the food industry can use in its products. The “Regulations relating to the reduction of sodium in certain foodstuffs and related matters” included a number of products targeted by the National Department of Health (NDoH). The sodium reduction goals were targeted across several industries that utilized high sodium levels. Mandatory guidelines for sodium levels only limit specific foods with high consumption rates in South Africa, including bread, margarine and soup mixes. By regulating sodium reduction, South Africa became the first country in the world to regulate sodium consumption at the manufacturing level for several industries. The new regulation will be enacted to reduce sodium levels in certain food products in two stages, defined by their respective deadlines of 30 June 2016 and 30 June 2019. Fines, enforcement methods, and penalties with respect to non-compliance with the new regulations are included in the legislation and checks will be undertaken by a combination of safety environment officers at the municipal level, although the capacity to perform this is not yet clear.

Even though this case does not show intersectoral work among different sectors of the government in great detail, it represents a very strong example of negotiation between government and other partners, such as academia and the food industry. The health sector leads this initiative, but convokes all relevant stakeholders to negotiate the new regulations. It also fulfils some of the criteria established through the analytic HiAP framework.

OPPORTUNITIES FOR INITIATION

› Policy change window. There is a strong political will for this initiative from the MoH. The Minister of Health himself pushed for regulations on the sodium levels in South African food products. The promulgation of this legislation shows the level of support for the initiative.

› International influences. South Africa’s case is inspired by other national efforts to reduce sodium intake (undertaken by 37 countries so far). Among them, only Portugal has enforced mandatory regulations. Most governments have relied on sets of voluntary regulations connected to industry’s ‘collaboration’, believing that such methods would be sufficient, but the results are mixed. In June 2013, just three months after South Africa passed its regulations, the Pan American Health Organization (PAHO) held a “Salt Smart” consultation to reduce sodium consumption by half in the Americas. Since the plan’s deadline is set for 2020 – similar to SA’s 2019 deadline – this might be beneficial to both South Africa and PAHO because the timeline overlap will allow for communication and collaboration on a global scale to see which methods are working most effectively in real time.

KEY DRIVERS OF IMPLEMENTATION

› Vision of health. Health is tackled from the absence of disease perspective, highlighting the benefits of reducing salt in food and the consequently reduction in non-communicable diseases.

› Relationships within governmental partners. No details are given with regards to the role of other sectors. However, the NDoH is actively supporting the legislative process and providing all necessary inputs to advance the negotiations showing collaboration between two different government branches.

› Levels of administration of the government involved. Safety environment officers at municipal level will be
responsible for enforcing the law, demonstrating that different governmental levels are participating.

› **Relationships between governmental and nongovernmental actors.** Partnerships were built during the development and design of the law. Interaction with the academic sector provided a link for the production and presentation of local research, which helped in the understanding of hypertension in the South African context, the feasibility of adopting regulations to decrease sodium, especially in bread, and the potential to save lives. The NDoH also reached out to representatives of the food industry, and devoted a significant amount of time and effort in order to understand its concerns. As a result, adjustments were made to the law, such as the timeline established for the reduction of salt in food production. The industry was given two more years to reconfigure recipes and explore technical adaptations. The NDoH has also engaged the Heart and Stroke Foundation South Africa to prepare a discretionary salt use campaign to run simultaneously with the regulations. The Heart and Stroke Foundation South Africa formed a lobby group called Salt Watch in March 2013 to raise public awareness about appropriate sodium consumption levels, as well as health/nutrition choices.

**KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS**

› **Entry points to addressing social determinants of health.** Structural social determinants of health are addressed in an effort to limit salt consumption by changing laws that regulate food production.

› **Coverage approach.** The law affects all citizens, so it could be universal in that sense. However, the legislation regulates salt levels in specific food products, such as bread, but not in others, which are consumed in less quantity.

› **Equity as an explicit target outcome of HiAP.** Equity is not an explicit target outcome of this case.

› **Main approach to addressing equity.** There is no specific approach to addressing equity in this case.

› **Roles of health in the policy process.** The health sector has headed the policy development process and provided all necessary inputs for the adoption of the law. It also brokered and negotiated with the identified partners in academia, civil society and the private sector.

**KEY DRIVERS OF SUSTAINABILITY**

› **Mandates of structures, organization and budget.** No information is provided with regards to this item, and the enforcement of the law has yet to be tested, given its recent adoption.

› **Tools and mechanisms to strengthen interchange between sectors.** No evaluation process was described in the presentation of this case.

› **Knowledge and skills of stakeholders.** A campaign was launched by NDoH to sensitize citizens on the application of the law.

**FINAL REFLECTIONS**

- The process towards sodium reduction policy was successful in great part due to the intersectoral collaboration between government, academia, and industry that the NDoH headed.

- The novelty of this case is the inclusion of an enforcement mechanism, which calls for the government to maintain a strong position and commitment to monitoring industry’s compliance, especially as the food industry increasingly markets its products transnationally.

- The results of a reduction in sodium intake would also have national fiscal, reducing the direct costs of tackling health challenges that arise from use of sodium, such as hypertension and strokes, as well as the indirect costs that these disabilities can incur for families.
SUCCESSFUL TOBACCO LEGISLATION IN SOUTH AFRICA

This case presents the roadmap of the Tobacco Products Control Act of 1993, its subsequent regulations and amendments, and the intersectoral process undertaken to address the tobacco epidemic through legislation. The economics of tobacco played a significant role in tobacco legislation, and country-specific research and econometric models measured the costs and benefits of tobacco consumption. Public opinion polls complemented quantitative data and revealed a majority of South African citizens supported all forms of tobacco regulation. As a result of the multifaceted evidence and attention provided, the Government of South Africa passed the Tobacco Products Control Act in 1993, which among other things increased taxation on tobacco products. Efforts to add and strengthen tobacco regulations resumed in the post-apartheid transition under the African Nation Congress’s leadership. Regulations were enacted in 1995. The Tobacco Products Control Amendment Act of 1999 was passed, in spite of the tobacco industry’s resistance, to address the loopholes in the 1993 Act.

Even though this case does not present greater detail on intersectoral work between government agencies, it does showcase an example of how the government, with the leadership of the health sector, has to negotiate with other stakeholders, such as the tobacco industry and academia. It fulfils a few of the criteria established through the analytic HiAP framework.

OPPORTUNITIES FOR INITIATION

- **Policy change window.** There was strong political will from the president in 1993 to regulate tobacco products, which was renewed in 1998, with major leadership from the Minister of Health, who committed himself to enacting stricter regulations.

- **International influences.** On 16 June 2003, the Government of South Africa signed the WHO Framework Convention on Tobacco Control (WHO FCTC), and used it as a basis when passing amendments to the 1993 Act in order to comply with the international deadlines for specific regulations. This international framework helped the government to overcome resistance and pressure from the tobacco industry. The National Department of Health continues to update the tobacco regulations and currently publishes a regular report card to inform the WHO of the country’s progress.

KEY DRIVERS OF IMPLEMENTATION

- **Vision of health.** The vision of health seems to be closer to absence of disease, as the law seeks to minimize the effects of tobacco use.

- **Relationships within governmental partners.** No information is provided on the relationship with other government sectors, although authorities in the economic sector provided information on the impact on the tobacco industry’s business. This relationship has focused on information sharing.

- **Levels of administration of the government involved.** The national government was involved in the negotiations for the advancement of the tobacco regulations.

- **Relationships between governmental and nongovernmental actors.** Other actors were consulted during the negotiating process. Academic institutions and NGOs have provided country-specific data on the health burdens of tobacco and used them as effective evidence to advocate for tobacco regulation. Although originally opposed to this process, the tobacco industry was summoned to provide inputs and were forced to accept the initiative after President Mandela endorsed...
it. However, fewer consultations were held during the negotiations for the 1999 Amendment Act, as they were geared to address loopholes in the first Act. Despite the tobacco industry’s attempts to use overseas experts to dilute the Bill, the tobacco control advocates succeeded by using context-specific research and data showing the negative effects of tobacco on the country.

KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS

➢ Entry points to addressing social determinants of health. The policies address intermediate social determinants of health, as laws were adopted to change behaviour with regards to tobacco use.

➢ Coverage approach. The coverage is universal, as the law applies to all people in South Africa.

➢ Equity as an explicit target outcome of HiAP. Equity is not an explicit target in this case.

➢ Main approach to addressing equity. Even though equity is not addressed, it is understood that smoking prevalence is not uniform with respect to ethnicity, gender, age and income.

➢ Roles of health in the policy process. The MoH led the negotiations with other sectors and with Parliament for the adoption of the law and its amendments.

KEY DRIVERS OF SUSTAINABILITY

➢ Mandates of structures, organization and budget. There are no formal structures that can enable and sustain intersectoral work.

➢ Tools and mechanisms to strengthen interchange between sectors. The Government of South Africa and the academic sector continue to monitor smoking prevalence amongst the population by using different surveys and data collection methods. Monitoring smoking has been key in tracking the overall trend in smoking prevalence rates and showing the effectiveness of legislation, education, and taxation against the tobacco industry. In 1998, a new question was added to the South African death registration certificate, asking whether or not the deceased was a smoker five years prior to death. This new addition to the death registration form has allowed researchers to find statistical correlations between smoking and the immediate causes of death. Other methods of research include the All Media and Product Survey (AMPS), South African Demographic and Health Survey (SADHS), Global Youth Tobacco Survey (GYTS), and other general household surveys. Local monitoring proved that initial fears about the negative impacts of the tobacco regulations on the economy were not well founded. While about a third of South Africans smoked in 1993, the smoking population had dropped by half to about 16.4% in 2012. Tobacco regulations in South Africa have had the biggest impact on Black South Africans with respect to ethnic groups and on 16–24-year-olds with respect to age. The large decrease in tobacco consumption in these two groups reflects their high-price sensitivity to tobacco tax increases.

➢ Knowledge and skills of stakeholders. No information is provided on this matter.

FINAL REFLECTIONS

➢ Taxing as a policy to change behaviours can be very effective, as this case proved. However, according to the information provided, a parallel marked for illicit cigarettes was strengthened, which shows how important it is to have intersectoral dialogue and collaboration, in order to tackle all the potential new challenges that a law could create. New regulations will be needed to tackle this problem.

➢ The South African example has shown the significance of persistent anti-tobacco advocacy by both academics and NGOs. Policy-makers must collaborate with local academic institutions and NGOs in order to obtain data to form evidence-based decisions.

➢ This case also showcases the importance of the global governance on tobacco control and how it can effectively be used as a mechanism to influence national and local commitment.
EXPERIENCES OF INTERSECTORAL ACTION BY WHO REGION:

SOUTH-EAST ASIA
# CASE STUDIES

## THEMES ADDRESSED BY THE 8TH GLOBAL CONFERENCE ON HEALTH PROMOTION (HELSINKI)

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<sup>a</sup> Funded by WHO Ethics and Social Determinants of Health Department through Rockefeller Foundation Grant for Supporting Regional Positions on Health in All Policies, with WHO Regional Office for South-East Asia and WHO country offices in Bhutan, Nepal, Sri Lanka and Timor Leste.

<sup>b</sup> Funded by WHO Centre for Health Development (Kobe Centre) in collaboration with WHO Regional Office for South-East Asia and WHO country offices for India and Thailand.

<sup>c</sup> Funded by WHO Ethics and Social Determinants of Health Department through the Lighthouse project, supported by a grant from the Government of Brazil.
IMPLEMENTATION OF TOBACCO CONTROL POLICY IN BHUTAN: A VITAL PLATFORM FOR INTERSECTORAL ACTIONS

This example showcases progressive actions taken by the Royal Government of Bhutan to implement regulations that would progressively restrict and eventually ban the production, trade and use of tobacco. Many of these actions were enhanced by religious and temporal leaders who supported tobacco control. The government issued a ban on the sale of tobacco products in the whole country in 2004 and introduced smoke-free areas in 2005. The policy formulation went through a rigorous process of debates in the Parliament, and finally the Tobacco Control Act of Bhutan was enacted in 2010. The Act completely bans the cultivation, harvest, manufacture, supply, distribution and sale of tobacco and tobacco products in the country and imposes strict penalties for non-compliance. It not only empowered existing agencies to enforce tobacco control measures but also strengthened partnerships between different sectors. In 2011, with the Act fully in force, implementation of tobacco control measures became much more effective. The Act was further revised by Parliament in 2011, when legislation on Tobacco Control Rules and Regulations 2011 was enacted.

This case represents an example of intersectoral coordination and integration where the health sector plays a partnership role in a national initiative that exemplifies a whole-of-government approach to restricting the production, trade and use of tobacco. It fulfils many of the criteria established through the analytic HiAP framework.

OPPORTUNITIES FOR INITIATION

➢ Policy change window. The political will for HiAP is present at the highest level of the Royal Government of Bhutan, which took the main responsibility for leading negotiations and passing the Act through Parliament. The government also took responsibility for the implementation of the National Health Policy, through collaborative action at national, regional and international levels.

➢ International influences. The case follows international mandates, which the Kingdom of Bhutan not only agreed to but was also one of the leading countries in advancing and supporting. It signed the WHO Framework Convention on Tobacco Control in December 2003, which was ratified by the National Assembly, after reaching a consensus on imposing a nation-wide ban on tobacco sales and prohibiting smoking in public places. In compliance with the Framework, the government initiated the drafting of the Tobacco Control Bill in 2007.

KEY DRIVERS OF IMPLEMENTATION

➢ Vision of health. The government accords high priority to the happiness of its population through the model of Gross National Happiness (GNH), developed as the vision to promote sustainability, eradicate poverty, and enhance well-being and profound happiness – health being one of its pillars. The government integrates the GNH values into all of the national policy-making processes. Health is recognized as a requirement for economic development and poverty reduction.

➢ Relationships within governmental partners. The government has mandated that there should be a strong level of coordination between departments. From 2004 to 2010, it conducted a series of stakeholder meetings to enforce the regulations on the tobacco ban and tobacco smoke-
free areas more effectively. In 2010, it established the Tobacco Control Board, comprising: MoH, Secretary of Education, Ministry of Home and Cultural Affairs, the Police Department, Ministry of Economic Affairs, Ministry of Finance, as well as civil society members. The Narcotic Control Agency is the Member Secretary. This intersectoral action has a whole-of-government approach, where all relevant actors are involved in the design of the Act, the development of the policy and its implementation. The Tobacco Control Board and Tobacco Control Office implement the provisions of the Act in close collaboration with the relevant agencies. The Ministry of Economic Affairs supports the ban involving the production, manufacturing and sale of tobacco and tobacco products, while the Ministry of Finance regulates the importation of tobacco products. The Royal Bhutan Police, along with other agencies, enforce measures on the prohibition of smoking in the non-smoking areas, sale of tobacco products, and tobacco advertisements and promotion. The MoH is responsible for setting up demand reduction strategies, and establishing cessation clinics.

Relationships between governmental and nongovernmental actors. There is limited participation of non-state actors according to the information provided.

Key Domains of an Equity Lens in Policies and Interventions

Entry points to addressing social determinants of health. The policy addresses intermediate social determinants of health, as there are new regulations in place that affect all aspects of production, use and trade of tobacco. Health and the health impacts of tobacco are only a component of this multisectoral policy. The production and trade of tobacco is banned and its use is penalized. The focus is, however, on penalization rather than obtaining compliance through education and building communities’ awareness, so behavioural changes are predominantly based on the establishment of fines.

Coverage approach. The coverage is universal. The programme targets residents in Bhutan. However, it focuses on vulnerable groups, such as poor communities, difficult-to-reach populations, urban youth and schoolchildren.

Equity as an explicit target outcome of HiAP. Equity is not an explicit target outcome of this HiAP case, as the actions taken affected all populations equally. The policy affects the whole population and compliance is immediate.

Main approach to addressing equity. The policy does not tackle equity, as it affects the whole population. It does, however, develop specific actions affecting some vulnerable groups.

Role of health in the policy process. The Act emerged under the leading role of the MoH, which since the 1980s has provided information to other sectors to reduce and control tobacco use. The MoH implements the demand reduction strategies, including the establishment of cessation clinics, collects data related to the health impacts of tobacco use, trains personnel and raises citizens’ awareness of the harmful effects of tobacco.

Key Drivers of Sustainability

Mandates of structure, organization and budget. There are formal structures that can enable and sustain intersectoral work. The success of the tobacco control policy in Bhutan is mostly attributed to the sustained support it received from the different sectors and agencies at national, district and community levels. The membership of the Tobacco Control Board is intersectoral in nature, consisting of 11 members representing different government sectors and civil society organizations that
provide policy guidance to the Tobacco Control Office. Given that this case is an enforcement mechanism of the Act, there is no additional budget for its implementation, other than that already assigned to each participating agency.

- **Tools and mechanisms to strengthen interchange between sectors.** No tools and mechanisms in the information provided.
- **Knowledge and skills of stakeholders.** Although participation at the design stage was limited, since its inception in 2010, the Bhutan Narcotic Control Agency (BNCA) has been carrying out a public advocacy programme on the tobacco control Act and other measures for government officials, institutions, local government staff, security forces, students, the business community, taxi drivers, etc. As a result, people have become increasingly aware of the Tobacco Control Act 2010 and its regulations. Additionally, the Ministry of Education has been entrusted with developing awareness activities for the student population.

**FINAL REFLECTIONS**

- Key to the success of this initiative in Bhutan is the strong political will from all the governmental agencies and especially the executive power; the active engagement of key stakeholders from the beginning and joint planning of the regulations; the multisectoral approach of addressing the challenges of tobacco production, trade and use; and ownership and participation of key civil society figures, such as religious leaders. However, the sustained engagement of all sectors needs to be ensure at the implementation phase.
- The case also highlights the importance of the international movement and development of legal framework to address national challenges such as tobacco use. At the same time, given the leadership of Bhutan on the matter, global policy has also advanced with its contribution.
- Strong economic arguments support the implementation of tobacco control and regulation policies, which reduce the burden and cost to the health sector.
HAPPINESS FOR HEALTH AND HEALTH FOR HAPPINESS: DETERMINANTS OF HEALTH IN THE CONTEXT OF GROSS NATIONAL HAPPINESS IN BHUTAN

The concept of Gross National Happiness (GNH) was developed by Jigme Singye Wangchuck, the fourth King of Bhutan, in the late 1970s as a development philosophy, and since then it has guided modern development in the country, including development policies, projects and legislation. Its role and relevance increased during the reign of the present and the fifth King, His Majesty Jigme Khesar Namgyel Wangchuck due to the rapid transformation of the Bhutanese society triggered by the forces of globalization and the introduction of a parliamentary democracy in 2008. Bhutan’s pursuit of GNH has four pillars: equitable and balanced socio-economic development; conservation of natural environment; preservation of culture; and promotion of good governance. The four pillars have been the priority areas of the Royal Government of Bhutan’s five-year development plans. For the purpose of measuring GNH, nine domains were developed: psychological well-being; community vitality; health; education; living standard; good governance; cultural diversity; time use; and ecology. For many years, the GNH concept remained mostly as a value both at societal and governmental levels and the integration of its values into public policy was not empirically based, but intuitive. However, in 2010, the integration process was made systematic through the construction of the GNH index, a set of indicators and tools for screening GNH policies and projects. Bhutan’s efforts to measure variables of happiness are for no other practical reason than to inform policies, and address problems of the conventional growth domestic product (GDP) growth model.

This case represents an example of intersectoral integration towards the consolidation of a vision of development, where health sector is one of the sectors that needs to be addressed in order to achieve this vision of happiness. This example fulfils most of the criteria established through the analytic HiAP framework.

OPPORTUNITIES FOR INITIATION

› **Policy change window.** This endeavour, which informs all government actions, has the highest political support. The fourth and fifth Kings of Bhutan advanced it, and it has also been relevant during times of political change.

› **International influences.** Even though this approach is not influenced directly by international actions, it is aligned with the framework and vision established through the Millennium Development Goals (MDGs) debate and components, as well as the social determinants of health approach developed at the WHO.

KEY DRIVERS OF IMPLEMENTATION

› **Vision of health.** The Bhutanese people’s conception of health has both physical and mental components, and attainment of good health is not an end in itself, but only a means towards obtaining happiness, which is the ultimate end. The absence of diseases and mental sorrows is not enough; one must be enjoying happiness and peace. This traditional Bhutanese understanding and conception of health correlates with WHO’s definition: “Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.”
Relationships within governmental partners. GNH attempts to restructure government institutions towards fulfilling its goals, in an effort to integrate their work. The current government’s institutional structure corresponds with and echoes the sector composition of GDP in terms of ministries looking after agriculture, fisheries, forestry, electricity, mining, manufacturing, banking, etc. It is meant to deliver GDP and its growth. If happiness is the main public good, new organizations must be established to deliver it. It is to this end that the Gross National Happiness Commission (GNHC) was set up in 2008 to establish a common public policy and project framework for all government ministries and sectors, and streamline GNH into development plans. GNHC is driving socioeconomic development planning in Bhutan, with members comprising government secretaries, and chaired by the prime minister. It has improved efficiency and coordination between government ministries and departments so that they tread the same path towards a common goal.

Levels of administration of the government involved. GNH is fundamentally a holistic development concept. Multi-sector or multiple stakeholder participation at various levels with varying responsibilities is crucial. At the central level, there is GNHC and its secretariat, which is the overall coordinating body for the country’s development plans, policies and projects. At the ministerial level, there is a policy and planning division serving as the lead agency, which reviews policy and project proposals and aligns them with GNH. The policy and planning division then submits the policy to the GNH Committee established at the ministerial level. Once it passes the screening test, it is formally submitted to GNHC, which will form a GNH task force, with members coming from the GNHC secretariat, the Centre for Bhutan Studies and the policy and planning divisions of the lead agency (in ex-officio capacities), and other members pooled from different occupational and professional backgrounds. After studying the policy, the task force members will score against each indicator and aggregate the results. To reduce individual subjectivity, especially from those members coming from respective sectors, every task force member has to give reasons for their score. The GNHC will approve the policies that passed the test while those that fail will be sent back for review, or cancelation.

Relationships between governmental and nongovernmental actors. The approach calls for the participation of multiple stakeholders, although no specific examples are given with regards to the roles of nongovernmental institutions. Given the political structure, space for the participation of other sectors seem challenging.

Entry points to addressing social determinants of health.
The premise of this development philosophy is that money (GDP) alone is not enough to provide the people with a deeper level of well-being. Besides the economic capital that GDP tries to measure, GNH recognizes, values and measures other forms of capital or resources (social, cultural, human and ecological), which are equally important in creating conditions to achieve full human potential and optimize happiness. Under this perspective, the GNH strategy seems to address intermediate and structural determinants of health.

Coverage approach. Since this is a philosophy that informs all public actions and calls for the well-being of all its citizens, the approach is universal. At the same time, it is stated that the government pursues deferential policy to correct the inequalities generated by existing unjust institutions and structures. They understand that there can never be equity without giving preferential treatment through targeted policy and project interventions to vulnerable sections of society, such as ethnic minorities, women, the poor, the handicapped, or the illiterate, among others.

Equity as a target outcome, explicitly. GNH is concerned with equity affecting both present and future generations. Equitable and balanced socioeconomic development is one of the pillars of this vision. It has been the government’s explicit policy to achieve sustainable development, and to share the benefits equitably among different individuals, income groups and regions, thereby promoting social harmony and
justice. Health, education and other social and economic services are provided free by the State.

Main approach to addressing equity. Addressing an equity gap is one of the 26 indicators used for selecting all types of policies originating from different public sectors. Policy-makers and planners must ensure that whatever public policy or project they initiate must reduce the equity gap. Those policies or projects that address the equity issue are accordingly rewarded at the time they are screened. Similarly, “the government’s performance in reducing the income gap” is one important indicator in the good governance domain. The GNH index methodology, the depth measure (the depth of experience, i.e. the distance of persons from sufficiency conditions) looks at the average depth of deprivation and identifies whether the gap below the sufficiency cut-off is deepening or narrowing across time. This will allow the policy-makers to disaggregate the poorest or the unhappiest, and allocate additional budget, or shift resources from the happiest to the unhappiest.

Role of health in the policy process. Being one of the nine domains for policy development, the government assesses the health status of the population, the determinants of health, and the health system. Its indicators show information on self-rated health, disabilities, body mass index, number of healthy days per month, the prevalence of knowledge about HIV transmission, breastfeeding practices, and barriers to health services in terms of walking distance to the nearest health facility. Indicators were developed to assess the link between happiness and health. Based on surveys, this correlation was proven right, given that higher levels of health lead to happier life.

KEY DRIVERS OF SUSTAINABILITY

Mandates of structure, organization and budget. Creating new government institutions to reflect the thrust of GNH will become an important part of the institutional restructuring of GNH, if it is to gain deeper traction. Budget allocation happens through the traditional budget planning processes of the State, and since there is strong political support, it can be expected to be sustained.

Tools and mechanisms to strengthen interchange between sectors. It is very important to note the development of indicators for GNH as a tool for policy design and decision-making. The Centre for Bhutan Studies decided to measure GNH so that the empirical evidence generated can be used to influence public policy and projects. A wide range of indicators important for ensuring holistic development as well as ensuring maximum happiness for the people are measured within this framework.

Knowledge and skills of stakeholders. No information with regards to personnel training on the GNH strategy, although given its wide implementation, as well as the years since it was developed, there are new generations of public officers that are well informed on this philosophy.

FINAL REFLECTIONS

- One of the strengths of this example is the development of a holistic vision of governance and the role of the state that informs all actions and policies of the government – enhancing the importance of having a guiding principle for all policy design and implementation.
- Bhutan’s current political transition will be a test of how strong this philosophy is among the population and the levels of government, in order to adapt to the new institutional arrangement.
- Even though intersectoral institutional arrangements were not described sufficiently to understand how they function, the broader vision is based on an integrated approach to the role of the state and the well-being of its people.
THE ROLE OF INTERSECTORAL ACTION IN IMPLEMENTING THE WHO FRAMEWORK CONVENTION FOR TOBACCO CONTROL IN INDIA

The WHO Framework Convention on Tobacco Control (WHO FCTC) is a legally binding global treaty ratified by India in 2004. It provides the foundation to manage tobacco control programmes and elicit the cooperation of related sectors. A high-level governance structure, the National Tobacco Control Cell (NTCC) has been established in the Ministry of Health and Family Welfare (MOHFW) in collaboration with the WHO Country Office for India (WCO India) for overall policy formulation, planning, monitoring and evaluation of different activities envisaged under the programme. Every state has a State Tobacco Control Cell (STCC), which is responsible for planning, implementation and monitoring at state level. To drive the implementation of the WHO FCTC by different sectors, high level coordination committees have been established at national, state and district levels. Sensitization and training workshops on key topics are held regularly to help multisectoral stakeholders/ministries understand their role and how to implement the provisions of WHO FCTC. Some successes where intersectoral action has played a key role are evident. India has been able to achieve varying levels of compliance on most of the key provisions of WHO FCTC and MPOWER package.

This case describes how intersectoral action for health has contributed to the implementation of the WHO FCTC in India. It identifies the key mechanism and capacities that have enabled successful intersectoral action during the implementation, describes the outcomes and impacts that have been reached and identifies the key challenges and opportunities. This example fulfills many of the criteria established through the analytic HiAP framework.

OPPORTUNITIES FOR INITIATION

› **Policy change window.** The political will for HiAP is high, acknowledged by the fact that the Indian Parliament passed comprehensive tobacco legislation in 2003 called the “The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act. The law provides a mechanism to explore the interconnections between tobacco control targets with sectors other than health. It provides a platform to establish tobacco control as a ‘whole-of-government’ concern.

› **International influences.** India took a leadership role in the formulation of the WHO FCTC, and was among the first seven countries to ratify it in February 2004. The National Tobacco Control Cell (NTCC) was established in the Ministry of Health and Family Welfare in collaboration with WHO Country Office for India.

KEY DRIVERS OF IMPLEMENTATION

› **Vision of health.** The consequences of both direct tobacco use and tobacco attributed medical expenditures can be significant, specifically in a limited resource household. In a study conducted in 2011, findings showed that 18% of medical expenditures by rural households and 17% of medical expenditures by urban households were attributed to tobacco use. To address these health challenges, the MOHFW is working on intersectoral action between government bodies,
relationships within governmental partners. At the national level an inter-ministerial task force has been constituted under the Chairpersonship of Secretary (Health). The task force consists of Secretaries from 12 Ministries and/or Departments of the Government of India, which include the Ministry of Labour and Employment, Department of Commerce, Department of Revenue, Department of Industrial Policy and Promotion, Ministry of Agriculture, Ministry of Information and Broadcasting, Department of Higher Education, Ministry of Rural Development, Ministry of Tribal Affairs, Department of Women and Child Development, Department of Youth Affairs and Sports and the Food Standards and Safety Authority of India. The Ministries that have contributed towards tobacco control at the national and state level include: Ministry of Human Resource Development, Ministry of Information and Broadcasting, Ministry of Home Affairs, Ministry of Labour, Ministry of Railways and Ministry of Finance. In addition the Parliament, judiciary, civil society and media have also been significant allies for the advancement of tobacco control in India. Preliminary work is underway with the Ministry of Agriculture, Ministry of Labour, Department of Rural Development and Ministry of Environment and Forest for working out strategies to provide alternative livelihoods for those engaged in “ bidi-rolling”, “tendu leaf plucking” and tobacco cultivation.

Levels of administration of the government involved. The Ministry of Health and Family Welfare (MOHFW) established high-level coordination committees at the national, state and district levels. These serve to reiterate the role of other departments and ministries in tobacco control and bring them on board for implementation. Various guidelines and training manuals have been developed for state governments and other ministries and departments to facilitate effective implementation of specific sections of COTPA. To ensure effective and timely implementation of activities, the MOHFW sends notifications and communications to relevant central government ministries/departments as well as state governments. Wherever relevant, the central government sends these notifications to their state level counterparts.

Relationships between governmental and nongovernmental actors. NGOs have contributed by conducting advocacy with parliamentarians and other key stakeholders as well as generating awareness and mobilizing communities and conducting public rallies on key components of WHO FCTC. Litigation filed by civil society organizations has facilitated the government in the implementation of the tobacco legislation. The media in India is independent but plays an important role in awareness generation by keeping tobacco issues high on the public policy agenda.

Experiences of intersectoral action by WHO region: South-East Asia

KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS

Entry points to addressing social determinants of health. The policies address the intermediate social determinants of health. The consequences of both direct tobacco use and tobacco attributed medical expenditures can be significant, specifically in a limited resource household. Tobacco-related medical expenditure increased the poverty level to 28.4% in rural India and to 25.7% in urban India. Analysis of the second and third rounds of National Family Health Survey (NFHS) data revealed higher tobacco use among less educated, lower wealth, rural residence or lower caste men.

Coverage approach. The coverage approach is mainly universal as it affects the whole population.

Equity as a target outcome, explicitly. Equity is not an explicit target outcome in this case.

Main approach to addressing equity. Policies and strategies developed affect the whole population, but through the prioritization exercise, vulnerable populations’ needs are taken into consideration.

Role of health in the policy process. The MOHFW established a high-level coordination committee on tobacco control at the national, state and district levels. These serve to reiterate the role of other departments and ministries in tobacco control and bring them on board for
implementation. At the national level an inter-ministerial task force has been constituted under the Chairpersonship of Secretary (Health).

**KEY DRIVERS OF SUSTAINABILITY**

- Mandates of structure, organization and budget. The intersectoral partnerships set in place for the WHO FCTC/COTPA roll-out are made sustainable through the governance structures described previously. A sum of US$ 26.6 million was released by MOHFW to the National Tobacco Control Programme (NTCP) till 2012. Many of the intersectoral activities are supported by the MOHFW under NTCP.

- Tools and mechanisms to strengthen interchange between sectors. The NTCC is responsible for monitoring and evaluation and has developed detailed formats where intersectoral action (such as number of meetings held with different stakeholders, number of schools covered by the tobacco control programme, number of meetings held with relevant state government departments) is an important component.

- Knowledge and skills of stakeholders. Detailed guidelines and continuous training programmes of the implementers in the STCC, law enforcers, other nodal ministries, and representatives from the civil society ensure sustainability.

**FINAL REFLECTIONS**

- Strong political leadership along with bureaucratic support has been the guiding force behind the success of intersectoral action. In many states, cooperation and collaboration on key tasks/orders or release of funds to the programme could only be achieved after an order from the senior most official in the Nodal Department/Ministry.

- Catalytic role of the National Tobacco Control Cell and State Tobacco Control Cell: They facilitate the participation of key ministries in relevant meetings and conferences. This helps in sensitizing the stakeholders from other sectors and builds their ownership.

- Intersectoral coordination committees and consultations: The meetings at state and district level, which are convened at regular intervals, create a platform for dialogue with different stakeholder departments in the development of joint action plans. Formation of intersectoral committees provide a platform to sensitize other stakeholder departments on their role in tobacco control.

- National, regional, state and district level advocacy workshops on tobacco control organised by WHO/MOHFW in collaboration with CSO’s and state governments has catalysed implementation at all levels through the sensitization of key officials in various departments. Constant interaction has also helped in sensitizing new officials on the job.
In 2012, the Government of Nepal developed and implemented the Multisectoral Nutrition Program (MSNP) to address the causes and consequences of malnutrition through agreed nutrition determinants especially among infants, young children, adolescent girls and women. This was done through nutrition-specific as well as nutrition-sensitive interventions. Nutrition-specific interventions were targeted at improving feeding and care practices mainly through the health sector. Nutrition-sensitive interventions, such as food availability, affordability, access and quality were aimed at families and communities. These interventions were implemented through non-health sectors (agriculture, education, local development, and water supply and sanitation sectors, for example). In the 1970s and 1980s, Nepal developed strong multisectoral actions for nutrition that were discontinued because of several reasons, such as inadequate country capacity, and fluctuating donor policies and support. Based on 2009 research on nutrition undertaken by the government, the National Planning Commission (NPC) reconstituted the national Nutrition Steering Committee. With the support from the international community the MSNP was developed, and completed in 2011 through wider consultative and collaborative efforts involving various actors from the government, major donors, NGOs and civil society. Structures for intersectoral negotiation were very strong and have been present since the design of the programme. A multisectoral planning framework was used within the NPC to define strategic objectives, interventions, expected outputs, estimated budget, and monitoring indicators for each sector. Coupled with the existing decentralized governance structure under the mandate of the Local Self Governance Act (1999), this framework included the expansion of infrastructure for public health, education and agriculture.

This case represents an example of intersectoral coordination and integration, where the health sector is a partner with specific responsibilities within a broad and joint multisectoral framework where all relevant actors are involved. This example fulfils most of the criteria established through the analytic HiAP framework.

**OPPORTUNITIES FOR INITIATION**

› **Policy change window.** There is strong political will for HiAP, as these actions were coordinated by the government who convoked all relevant agencies. The Ministry of Health and Population raised concerns on achieving the MDGs 4 and 5 and the overall situation of nutrition in the country. Based on this, the NPC took a leading role in generating political commitment for a multisectoral intervention.

› **International influences.** There is an international mandate for this endeavour, within the MDGs, to which Nepal has subscribed. The international community, through UN agencies predominantly, has supported and accompanied the development and implementation of the MSNP.
KEY DRIVERS OF IMPLEMENTATION

› **Vision of health.** The lifelong consequences of malnutrition are of the highest concern. The programme involved actions by other sectors and in social policies, focusing on the social determinants that impact on nutrition. The health sector was instrumental in presenting the data and motivating the NPC to take multisectoral action.

› **Relationships within governmental partners.** There is strong coordination and even integration within and between governmental partners. Governmental agencies are all equal partners called in to jointly address this issue. Structures were put in place to guide the national focal officers of sectoral ministries and external development partners. Provisions for cross-sectoral linkages were included in the plan as determined by systematic consultations in the MSNP. A prioritization exercise was undertaken to finalize the costing and to develop a detailed plan of action. Supporting the coordinating actions of the NPC, goals and roles were defined for the Ministry of Health and Population, Education, Physical Planning and Works, Agriculture and Cooperatives, Local Development and Social Protection, among others. The interventions and their expected MSNP outputs through these agencies were: policies and plans updated/reviewed to incorporate nutrition-specific indicators at national and local government levels; multisectoral coordination mechanisms functional at national and local government levels; maternal and child-care service utilization pattern changed; adolescent girls’ education, life skills and nutritional status improved; reduced episodes of diarrhoeal diseases and acute respiratory infections among mothers, adolescents, infants and young children; feeding behaviours improved with increased availability and access to appropriate food (in quality, quantity, frequency and safety); capacity of national and local government enhanced to provide appropriate support to improve maternal and child nutrition; and multisectoral nutrition information updated and linked both at national and local government levels.

› **Levels of administration of the government involved.** All levels of the government are involved, where roles, actions and follow-up mechanisms are assigned to all participating agencies, including their local and district-level operators. The implementation was decentralized and was gradually phased in the regions. Initially, it was developed in selected districts (2012–2014) and will be gradually scaled up to all other districts by 2016.

› **Relationships between governmental and nongovernmental actors.** The role of external development partners and NGOs has been to support and strengthen the government system. Additionally, media, especially newspapers and television, have been very helpful in publicizing the MSNP.

KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS

› **Entry points to addressing social determinants of health.** This case addresses the social determinants of health at a structural and intermediate level, as recommended by the Nutrition Assessment and Gap analysis (NAGA) developed by the Ministry of Health and Population. It was understood that: consequences of stunted growth are profound, irreversible and span the life course; under nutrition contributes to more than one third of child mortality; and those children who survive malnutrition are most likely to lead a diminished life due to lowered economic productivity and increased risk of nutrition-related chronic disease in later life. Hence, multisectoral action was called to: improve nutrition architecture, food availability, access and affordability, and food and care-related programmes; and strengthen the design, targeting and monitoring of nutrition interventions. The MSNP seeks to enhance human capital, improve maternal and child nutrition and put in place intersectoral structures and objectives to address social determinants that affect nutrition.

› **Coverage approach.** The coverage approach is universal and targeted, as it plans to reduce the gradient among quintiles on nutrition while focusing on the most vulnerable communities and eventually implement it throughout the country.

› **Equity as a target outcome, explicitly.** Equity is an explicit target outcome. The data used to design
the plan, such as periodic surveys from the Demographic Health Survey (DHS) have shown high levels of inequity between wealth quintiles, gender, geographical area and socially excluded communities in nutrition as well as other health areas. Achieving equity has been one of the major factors triggering the selection of deprived and remote regions for rolling out the MSNP during the first phase.

- **Main approach to addressing equity.** Focus placed on gradient gaps, as this initiative seeks to respond to a widening of the gap in nutritional status across wealth quintiles – where children from lowest wealth quintiles have the highest burden of malnutrition.

- **Role of health in the policy process.** The health sector has been actively involved in the policy development and implementation of the initiative, as becomes a partner with the other sectors for a multisectoral framework where all relevant actors are involved.

**KEY DRIVERS OF SUSTAINABILITY**

- **Mandates if structure, organization and budget.** A strong mandate and structures enable and sustain intersectoral work. The NPC has designed both horizontal and vertical mechanisms for coordinating development and implementing the MSNP in Nepal. Horizontal coordination mechanisms include:
  - High-level National Nutrition and Food Security Steering Committee (NFSSC) chaired by the Vice-Chairman of the NPC, which leads coordination among sectoral ministries and development partners, and gives policy directives to sectoral ministries;
  - technical committee with key technical experts from government, development partners, the private sector, academia, and civil society organizations under the NFSSC;
- Nutrition Secretariat: nutrition information management and monitoring and evaluation, advocacy and coordination, and capacity building.

Vertical coordination mechanisms include district and village level coordination committees. They review and endorse nutrition-related programmes, which will be implemented in the districts and at the Village Development Committee level. With regards to funding, a budget was secured for the initiative. A Basket Fund was established by pooling donor and government funds and is administered by the Ministry of Finance. The Management and Reconciliation of the Basket Fund is carried out by a secretariat established at the NPC. AID coordination is the responsibility of the NPC.

- **Tools and mechanisms to strengthen interchange between sectors.** Indicators were developed for goals, purpose, and outcomes and outputs for all sectors. As the MSNP was rolled out in April 2012, an impact evaluation has not yet been carried out. There is a plan to do baseline, mid-term and final evaluations.

- **Knowledge and skills of stakeholders.** Limited information is provided. Nonetheless, when interviewed, the stakeholders acknowledged the need to raise awareness and train human resources at all levels. The need to strengthen the institutional capacity at national and district levels was also raised.
• The role of the health sector was key in mobilizing the Government of Nepal in order to address nutritional challenges from a multisectoral perspective – showing a better understanding of the consequences of under nutrition and its negative impact on human resources, which can retard national development efforts.

• Along with strong political support, the existing decentralized governance structure under the mandate of the Local Self Governance ACT (1999) was crucial in ensuring an all of government approach.

• Lessons learnt from the evolution of the MSNP, including advantages and disadvantages, and the latest revitalization and restart of the programme, indicate that HiAP can be institutionalized. MSNP in Nepal provides an extensive and detailed process of programme development through intersectoral collaboration, as well as the development of a five-year strategic plan with all the necessary linkages, roles and responsibilities of each sector identified, budgets assigned and monitoring and evaluation processes in place.
LEARNING FROM LOCAL CASES AND INNOVATION TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH IN SRI LANKA: THE METRO COLOMBO URBAN DEVELOPMENT PROJECT

The Ministry of Defence and Urban Development (MoDUD) of the Government of Sri Lanka was in charge of the Metro Colombo Urban Development Project (MCUDP), with goals to reduce flood risks and improve urban infrastructure and services, and to support local authorities in the Colombo Metropolitan Area to rehabilitate, improve and manage local infrastructures and services. The project consists of two components. The first one focused on interventions to address the urgent issue of urban flooding, which regularly paralyzes the economy of the Colombo Metropolitan Area with high socioeconomic costs. The second component focuses on urban development and infrastructure rehabilitation for Metro Colombo Local Authorities through strengthening strategic planning processes at the metropolitan level, and supporting local authorities to: (i) rehabilitate and manage their drainage infrastructure and streets; and (ii) improve solid waste collection. The total population of the four local areas was about 1 066 000 in 2011. Activities included improving pedestrians’ access to pavements and parking within the metro Colombo area, reducing traffic and improving the general living standards of the residents. While thus far, the Public Health Department of the Colombo Municipal Council have not been involved in the planning, implementation, or the monitoring and evaluation of the project, positive results have been observed for health. These include lower pollution levels, and a reduction in the incidence of dengue, which had been prevalent in the areas with slum dwellings.

This case represents an example of limited intersectoral action of collaboration and coordination, where the health sector is not an active participant, but where health benefits are observed from the implementation of the project. This example fulfils some of the criteria established through the analytic HiAP framework.

OPPORTUNITIES FOR INITIATION

- **Policy change window.** The political will for HiAP seems to be weak, as the health sector was not formally consulted nor did not coordinate in the design and implementation of this project, which, as stated in the information provided, could have benefited the impact of the intervention. Nonetheless, some health aspects were considered by the operating agencies.

**International influences.** A WHO regional consultation held in Sri Lanka in 2007 led to the development of the Regional Strategic Framework on Inter-sectoral Actions addressing Social Determinants of Health. The Colombo Call for Action that emerged in 2009 supported mainstreaming health equity in all policies, empowering individuals and communities, and advocating for good governance and corporate social responsibility.

KEY DRIVERS OF IMPLEMENTATION

- **Vision of health.** There is no explicit vision of health. Health is not the broad objective of the initiative. Health is addressed by improving infrastructure and behavioural
issues within the communities where the programme intervenes, for example in terms of waste management to minimize flooding from drainage obstruction.

**Relationships within governmental partners.** Significant relationships within and between governmental partners are predominantly through the exchange of information processes. The project was implemented in coordination with four urban local government bodies: (1) Colombo Municipal Council, (2) Dehiwela-Mount Lavinia Municipal Council, (3) Sri Jayawardenapura-Kotte Municipal Council, and (4) Kolonnawa Urban Council.

**Levels of administration of the government involved.** The MoDUD of the Government of Sri Lanka was the ultimate responsibility of the experience via the MCUDP, although this was predominantly developed by the local authorities, and no further description is provided with regards to central government.

**Relationships between governmental and nongovernmental actors.** There is limited participation of civil society.

### KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS

- **Entry points to addressing social determinants of health.** This case addresses the social determinants of health predominantly at structural and intermediate levels. The key social risks and issues identified in the social impact assessment were: (i) mitigating potential involuntary resettlement, and any adverse impacts on physical and cultural resources; (ii) promoting social inclusion and accountability; and (iii) supporting sustainable management of the resettlement sites developed.

- **Coverage approach.** Universal, addressing the needs of the whole community served.

- **Equity as an explicit target outcome of HiAP.** Equity is not an explicit target outcome of this case. Past analyses of health for all Sri Lanka laws and policies showed commitment to universal social welfare policies in relation to health services, education, land development, agriculture and food. However, these policies had no specific explicitly formulated aims to address health equity and measure change.

- **Main approach to addressing equity.** The programme focuses on vulnerable groups, by selecting the communities served at risk of flooding and its social consequences.

- **Role of health in the policy process.** The health sector does not participate in this initiative.

### KEY DRIVERS OF SUSTAINABILITY

- **Mandates of structures, organization and budget.** There is not a strong mandate or structures that can enable or sustain intersectoral cooperation. On the contrary, concerns were raised in the social assessment of the project. Intersectoral collaboration was limited, and the health sector was even excluded from this initiative. The budget is not assured for the long term. The Government of Colombo received financial assistance from the World Bank for this initiative, although it is not clear if that support is continuing.

- **Tools and mechanisms that can strengthen interchange between sectors.** Social and environmental impact assessments were developed to inform the implementation of both components of the project. One of these assessments revealed that it is possible that the involvement of the health sector would have improved the interventions, especially when considering alternative residential facilities.

- **Knowledge and skills of stakeholders.** Through this programme, the Government of Colombo supports local authorities to enhance their capacity to deliver sustainable and quality local services, and coordinate at the metropolitan level. It also provides institutional strengthening support for local authorities by providing on-the-job training to implement a number of selected demonstration projects and to respond effectively to local demand for better services and infrastructure.
This case shows that a HiAP approach will be considerably weaker when the health sector does not participate. The project would have benefited from inputs from the health sector especially when considering alternative residential facilities and providing psychosocial support to affected persons during the implementation of the project.

It is very premature to see this case as a HiAP example. Apart from the exclusion of the health sector, there is a need to sensitize and to make other sectors aware of the need to consider HiAP and of the benefits of considering HiAP as an instrument for sustainable development.
LEARNING FROM LOCAL CASES AND INNOVATION TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH IN SRI LANKA: THE ALAWWA HEALTH PROJECT

The Alawwa Health Project was initiated with the goal of addressing health inequalities in the Alawwa Division through coordinated action on social determinants of health and revitalization of the primary health care (PHC) approach by: (1) identifying the disparities and inequalities in health-service delivery, and utilization and health outcomes, particularly in relation to NCDs, malnutrition, tobacco and harmful use of alcohol; (2) analysing the social determinants that have caused these disparities (income, education, gender, social exclusion), and determining the potential areas and pathways for intervention; and (3) introducing HiAP in the PHC model, at policy and implementation levels that would reduce and mitigate the inequalities caused by social determinants. The project was located in the Alawwa Divisional Secretariat area of the Kurunegala District of the North Western Province of Sri Lanka. It is a rural area with an economy primarily based on agriculture predominantly with paddy and coconut cultivation. Poverty is a major problem in the area where, in spite of land ownership by the community, there is no proper land development.

This case represents an example of local intersectoral collaboration and cooperation, where the community identifies challenges in the framework of social determinants of health and works towards solutions. This is a bottom-up example that, in spite of not having a national mandate, has had a real impact on the community and an example that fulfils some of the criteria established through the analytic HiAP framework.

OPPORTUNITIES FOR INITIATION

› Policy change window. The political will for HiAP is present at the local government authority level.
› International influences. WHO provided assistance to initiate the project.

KEY DRIVERS OF IMPLEMENTATION

› Vision of health. The vision of health is closer to social indicators as all aspects of the community’s life were considered in order to address PHC and access to health, especially as a consequence of NCDs, malnutrition, tobacco use and the harmful use of alcohol.
› Relationships within governmental partners. At local level, there are cooperation and coordination relationships within and between partners, although not all of them are governmental actors. The concept of a health promotion village was based on the perceived needs of villagers to tackle common problems identified by the same communities, such as lack of interaction between preschool children, alcohol abuse, neglected lands, garbage disposal breeding mosquitoes with dengue, lack of information on nutrition, and NCD prevention. The Medical Office of Health staff guided this needs assessment process.
› Levels of administration of the government involved. This is a local initiative. Participation of other levels is limited and only responds to specific needs. For example, state sector institutions provided technical assistance for the design of programmes that could improve agricultural practices (such as a one-day programme on composting,
improving the efficiency of coconut cultivation, and education and plant distribution programmes targeting minor crops). To face the uncertainty of the weather and scarcity of water, a reservoir was built in land donated by philanthropists using technical input provided by the Department of Irrigation. This reservoir ensured a sufficient supply of water for cultivation in the village throughout the year.

> Relationships between governmental and nongovernmental actors.
Intersectoral groups with formal and informal representation to promote health in all policies were established including civil society actors for decision-making and priority setting exercises listed below.

- Village level activities spearheaded by the Grama Niladhari (Village Headman), Public Health Midwives and Agriculture Extension Officers, teachers and religious leaders. At this level, emphasis was placed on the implementation of policies that supported and promoted health, and on the identification and resolution of health inequalities.
- Divisional level activities under the auspices of the Divisional Secretary in collaboration with representatives of civil society groups, local government bodies and the private sector.
- There is evidence of integrated policy development and implementation for dengue control and nutrition. Interventions on sustainable primary NCD prevention activities, home gardening which affects income as well as nutrition and first aid training for school children have been introduced.

Additionally, civil society is engaged at the implementation level, where the community become their own agents of change. Initially 15 consenting villagers from each village are requested to attend a meeting with the area Public Health Midwife, the field worker primarily in charge of maternal and child health, to form a committee that would liaise health promotion activities in the village. Other villagers are also invited to join at any time if they so wish. This group then identifies problems they perceive as important. The problems are analysed and suitable solutions are worked out considering the resources available and the advice of the Medical Office of Health staff.

KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS

- **Entry points to addressing social determinants of health.** The programme addresses social determinants of health predominantly at an intermediate level, responding to immediate needs and seeking informal solutions, rather than reverting the structure that creates them. It also tackles structural determinants at local level where the community leaders adopt actions that strengthen a more HiAP approach to PHC.
- **Coverage approach.** Universal, within the relevant communities.
- **Equity as a target outcome, explicitly.** Although it is not an explicit goal, the project was developed to address health inequalities in Alawwa Division through coordinated action on social determinants of health and the revitalization of the PHC approach.
- **Main approach to addressing equity.** The focus is on the gradient and gaps in PHC in the communities where the intervention is undertaken.
- **Role of health in the policy process.** The participation of other sectors such as health is convoked as needed during implementation. The health sector provided a NCD clinic that was run every Saturday by the Medical Office of Health staff to screen blood pressure, sugar levels and body mass index.

KEY DRIVERS OF SUSTAINABILITY

- **Mandates of structure, organization and budget.** Although the project was initiated with a very broad objective and no specific measurable goals to achieve, it has built bridges between the health sector and other sectors, such as agriculture, education, local government, community groups and voluntary organizations. Nonetheless, there is no strong mandate or structures to enable or sustain intersectoral cooperation in this
local example. Hence, according to the data, stronger institutionalization at local level is needed. WHO funded this project. The Provincial Health Authority provided the funds for the NCD clinic. Each component of the project depends on finding its own funding. There is, however, some commitment where local authorities allocate approximately 23% of their annual budget for health-related activities.

- **Tools and mechanisms to strengthen interchange between sectors.** The exercise mapped all households with layers of social determinants of health which could become a baseline to compare the results of the intervention, and a database for further analysis of the information.

- **Knowledge and skills of stakeholders.** Education and training of a group of leaders on the prevention of substance abuse and healthy living was an important component of the project. Additionally, public health field staff provided the community with lectures and demonstrations. The topics vary depending on the preferences of the community and include issues such as nutrition, smoking, and drug and alcohol abuse. Finally, 80 volunteers were trained in several disciplines. These included home gardening and first aid. Other topics covered were NCD and alcohol abuse. The challenge has been to retain the trained volunteers as many move when they get married or find employment.

**FINAL REFLECTIONS**

- The example in the Alawwa Health Project shows how an all of government, and even all of stakeholders and community, approach can be effective at a local level. Working with local government authorities is relatively easy as less coordination is required and the project has a direct impact on the community.

- PHC at grassroots level is closely engaged with the community. Community ties and bonds can be harnessed to show results. This may also be used to sensitize policy-makers on the need to consider HiAP and the benefits that can accrue.

- Good leadership and governance, and strong political commitment are essential nonetheless. This project had the support of the local government authority.

- This case is heavily dependent on a strong and engaged community, as social participation is present both when identifying needs and health considerations, and at the implementation phase. It also risks losing volunteers, who after training could become more marketable for formal employment outside the community.
THAILAND’S NATIONAL HEALTH ASSEMBLY: INTERSECTORAL ACTION FOR HEALTH

In 2000, the National Health System Reform Committee and the National Health System Reform Office (HSRO) were established to steer health systems reform in Thailand and mandated to draft the National Health Bill. Roles of civil society were promoted to engage in the health reform activities, and, since then, active intersectoral collaboration has begun. The draft National Health Bill was discussed, revised and completed with more than 500 brainstorming sessions attended by over 400,000 people from various sectors and organizations. The draft Bill was passed and enacted in 2007. The Act serves as an effective legal framework to set guidelines on the national health development in which all parties in society, not only in the health sector, have a stake through participatory approaches and intersectoral actions. The National Health Assembly (NHA) was mandated by Law to be convened annually. The NHA is a legitimate multi-stakeholder platform to support participatory public policy formulation taking into account a health lens in such policy-making with full engagement by the three powers at all stages of policy development. A National Health Commission (NHC) was established to ensure intersectoral coordination. The NHC can make suggestions or give advice to the Cabinet related to policies and strategies on health, which approves policies and strategies.

This case represents an example of an intersectoral coordination and integration effort, where all the state apparatus realigns its priorities and objectives to collaborate in the design and implementation of health policies throughout the various sectors and levels of government. Many of the HiAP criteria are present in this case.

KEY DRIVERS OF IMPLEMENTATION

› Vision of health. According to the Act, the paradigm of the health system has radically shifted as health is now defined not merely as the absence of disease or infirmity, but as a broader term, which includes physical, mental, spiritual and social aspects interrelated holistically in a balance manner.

› Relationships within governmental partners. This is an effort to integrate all levels and sectors of government in order to address health challenges. Intersectoral participation and actions in the organizational structure include: the National Health Assembly Organizing Committee (NHAOC) (which convenes the NHC and is represented by three powers of government); the NHA forum (with more than 230 constituents from the provincial level, national government, political actors and the knowledge sector); agenda setting (health issues and concerns are submitted by partners from all sectors to the NHAOC and are the considered for the NHA agenda); development of evidence and information (basic documents and draft resolutions developed based on the agenda items and including multiple stakeholders consultations, negotiations and consensus); the NHA forum (where quality deliberations take place and the adoption of resolutions are made by consensus); implementation and

OPPORTUNITIES FOR INITIATION

› Policy change window. There is strong political will for HiAP, as this has been a process led by the prime minister, who convoked all sectors for an integral approach to health.

› International influences. There is no international mandate or influence referenced in this case.
impacts of NHA resolution (NHA resolutions are submitted to the Cabinet, for either acknowledgment or approval for further actions by the concerned department, ministries and agencies).

- **Levels of administration of the government involved.** This is a case of a whole-of-government approach, where all levels of government have a voice. Additionally, the health assembly can be organized at different levels (locally, area-based, and at national health assemblies).

- **Relationships between governmental and nongovernmental actors.** Nongovernmental actors are actively involved in setting the agenda, and in the planning and decision-making processes within the NHA.

**KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS**

- **Entry points to addressing social determinants of health.** The case addresses social determinants of health predominantly at an intermediate and structural level, given mandates for implementing programmes and strategies for specific health issues to all relevant sectors of government through the NHC.

- **Coverage approach.** The coverage approach is mainly universal as it affects the whole population.

- **Equity as an explicit target outcome of HiAP.** Equity is not an explicit target outcome of this initiative.

- **Main approach to addressing equity.** Policies and strategies developed affect the whole population, but through the prioritization exercise, vulnerable populations’ needs are taken into consideration.

- **Role of health in the policy process.** The health sector was involved in the policy development, implementation, and monitoring and evaluation stages of this initiative.

**KEY DRIVERS OF SUSTAINABILITY**

- **Mandates of structure, organization and budget.** The broader scope of health and the emphasis

on the importance of the participatory process have led to the establishment of a new organizational structure, the National Health Commission (NHC), chaired by the prime minister. To ensure intersectoral coordination on health, composition of the NHC includes representatives from three major constituencies: (a) the government sector (ministers from related ministries such as the Ministry of Public Health, Ministry of Social Development and Human Security, Ministry of Education, Ministry of Interior, Ministry of Agriculture and Cooperatives, as well as representatives from Local Administrative Organizations at all levels); (b) the professional sector (both senior experts from different fields and representatives from health professional councils); and (c) the people (provincial representatives of non-profit organizations).

- **Tools and mechanisms that can strengthen interchange between sectors.** The NHC established the Monitoring and Evaluation Committee as a mechanism to continuously follow the progress and impact of the resolutions.

- **Knowledge and skills of stakeholders.** No information is provided on this issue.

**FINAL REFLECTIONS**

- This is a very strong HiAP case for policy design and implementation.

- Although more information will be needed to understand its effectiveness, this collective process will ensure strong support from all stakeholders for the implementation of the strategies that may be agreed upon and mandated by the Cabinet.

- The case is also a strong example of the importance of political will and commitment throughout an extended period of time in order to ensure the success of the policy design model developed.

- It will be important to monitor the impact on health of the implementation of the strategies designed through this process, as well as the potential influence of interest groups.
The recent and fragile state of Timor Leste has undertaken actions to improve its governance, and rebuild its state after the era of conflict. This plan included the design of intersectoral strategies in public policies. Within the framework, the Timor-Leste Strategic Development Plan 2011–2030 (SDP) was launched in July 2011 (among other strategies and policies), as a long-term development vision on social capital, infrastructure development and economic development. Within social capital, issues of education and training, health, social inclusion, environment, culture and heritage are included. Specific policies and strategies were later developed in each sector, health being among them. The first National Development Plan in 2002 put forward a development vision on agriculture, education, health and infrastructure. The Plan proposed focuses on the reduction of poverty in all sectors and regions of the nation, and the promotion of economic growth that is equitable and sustainable, improving the health, education and well-being of everyone in East Timor. Other governmental actions that proposed intersectoral actions include the Program of the V Constitutional Government, 2012–2017, the National Program for Development of Sucos (Villages), 2013–2020.

This case represents an example of an intersectoral coordination effort, where all of the state apparatus realigns its priorities and objectives and is rebuilt after the era of conflict. Even when this presentation does not provide information specifically on HiAP, it can be argued that some criteria established through the analytic HiAP framework are present.

**OPPORTUNITIES FOR INITIATION**

- **Policy change window.** There is political will for HiAP, since there is a strong intersectoral approach to governance as a whole. The institutional rebuilding of the country is based on multisectoral strategies and policies.
- **International influences.** There is no international mandate for these actions, although some of the policies and strategies were guided by the commitment to advance the MDGs.

**KEY DRIVERS OF IMPLEMENTATION**

- **Vision of health.** The vision of health seems to be closer to social indicators. The Health Policy Framework, 2002, was the first policy document produced by the MoH in June 2002 and approved by the Council of Ministers in 2003. Recognizing the role of other determinants of health, it underlined the need for a multisectoral approach to health. The National Health Sector Strategic Plan 2011–2030 is based on the National Health Policy Framework 2002, and the National Strategic Development Plan 2011–2030. NHSSP provides a 20-year vision for health. The vision statement “Healthy East Timorese people in a healthy Timor-Leste” is a reflection of the role of other determinants of health: education, income, housing, food, water and sanitation. It underscores the need for a multisectoral approach. Promoting inter-sector collaboration is one of the guiding strategies under the sector-wide approach to health-service delivery.
- **Relationships within governmental partners.** The policy and normative body established within this
state calls for strong cooperation within and between governmental institutions. The policy clearly assigns roles and responsibilities to the main stakeholders. Its development process was resource intensive and lasted for three years. Existing intersectoral governance structures and mechanisms can serve as an important way of strengthening intersectoral action for health, and promoting the implementation of HiAP. Key among these are the Presidency of the Council of Ministers (which approves all governmental policies for implementation), the Parliamentary Committees, the National Priorities Process, the Thematic Technical Working Groups and the Inter-ministerial Coordination Committees and processes for stakeholder engagement.

- Levels of administration of the government involved. The majority of the intersectoral strategies and policies were drafted to inform national level government actions. Nonetheless, it is noted that over 70 community consultations in sucos [villages] across Timor-Leste were part of the Strategic Development Plan 2011–2030 design process.

- Relationships between governmental and nongovernmental actors. At this planning phase, there seems to be limited participation of other partners including civil society organized and unorganized.

**KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS**

- Entry points to addressing social determinants of health. The case addresses social determinants of health predominantly at an intermediate level. There is an understanding that health requires multisectoral structures and actions, as their policies call for: a reduction in the negative environmental determinants of health and well-being (water, air, sanitation, food supply and quality, physical safety, etc.); the treatment of illness, prevention initiatives and interventions for common disabilities; the improvement of knowledge, skills and competencies for individuals and groups; better use of and improved access to essential resources to those in need; and the strengthening of social support mechanisms, practices and policies; among others.

- Coverage approach. The coverage approach is mainly universal as it affects the whole population.

- Equity as an explicit target outcome of HiAP. Equity is not an explicit target outcome of these strategies and policies. The National Development Plan, which framed the specific strategies and policies that affect health focused on two overriding development goals: to reduce poverty in all sectors and regions of the nation; and to promote economic growth that is equitable and sustainable, improving health, education, and the well-being of everyone in East Timor.

- Main approach to addressing equity. Focuses on vulnerable groups.

- Role of health in the policy process. In the formulation of policies as part of the Strategic Development Plan, the health sector collaborated with education, social services, agriculture, infrastructure, state administration, transportation and the police. For example, health education is led by education but in coordination with health; nutrition and food security is developed with agriculture and fisheries, national disaster risk management and preparedness is led by social solidarity along with health; food safety bring together the ministries of tourism, commerce and industry, agriculture and fishery, education and finance.

**KEY DRIVERS OF SUSTAINABILITY**

- Mandates of structure, organization and budget. There is a strong mandate and structures that have the potential to enable or sustain intersectoral cooperation in the policy design for HiAP, although it is reported that given its recent establishment, it remains to be seen how effective they are in the implementation phase. The budget allocation is ensured through the traditional budgetary process coordinated by the Ministry of Finance. No further information is provided with regards to funding of the specific intersectoral structures set up and their action plans.

- Tools and mechanisms that can strengthen interchange between sectors. No monitoring and
evaluation mechanisms have been established in this first phase of the programming.

Knowledge and skills of stakeholders. It is highlighted that experience thus far indicates that intersectoral work has been hampered by the lack of financial and human resources, limited intersectoral and intra-sectoral coordination capacity within MoH, which includes a limited understanding of where the substantive inter-linkage among sectors lies. The Intersectoral Action Framework (IAF) identifies “improving knowledge, skills and competencies for individuals and groups” as a key insight into how health can address the issue of inter-linkages with other policies.

FINAL REFLECTIONS

• The case presented showcases the drafting and first phase of implementation of policies in the framework of the initiation of a new government. Potential to adopt HiAP is strong, given the establishment of intersectoral policies, strategies and bodies, although the state it is still in its formative stage.

• Given the recent revision of the state apparatus, training and capacity building should be strengthened.

• Not only there is a strong political will to rebuild the state apparatus, but also the opportunity for social change through intersectoral actions, such as HiAP, that can affect a post-conflict population.

• Human resources will require preparation to respond to this vision, given the lack of cross-disciplinary working in implementation and intra-sectoral coordination within health sector, which are also key considerations.
EXPERIENCES OF INTERSECTORAL ACTION BY WHO REGION:

WESTERN PACIFIC
# CASE STUDIES

## THEMES ADDRESSED BY THE 8TH GLOBAL CONFERENCE ON HEALTH PROMOTION (HELSINKI)

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* Not determined.

* Funded by WHO Ethics and Social Determinants of Health Department through Rockefeller Foundation Grant for Supporting Regional Positions on Health in All Policies.
Using Emergency Power to Mobilize Improved and Whole-of-Society Action on NCDs: The Case of Palau

In May 2011 the former president declared a State of Health Emergency on Non Communicable Diseases (NCDs) and ordered the use of the Ministry of Health Incidence Command System to manage the crisis brought about by NCDs. As part of Executive Order 295, he also ordered all ministers and heads of national government agencies in Palau to assist the Minister of Health in this effort as required. On 26 January 2012, the first national summit on NCDs was held in Palau where all attendees presented the services that they performed and indicated future activities to contribute to reducing the burden of NCDs. The summit resulted in the development of a draft National Strategic Action Plan for the Prevention and Control of Non-Communicable Diseases, which has seven strategic areas, although it is still in development and is not an official document.

This case represents an example of intersectoral cooperation and coordination, where the president puts the whole state apparatus under the leadership of the MoH to develop a national plan to address NCDs. It fulfills many of the criteria established through the analytic HiAP framework, and has the potential of being a strong example once the plan is approved and implemented.

Opportunities for Initiation

- Policy change window. There is political will for HiAP at the highest level, given the president’s personal commitment and the call for action through the Declaration and executive orders that were issued.

- International influences. The case follows an international mandate. In April 2010, at their 48th meeting the Pacific Islands Health Officers Association (PIHOA) – a non-profit organization – generated a resolution declaring a regional state of health emergency on NCDs and calling for all countries within the Association to make a similar declaration at national level. The ministers called on leaders of the Pacific Forum to tackle the crisis through eight actions including: positioning NCDs as a health and development crisis, pursuing a whole-of-government and whole-of-society response involving all sectors, and requiring all agencies and regional health agencies of the Council of Regional Organizations in the Pacific (CROP) to play an active part and report back every two years to the Pacific Leaders Forum on actions and progress.

Key Drivers of Implementation

- Vision of health. The vision of health for this initiative is closer to social indicators, as NCDs are addressed from sectors outside health, and the emergency situation is not only tackled from the exclusive clinical perspective.

- Relationships within governmental partners. There is cooperation and coordination among the different federal agencies at this stage of the planning process. There are structures for intersectoral negotiation. The Hazard Mitigation Sub-Committee (HMSC) of the National Emergency Committee (NEC) is responsible for ensuring that the outcomes of the 2012 Summit are developed into concrete actions. This multisectoral body is comprises the sectors of: health, education, Palau National Olympic Committee, the President’s Office, public safety, revenue and taxation, cultural affairs, public works, Palau Community College, the Attorney General, agriculture, lands and survey, marine resources and the
Palau National Congress (the OEK). Other sectors and agencies, which are not members of the HSMC but participated in the Summit, are also considered to be members during the NCD crisis.

- **Levels of administration of the government involved.** Only the national government is involved at this planning stage, according to the information provided. It remains to be seen how sub-national agencies will act during the implementation phase.

- **Relationships between governmental and nongovernmental actors.** These actions were spearheaded by PIHOA, which is an international non-profit organization, whose advocacy influenced governmental action. They have hence supported the priority setting process, although their involvement in the implementation phase is not clear.

### KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS

- **Entry points to addressing social determinants of health.** Intermediate social determinants of health are addressed. The PIHOA, Palau and related declarations underline the importance of tackling the social determinants of NCDs. It is not clear that structural social determinants of health are addressed in the proposed plan, as it only seems to be calling for action from among the current institutional arrangements and regulations of the country, rather than proposing changes.

- **Coverage approach.** The coverage approach is universal, as the plan targets the whole population.

- **Equity as an explicit target outcome of HiAP.** Equity is not an explicit target outcome of this HiAP case, although it acknowledges health equity issues arising from NCDs among indigenous populations within the country. The indigenous population of Palau is approximately 70%.

- **Main approach to addressing equity.** The main approach to addressing equity is to focus on gradient gaps. In 2012, the WHO Regional Office for the Western Pacific prepared a profile of NCDs classifying country-specific data by income category to reflect the variations among countries in the region. There is also a big difference between males and females in Palau. With rates of age standardized, the overall mortality rate for women in Palau is just over 400 per 100,000 and for men just under 800 per 100,000 (2008). Analyses were also carried out with regards to premature mortality from NCDs (under 70 years and using 2008 data), or from specific issues such as tobacco or alcohol use.

- **Role of health in the policy process.** The planning of the action plan represents a call for the whole-of-government approach. The Office of the President, the MoH as well as the sectors of education, environment, agriculture, fisheries, parks and recreation, public safety, revenue and taxation, cultural affairs, public works, and traditional leaders and community groups are included in the development of the proposed plan. The former president requested the Minister of Health to:
  - utilize the MoH Incidence Command System to coordinate activities to manage the crisis brought about by NCDs and related processes;
  - align all policies, programmes, services and activities of the MoH in order to stop, reduce and eliminate the incidences of NCDs;
  - keep all records of requests for assistance from the ministers and heads of national government agencies, to include any form of assistance provided and to report to the president every six months;
  - call on all ministers and heads of national government agencies, when called upon, to assist the Minister of Health in his effort to tackle this national crisis.

### KEY DRIVERS OF SUSTAINABILITY

- **Mandates of structures, organization and budget.** There are formal structures that can enable and sustain intersectoral work, through the Hazard Mitigation Sub-Committee (HMSC) of the National Emergency Committee (NEC), if the plan maintains this body for the implementation phase when it is approved. The PIHOA, Palau and related declarations underline the need for a whole-of-government and whole-of-society response. There seems to be a limited budget, other than the funding already allotted to the participating institutions.
It is argued that funding is not being provided to match the scope of the problem. Despite all good intentions among global policy-makers and from external funders, the proponents of the declarations are stating that processes and funding mechanisms need to change.

› **Tools and mechanisms to strengthen interchange between sectors.** The draft NCD action plan developed by the National Emergency Committee has yet to be finalized and endorsed by government. It outlines a suggested approach for monitoring and evaluation of both the state of emergency and the NCD action plan and goals. For example, it is proposed that the HMSC meet annually to assess progress and that, at the end of the fifth year, the MoH would undertake a comprehensive evaluation of the national response to assess if it is progressing in the right direction and what fine tuning might be required. As part of this proposed approach, if the evaluation suggests that NCDs are decreasing, then a recommendation might be made to the president to end the state of emergency. For overall monitoring of NCDs, the draft NEC national plan proposes that the MoH uses a STEP survey to evaluate the effectiveness.

› **Knowledge and skills of stakeholders.** No information is provided on this issue.

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**FINAL REFLECTIONS**

• In terms of political will and processes (at global and regional levels), the declarations illustrate that this is not only about providing more funding but changing the funding and resource mobilization processes as well as actions by other countries that impact on the health of the Pacific Island countries, e.g. trade and globalization policies.

• Implicitly the declarations refer to the ongoing inequity gap between countries, and the need for things to change if NCDs are to be tackled effectively. This contains an important message with regard to global policy-making for health in all sectors – what happens outside a country is just as critical to the development of effective whole-of-government/whole-of-society approaches as it is within a country.

• Given the risk and expansion of NCDs, these actions could be presented once the impact is assessed, as models for other countries in the same situation. It shows how NCDs by definition have to be addressed from a multisectoral perspective beyond the scope of health.
This example focuses on the Health Lens Analysis (HLA) Project for improving the mobility, safety and well-being of Aboriginal people in South Australia. The Aboriginal Road Safety project is intended to collaboratively identify ways of increasing Aboriginal healthy life expectancy by improving road safety through increasing safe mobility options. The South Australia HiAP approach is strongly linked to the achievement of the whole-of-government and whole-of-society objectives of South Australia’s Strategic Plan (SASP), specifically when referring to Aboriginal healthy life expectancy and well-being. Policy changes calling for increasing the requirements for people to obtain a licence – in an effort to increase the perceived safety of the community – has had the unintended consequence of creating a system which makes it extremely difficult for Aboriginal people to successfully obtain a licence. This results in people driving without a licence to achieve their daily activities and risking the consequences: increased rates of mortality and morbidity, and/or conviction for driving-related offences. The case study illustrates how making the pathways to obtaining a driver’s licence more accessible, through culturally appropriate systems and supports, can make a significant contribution to mobility, road safety and ultimately health and well-being.

This case represents an example of intersectoral cooperation and coordination for HiAP, where the health sector is a partner of the central state government that led the initiative. It fulfils the criteria established through the analytic HiAP framework.

**KEY DRIVERS OF IMPLEMENTATION**

- **Vision of health.** The vision of health for this initiative is closer to social indicators, addressing the general well-being and safety of the indigenous community served.
- **Relationships within governmental partners.** There is cooperation and coordination among the different state agencies. This case is a joint initiative between the Aboriginal Health and Public Health Branches of South Australia Health and, initially, transport, justice, the police and correctional services were invited by central government to participate as joint partners in the process. As part of the engagement process, however, the partner agencies identified that the agency responsible for education, employment, science and technology should be invited to be a joint partner. This continued throughout the other steps of the HLA as maintenance and development of the partnership is key to HiAP. When this project was established in 2009, HiAP was linked to the SASP, which sets targets across all government sectors/ portfolios.
Monitoring of the SASP targets was carried out through a Cabinet subgroup – the Executive Committee of Cabinet Chief Executives Group (ExComm CEG). ExComm was led by the Premier and included a small number of senior government ministers (although not the Minister for Health) and two independent members from outside government. The CEG was a sub-group of ExComm and oversaw both the ongoing performance of departments against their SASP targets and the implementation of HiAP across SASP.

› **Levels of administration of the government involved.** The local state government is involved in this initiative. Local partnerships are built in order to coordinate the driver’s licensing processes.

› **Relationships between governmental and nongovernmental actors.** This is predominantly a governmental initiative and civil society is only active as a recipient of the regulations and adherence to them.

**KEY DOMAINS OF AN EQUITY LENS IN POLICIES AND INTERVENTIONS**

› **Entry points to addressing social determinants of health.** Intermediate social determinants of health are addressed. Mobility is an important determinant of health – people need to travel for work, education, health care, family, recreation and or social reasons. People living in both urban, regional and remote areas need a range of accessible and appropriate mobility options. People often choose to drive rather than use public transport. Limited transport and mobility options therefore can have significant social and economic costs to society and governments. Aboriginal mobility in South Australia has been seriously affected by past and ongoing processes, which discriminate and limit their opportunities to get a driver’s licence. This in turn has had direct health consequences in terms of higher rates of mortality and serious injury from road accidents. These challenges are being addressed by increasing access through culturally appropriate pathways, i.e. changing cultural/social norms/values surrounding minority rights/need for culturally appropriate services, licensing policy.

› **Coverage approach.** The coverage approach is targeted, addressing the needs of the Aboriginal population. Improving the accessibility of the pathways should reduce the number of Aboriginal people who drive unlicensed and therefore the number of Aboriginal people who are convicted and or detained in the corrections system in South Australia.

› **Equity as an explicit target outcome of HiAP.** Equity is an explicit target outcome of this HiAP case, at it represents a set of actions that improve the well-being of a specific group of the population, namely, the indigenous Australians living in South Australia

› **Main approach to addressing equity.** The main approach to addressing equity is to focus on gradient caps and targeting the Aboriginal community. The initiative recognizes that the impacts of health determinants are not equally distributed among population groups in South Australia and aims at closing the health gap, in particular for Aboriginal people. This project provides the opportunity to consider the connections with related additional SASP targets including: closing the gap between Aboriginal and non-Aboriginal unemployment rates annually; reducing overall road fatalities; and reducing overall serious road traffic injuries. Furthermore, the example illustrates how using HiAP can inform the development of policy responses to contribute to closing the health gap between Aboriginal and non-Aboriginal people in South Australia.

› **Role of health in the policy process.** The planning of the action plan represents a call for the whole-of-government approach. The South Australian HiAP approach has been developed as a central process of government (not one run by and for the health sector) and as part of the SASP, which has as its objectives: growing prosperity; improving well-being; attaining sustainability; fostering creativity; building communities; and expanding opportunities. The Aboriginal Road Safety health lens project is a joint initiative and includes the following agencies: South Australia Health, the Department of Planning, Transport and Infrastructure (DPTI), the Attorney General’s Department (AGD), the South Australia Police
(SAPOL), the Department for Correctional Services (DCS), and the Department of Further Education, Employment, Science and Technology (DFEEST).

**KEY DRIVERS OF SUSTAINABILITY**

- **Mandates of structures, organization and budget.** There are formal structures that can enable and sustain intersectoral work. The governance processes to support it are well established. A small HiAP unit was established within South Australia Health to facilitate the HLA process and sustain the partnership with other government agencies in applying HiAP to their targets. To date eight HLA have been completed including: water sustainability, regional migrant settlement, digital technology access and use, healthy weight and active transport. From the available information, the budget seems to be allocated through the budgetary exercise at the state level, within the SASP. No further funding seems to be available.

- **Tools and mechanisms to strengthen interchange between sectors.** There are evaluation mechanisms in place, including health impact assessments. An evaluation of the South Australia model for HiAP was commissioned by South Australia Health and undertaken by researchers from the Community Health Research Unit at Flinders University. The evaluation was designed in conjunction with HiAP unit staff but the evaluation itself was independent. The focus was placed on project development and impacts, how the steps in the HLA process worked in practice, and whether participants considered their specific HLA objectives had been achieved. As part of a more comprehensive five-year evaluation funded by the National Health and Medical Research Council (NHMRC), a detailed assessment of the policy impacts of HLAs (most likely including the Aboriginal Road Safety HLA) and the mechanisms that led to these impacts will be undertaken. This case and its findings are also being used to inform and support related work on road safety at the national level.

- **Knowledge and skills of stakeholders.** The evaluation of the South Australia model for HiAP found that the approach used had built partners’ capacity to better realize their policy goals, and had facilitated the exchange of evidence and knowledge across sectors. The Aboriginal improving mobility HLA project has strengthened and consolidated evidence across a range of sectors.

**FINAL REFLECTIONS**

- This HiAP case represents an all-of-government approach to respond to a very specific issue with regards to mobility within the indigenous community in South Australia. This show how the intersectoral approach can be used for macro-level policies, as well as specific and targeted goals.

- Health is a partner, although it does not lead the process, health implications were included in the planning of the project.

- This programme can become an engine for social change, empowering a traditionally marginalized community and opening up opportunities for development, growth and employment.
REDUCING FATALITY AND SERIOUS INJURY FROM ROAD TRAFFIC INJURIES THROUGH MULTISECTORAL COLLABORATION: THE NATIONAL HELMET LAW IN VIET NAM

This example outlines the formulation, implementation and monitoring of a national helmet law included as part of Resolution 32 and released by the prime minister of the Socialist Republic of Viet Nam on 29 June 2007. It came into force as a decree on 15 December 2007. Resolution 32 is a government decree focusing on a range of road safety and traffic alleviation measures. As well as requiring all riders and passengers on all types of roads to wear helmets, the new regulation substantially increased fines compared to previous regulation. After the country enacted a motorcycle helmet law in 2007, the helmet-wearing rate jumped from below 30% to over 95%. This change alone was estimated to have saved more than 1500 lives and prevented almost 2500 serious injuries. The law also had special regulations for children, given that in Viet Nam the motorcycle is the primary mode of transportation, and children are the most vulnerable passengers while riding with their parents because of the widespread lack of helmet use. The Helmets for Kids (HFK) programme has been in place since 2000 and is currently implemented at 32 schools nationwide. As well as providing free helmets for kids, the programme incorporates helmets into the school curricula – effectively making helmets part of school uniforms. It also involves teacher and student training, public/media and corporate awareness and partnerships, and monitoring and surveillance.

This case represents an example of intersectoral coordination, where the health sector is a partner of the national initiative although it does not lead the effort. It fulfils many of the criteria established through the analytic HiAP framework.

OPPORTUNITIES FOR INITIATION

▸ Policy change window. There is political will for HiAP from the highest authorities, given that the regulations were issued by the president through executive orders and decree, which were implemented at national and later provincial levels.

▸ International influences. WHO, the Asia Injury Prevention Foundation (AIPF) and the United Nations Children’s Fund (UNICEF) have used the media and provided training workshops for senior officials and national legislators as part of this sustained advocacy effort to improve the wearing of helmets among children and to counter the myths about the dangers of helmet wearing.

KEY DRIVERS OF IMPLEMENTATION

▸ Vision of health. The incentive for action does not appear to have been primarily or solely to tackle a health issue per se. Instead, the focus of the overall decree is to improve road safety and alleviate traffic congestion – both of which have positive health benefits if implemented effectively.

▸ Relationships within governmental partners. The formulation, implementation and monitoring of the legislation is the result of the work of a multisectoral committee in place since 1997. The Ministry of Transport leads the committee, which reports to the prime minister and is truly multisectoral with representation from 15 other government agencies.
The relationship between and within governmental partners represents a case of intersectoral cooperation. In terms of sectoral responsibilities and tasks – the committee had overall responsibility for clearing all details of the helmet law including collaborating and consulting with provincial networks to ensure nationwide implementation, and reporting both progress and any barriers to the prime minister.

- **Levels of administration of the government involved.** All levels of government are involved. There is a committee in all 63 provinces in Viet Nam, and all were involved in the execution of the law.

- **Relationships between governmental and nongovernmental actors.** The multisectoral committee established partnerships with bilateral and multilateral agencies, NGOs (e.g. Asia Pacific Injury Foundation) and private companies (e.g. FedEx, UPS) to facilitate international assistance in achieving the national road safety objectives. One partnership has resulted in three national mass-media campaigns as well as the distribution of free helmets to schoolchildren (sponsored/funded by private companies).

**KEY DRIVERS OF SUSTAINABILITY**

- **Mandates of structures, organization and budget.** There are formal structures that can enable and sustain intersectoral work, such as the multisectoral committee. No additional budget seems to be allocated to the regular sectoral budget. Nongovernmental partners specifically funded some actions, such as the national campaign and media strategy addressing child safety.

- **Tools and mechanisms to strengthen interchange between sectors.** There are tools and mechanisms that can strengthen interchange between sectors, including health impact assessments. Implementation of the law has been monitored on a number of fronts: behaviour change in terms of compliance with helmet wearing and correct helmet wearing; reduction in prevalence of head injuries among road traffic injury patients admitted to hospitals; and helmet wearing among children. In addition, three studies have been undertaken looking at the impact of the legislation. Before the law was introduced, correct helmet wearing averaged 40.1% and 92.5% however there were significant differences between the time points and locations. In terms of health impacts, the MoH, the Department of Planning in Viet Duc Hospital and the WHO Representative Office in Viet Nam, undertook a before and after study of all road traffic injury patients with head injuries admitted to 20 provincial and central hospitals – three months before and three months after the law came into effect in December 2007. They found a 16% reduction in the number of head injuries and a 16% reduction in the number of patients admitted to hospital.
in risk of road traffic head injuries and an 18% reduction in the risk of road traffic deaths.

Knowledge and skills of stakeholders. This multisectoral initiative has built capacity for HiAP within Viet Nam and across ministries. As well as having a high-level multisectoral committee led by the ministry of transport, a deliberative effort has been made to learn from previous experience and consider the potential barriers to introducing what is an evidence-informed intervention. This was reflected in the studies of different impacts following the introduction of the legislation, which observed behaviour in relation to helmet use, as well as seeking public opinion about helmet use.

FINAL REFLECTIONS

- Political leadership, intensive advanced public education and stringent enforcement contributed to the successful implementation of the law in Viet Nam.
- The commitment of the government was reinforced by the regulation that required all government employees/civil servants to wear helmets three months before the law came into effect nationally.
- National estimates have illustrated that road traffic crashes cost countries between 1–3% of their gross national product (GNP), while the financial impact on individual families has been shown to result in increased financial borrowing and debt, and even a decline in food consumption. Hence these regulations have an economic impact.
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