Implementing Health in All Policies: a pilot toolkit

World Health Organization

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Abbreviations

BoD	burden of disease
GBD	global burden of disease
HiAP	Health in All Policies
NCD	non-communicable disease
SDG	Sustainable Development Goal
SDH	social determinants of health
WHO	World Health Organization

Executive summary

Health in All Policies (HiAP) is increasingly acknowledged as an effective and evidence-based governance strategy to tackle the social determinants of health (SDH) and health equity. The approach targets the key determinants of health through integrated policy responses across relevant policy areas with the ultimate goal of supporting population health and health equity. By incorporating the consideration of health impacts into the policy development processes of all sectors, a HiAP approach can support governments to address the determinants of health in a systematic manner, recognizing that the levers for policy action often sit outside the remit of the health sector itself.

To support countries implementing HiAP, this WHO document – *Implementing Health in All Policies: A pilot toolkit* - has been prepared to support HiAP practice across regions, and inform the development of a more nuanced toolkit.

This first pilot toolkit brings together key tools for HiAP implementation, informed by evidence and the experiences of HiAP practice to-date. It provides an accumulation of HiAP learning from the past three to four years, based on WHO HiAP activities, and, in particular, since the release of the WHO HiAP Training Manual in 2015. As HiAP is a new and evolving practice, this initial toolkit enables key tools for HiAP implementation to be tested, and in due course refined and further developed as the evidence for the enabling conditions of HiAP practice grows.

Chapter 1 sets the scene providing an overview of the connection between health outcomes, the determinants of health and the role that action to address these determinants can play through partnerships and collaboration with different sectors whose policies and programmes influence those determinants. While we refer to determinants of health to be inclusive of all determinants, we do adopt the social and ecological model of causality that underpinned the work of the Commission on Social Determinants of Health, and along with that the focus on addressing health inequities.

The determinants of health include the range of personal, social, economic and environmental factors which determine the health status of individuals or populations.

The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. Together the structural and intermediate social determinants shape the patterns and extent of health inequalities.

Importantly, the HiAP pilot toolkit responds to the increasing need for easily accessible social determinants of health resources that can be adapted for different contexts and country use. While the focus of the toolkit is to provide guidance for the early stages of HiAP planning and initiation, it is also useful for strengthening existing and more established HiAP models. It is increasingly recognized that countries are looking for guidance on the "how to", to effectively translate the theory of social determinants of health into practice. Thus, the toolkit contributes to building a package of HiAP information and resources to support capabilities (including technical and soft skills) for addressing the social determinants of health and health equity. Those who just want to know more about HiAP will also find it useful.

There are five key work streams in the pilot toolkit.

A. **Facilitating intersectoral collaboration: strengthening and creating networks across government** to engage key partners and stakeholders and to ensure the implementation and continued realization of HiAP in coordination with all relevant stakeholders;

B. **Framing and scanning the political and policy environment: connecting with broader society and influencers** to enhance the understanding of HiAP in public, political and technical arenas and its usefulness in influencing the social, economic and environmental determinants of population health; and to make politicians, opinion leaders and other decision-makers realize their role and importance in achieving health and well-being for their citizens;

C. **Capabilities for HiAP: working with the HiAP team to facilitate action and progress policy priorities** to promote the capacities and skills needed to implement HiAP and coordinate and facilitate intersectoral action;

D. **Governance and accountability: reinforcing the critical roles of decision-makers** to provide HiAP leadership and facilitate establishment and effective functioning of intersectoral governance and accountability;
E. **In-depth analysis to grow the scientific knowledge base: linking with academics and research institutions** to facilitate research for solid evidence and appropriately disaggregated data for analysis and policy-making; to ensure collection and monitoring of data at all levels across sectors and perform data analysis to inform and guide implementation.

Each work stream includes several tools that will be useful in achieving the intention of the work stream. This might involve gathering data and evidence, scanning policies and mechanisms and engaging stakeholders; facilitating leaders, developing champions and talking about HiAP in a coherent and relevant way. Governance is increasingly recognized as critical for successful HiAP and ideas are provided on developing governance arrangements as well as progressing legislation as an effective strategy. Research, monitoring, evaluation and reporting are all essential if HiAP is to develop, be accountable and measure outcomes.

Each tool describes the why, when, rationale and scope of action followed by a step-by-step guide to action with hints, further reading, references, templates and examples making practice as easy as possible.

The pilot toolkit is an interactive and iterative document. Feedback is welcome on the content to help shape a more refined and expanded toolkit, which builds on HiAP experience and evidence.

Chapter 1
Introduction

Overview

Health is created and destroyed by many different interacting and accumulating factors in society. Inequities in health arise because of the circumstances in which people are born, grow, live, work and age as well as the systems in place to deal with illness *(1)*. These determinants of health and well-being influence health behaviours, and in turn are shaped by political, social, economic and environmental policies and practices. Currently, health inequities are present in all societies to lesser or greater extents. Improving health and health equity requires action to ensure policies and practices support and promote good health and do not harm health. Health in All Policies (HiAP) is an approach to achieve this change.

The World Health Organization (WHO) defines HiAP as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity *(2)*." It aims to improve accountability of policy-makers for health impacts at all levels of policy-making; and includes an emphasis on the consequences of public policies on health systems and the determinants of health and well-being. Importantly, it seeks mutual benefits from collaborative approaches (see Box 1-1).

Although governments, as a whole, bear the ultimate responsibility for the health of their citizens, health authorities at all levels (national, sub-national and local) are key actors in promoting HiAP. Leadership and coordination are crucial during all stages of HiAP. Openings for healthy public policy arise regularly and astute and responsive health ministries can respond to these windows of opportunity.

The Sustainable Development Goals (SDGs) call for an integrated approach to "just, rights-based, equitable and inclusive" action to address contemporary challenges *(3)*. SDG 3 aims to "ensure healthy lives and promote well-being for all at all ages" *(3)* but health is influenced by and contributes to all other goals and targets. Such links are at the heart of health inequities and require intersectoral approaches like HiAP. Greater agility and collaboration are needed to help countries tackle the complex health and social challenges of the SDG era.

As HiAP is being implemented in more and more countries the need for resources and tools to assist practice is growing concurrently with the experience of what works and is effective in HiAP implementation.

About this pilot toolkit

This WHO guidance document aims to support countries implementing HiAP. This pilot toolkit brings together key tools for HiAP implementation, based on evidence and experiences of HiAP practice to date. It provides an accumulation of HiAP learning since 2015, based on WHO HiAP activities, and, in particular, since the release of the WHO HiAP Training Manual *(4)*. As HiAP is a relatively new and evolving practice, this first WHO HiAP pilot toolkit enables key tools for HiAP implementation to be tested and subsequently further developed as the evidence for the enabling conditions of HiAP practice grows. The toolkit is, therefore, not intended to be a comprehensive guide; rather it aims to provide an overview of key steps to consider for HiAP implementation.

As WHO strengthens its HiAP programme, there will be opportunities to work with HiAP partners (including relevant Collaborating Centres) across the WHO regions to develop a more detailed toolkit at a later stage. Thus, the toolkit contributes to building a package of HiAP information and resources to support capabilities for addressing the social determinants of health and health equity. Importantly, the HiAP pilot toolkit responds to the increasing need for easily accessible HiAP resources that can be adapted for different contexts and country use.

Target audience

This pilot toolkit is primarily aimed at people looking to start up and progress a HiAP approach. In some cases, this will be policy-makers with specific responsibility for HiAP implementation or a "HiAP team", though they may not be labelled as such. This team may be wholly focused on HiAP, placed in the Ministry of Health or comprise a network of key individuals with specified time allocations, and located among the health department or elsewhere depending on what is most appropriate in each country. The individuals themselves are sometimes referred to as HiAP practitioners. The information and tools presented in this document may also be of interest to those wishing to learn more about HiAP, possibly with a view to advocating for HiAP in the future.

The pilot toolkit provides a snapshot of the key considerations necessary when planning and initiating HiAP. The tools can be used for different purposes: providing inspiration for action; supporting more detailed guidance across multiple components of HiAP practice or by using individual tools to address or strengthen specific areas. For example, individual tools can be "hand-picked" depending on HiAP needs at different points in time. The tools are primarily prepared for use in the planning and initiation phases of a HiAP approach, however they might also be useful as the HiAP approach matures and moves into a more established phase. They can help practitioners reflect on their ways of working and through this process, support analysis of the tools to feed into the development of future global HiAP tools.

Box 1-1

About HiAP

HiAP practice is highly context-specific; the entry points for HiAP and the structures for intersectoral governance will vary. It is therefore difficult for a country to replicate exactly the model in another country, but it is possible for countries to consider the conditions or enablers under which different models were adopted and implemented. The tools presented here outline some of the key factors which have helped to initiate and implement HiAP based on an analysis of existing HiAP models and the experiences of HiAP practitioners from around the world. The pilot toolkit can be seen as a companion for creating a workplan for HiAP to guide an institutionalised process for working across government.

Further, this pilot toolkit refers mostly to action at the country level but is also applicable at the sub-national level.

The toolkit provides a set of practical suggestions for applying HiAP in planning and implementation at different levels of government and in different country contexts. The tools aim to support putting HiAP into practice, guided by the HiAP framework for country action (Figure 1-1) *(5)*. The HiAP Framework provides countries with guidance for taking country-level action across sectors for improving health and health equity. The framework can be used as a practical means to navigate the complex actions inherent in working across sectors for health improvement and realizing the benefits for other sectors so that co-benefits are optimized. While the framework can be used to address specific health issues, it was developed to promote the establishment of a more comprehensive, systematic approach to ensuring action across sectors for health and health equity, with a focus on the underlying determinants of health.

The framework covers six key elements that guide action:

- Establish the need and priorities for action across sectors

Establishing the need for action means determining what the specific needs are and how they might be addressed. Gaps in health and health equity must be identified, what works must be made known, and other sectors must be supported in developing and implementing policies, programmes and projects within their own remit, which optimize co-benefits.

Actions that can be taken to establish needs and priorities include: ensuring that there is high-level political will and commitment to action, identifying common interests and mapping power dynamics.

- Identify supportive structures and processes

This enables stakeholders from different sectors to interact through, for example, an interdepartmental committee or interagency network, and a process outlines the interaction and communication, including power dynamics and influences, between stakeholders.

Actions that can be taken include: identifying a lead agency to direct the actions, considering the use of legal frameworks, building on the existing structure and agenda, and improving accountability mechanisms.

- Frame planned action

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

Actions that can be taken to frame the planned action include: identifying data for planning and monitoring, identifying evidence-based interventions for implementation, developing a monitoring and evaluation strategy, and considering implications for staff, funding and accountability.

- Facilitate assessment and engagement

Assessing health needs is important to identify unmet gaps in policy formulation or service provision. The information can then be used to determine priorities for action across sectors, and to plan specific policy or service improvements to meet these needs. It is also essential to assess the health impact of policies in order to ensure that the expected outcome of the policy is achieved.

In general, the engagement of stakeholders within and outside of government is essential throughout the entire process of policy-making, from needs assessment, planning, implementation, to monitoring and evaluation. Creating awareness and facilitating the participation of stakeholders, through early involvement from the preparatory stages onwards, are critical to eventual success. Open and effective communication promotes a mutual understanding of policy priorities and planned actions.

Actions that can be taken include: assessing the impact of public policies on health and health equity, creating an inclusive policy-making process, using appropriate tools (for example, policy audits and health equity lens analysis) to assess the health impact of policies, and engaging key groups and communities.

- Ensure monitoring, evaluation and reporting

Mechanisms for monitoring, evaluation and reporting on progress provide evidence of what works and of best practices. It is recognized that each sector is probably already responding to its own key performance indicators and deliverables. Therefore, monitoring and evaluation indicators for intersectoral coordination, intervention and implementation would be additional requirements for stakeholders.

Actions that can be taken include: developing and agreeing on milestones; establishing baseline, targets and indicators; obtaining data that can provide estimates for different subpopulations; and disseminating lessons learnt.

- Build capacity

Promoting and implementing action across sectors is likely to require the acquisition of new knowledge and skills by a wide range of institutions, professionals (health and outside of health) and people in the wider community. Capacity building is essential for all sectors involved and needs to be tailored and adapted to the specific country and sectoral contexts.

Actions that can be taken to build capacity include: developing diplomacy and negotiation skills, encouraging sectors to share and exchange skills and resources for capacity building, building capacity on financing mechanisms to ensure long-term sustainability, and forming communities of practice.

These elements of the framework can be adopted and adjusted based on the context and, therefore, are not fixed in any order or priority. This recognizes that HiAP is a fluid and dynamic approach that needs to be continually adjusted and refined to maintain relevance for the governance system, and economic and social contexts within which it operates. The individual tools in the pilot toolkit can be used to progress and act upon the different components in the framework.

Figure 1-1 HiAP framework for country action

HiAP results-chain

The outputs of HiAP are healthy public policies and health and equity sensitive public institutions, including decision-making processes responsible for allocating power, money and resources. A healthy public policy [or institution] "is characterized by an explicit concern for health and equity in all areas of the policy [or decision-making] and by accountability for health impact"*(6)*.

Figure 1-2 shows how public policy influences population health and health equity (impact 1) through exposure and attributing risk factors as well as social determinants (outcomes 1, 2, and 3). However, the health benefits are also influenced by the benefits the policy creates in other sectors (impact 2) and the social determinants by the outcomes in these other sectors (outcome 4). Further, policy outcomes and impacts are all influenced by contextual factors and other policies. This makes it a challenge to predict the impact of and attribute changes in population health and health equity to a single policy, policy change or institutional change element though increasingly techniques are being developed to address measurement and attribution in complex systems.

The focus of the tools in this toolkit is the left-hand side of the results-chain in Figure 1-2; to support and guide the processes that generate products (analyses, reviews, reports, recommendations, etc.) and lead to healthy public policy and institutions. For practical purposes these processes and the related tools in the toolkit are grouped into five work steams. These are elaborated on in the following section.

Figure 1-2 **HiAP results-chain**

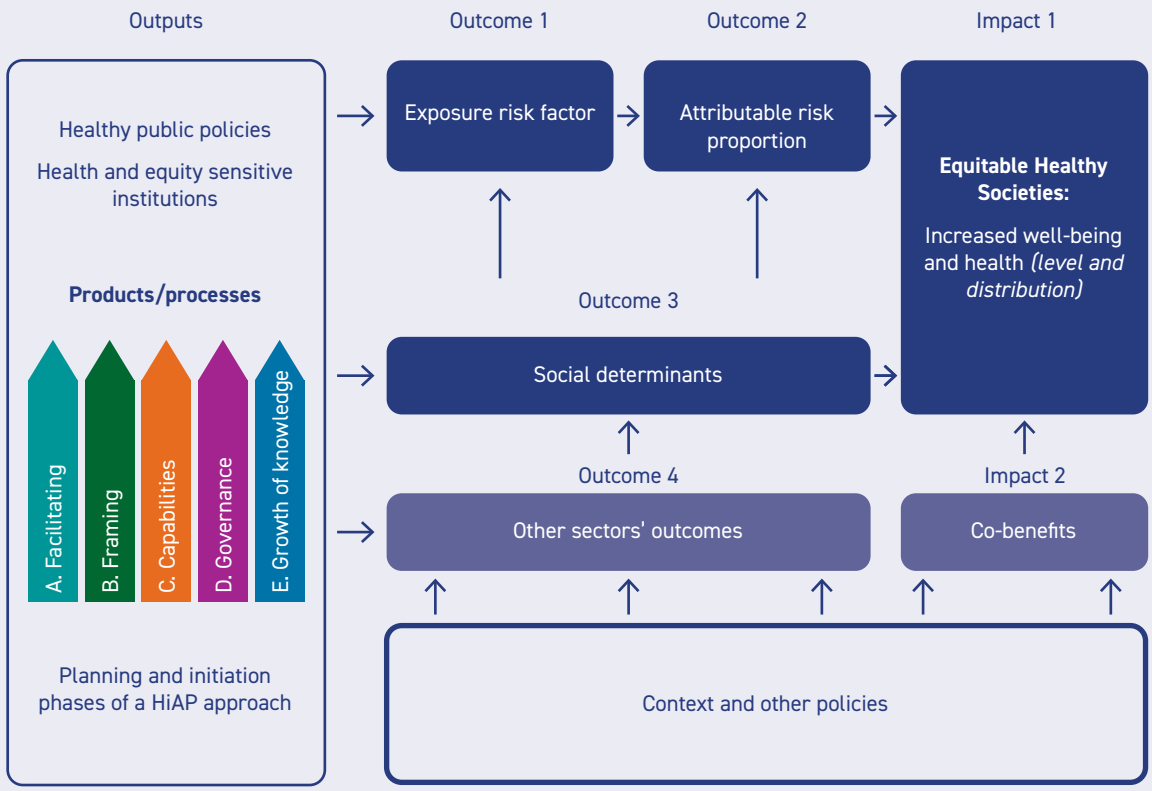

Table 1-1

Structure of the HiAP pilot toolkit

	A	B
Work stream	**Facilitating intersectoral collaboration:** strengthening and creating networks across government	**Framing and scanning the political and policy environment:** connecting with broader society and influencers
Specific tools	**A.1** **Analysis of health and determinants** (level, distribution and causes, introductory /in-depth) **A.2** **Scan of intersectoral policies and mechanisms for action** (establishing contact and learning) **A.3** **National consensus building** (problem, priorities, agenda)	**B.1** **Scan of societal, 'mega' trends** (context, opportunities and threats) **B.2** **Windows of opportunity** (identify, monitor, trigger and grab) **B.3** **Talking about HiAP** (values, benefits, and language) **B.4** **Policy champions** (identification, roles and support needs)

C

Capabilities for HiAP: working with the HiAP team to facilitate action and progress policy priorities

C.1

Vision and leadership
(create, facilitate and support)

C.2

Organizing the work
(work streams and strategic activities)

C.3

HiAP core team
(authority, competence and capacity)

D

Governance and accountability: reinforcing the critical roles of decision-makers

D.1

Models for governance and accountability
(governance structures and mechanisms)

D.2

Review and revise national plans
(health, co-benefit and equity lenses)

D.3

Public health legislation (legal tools)
(discussion only - tool not developed)

E

In-depth analysis to grow the scientific knowledge base: linking with academics and research institutions

E.1

Knowledge gaps and research agenda
(what, why and how much)

E.2

Monitoring and evaluation
(outputs, outcomes, indicators, results)

E.3

National population health report
(ensuring reporting)

Structure of the HiAP pilot toolkit

The toolkit consists of five work streams (A – E) and 16 individual tools across those streams (see Table 1-1). The work streams cover the following thematic areas:

A. **Facilitating intersectoral collaboration: strengthening and creating networks across government** to engage key partners and stakeholders and to ensure the implementation and continued realization of HiAP in coordination with all relevant stakeholders;

B. **Framing and scanning the political and policy environment: connecting with broader society and influencers** to enhance the understanding of HiAP in public, political and technical arenas and its usefulness in influencing the social, economic and environmental determinants of population health; and to make politicians, opinion leaders and other decision-makers realize their role and importance in achieving health and well-being for their citizens;

C. **Capabilities for HiAP: working with the HiAP team to facilitate action and progress policy priorities** to promote the capacities and skills needed to implement HiAP and coordinate and facilitate intersectoral action;

D. **Governance and accountability: reinforcing the critical roles of decision-makers** to provide HiAP leadership and facilitate establishment and effective functioning of intersectoral governance and accountability;

E. **In-depth analysis to grow the scientific knowledge base: linking with academics and research institutions** to facilitate solid evidence and appropriately disaggregated data for analysis and policy-making; to ensure collection and monitoring of data at all levels across sectors and perform data analysis to inform and guide implementation.

A natural sequence of use might be as proposed by the structure of this toolkit – following work streams A, B, C, D and E and the corresponding numbering of the tools in each work stream. For example, work stream A has three tools: A.1, A.2 and A.3. Each tool provides practical steps for action as well as links to practical examples, where available, and references for further reading.

The tools may be modified and adapted to local circumstances and as HiAP experience is gained. While the majority of tools in the toolkit are framed for use at the national level, the objectives and principles of each tool can be translated to different levels of government. Further, the tools may be used independently or as a compilation of tools to progress HiAP action across multiple components. Some tools may be more relevant at different points in time, depending on the context HiAP is operating in. For example, it may not be possible to establish a formalized governance structure for HiAP within the government from the outset (Tool **D.1**), and HiAP may need to operate at a more technical level until circumstances change and a transition to a formalized governance approach can take place. Or, the drivers to establish a dedicated HiAP team to co-ordinate and facilitate intersectoral work across government (Tool **C.3**) might come after implementation has begun. Thus, individual tools can be used on an "as needs" basis.

The work streams are designed to stand alone as a source of information on each thematic area, therefore some repetitiveness in content occurs across the five streams and their corresponding tools.

Thinking about who you are working with

The different tools should be considered in the context of who you are working with to promote the most effective outcomes for HiAP. Each work stream (Table 1-1) connects to the many different actors and partners involved in HiAP processes. For example, the use of tools in work stream E can support linkages with academics and research institutions for gathering and strengthening data and evidence on the policy issues being addressed by your HiAP work. There will also be other actors outside those listed in the work streams to consider when applying the tools. The suggestions are a starting point for considering your stakeholders and key players and should not be limiting.

Mapping the pilot toolkit against the HiAP framework for country action

As mentioned earlier in the introduction, the pilot toolkit supports the implementation of the six elements in the HiAP framework for country action that should be addressed to put a HiAP approach into practice (Figure 1-1). The individual tools can help to facilitate HiAP across the six elements of the framework, and this adds an additional layer for thinking about how the HiAP pilot toolkit can be used to enable the conditions for successful HiAP practice to be established. Table 1-2 maps the toolkit and its individual tools against the HiAP framework for country action and highlights some of the critical tools which can support each element in the framework. The tools which are mapped against the framework are those which are particularly relevant for the early phases of a HiAP approach or the 'initiation' phase.

Some tools support multiple components in the HiAP Framework and therefore appear more than once in Table 1-2. For ease of understanding, only the key HiAP tools for 'HiAP initiation' are mapped. Other tools (within and outside the toolkit) may also be relevant at different points in time and in different contexts to support HiAP implementation.

Table 1-2

Example of mapping of the HiAP pilot tools against the HiAP framework for country action

HiAP framework – enabling conditions for successful practice	Individual HiAP pilot tools
Establish the need and priorities for HiAP	A.1 Analysis of health and determinants A.2 Scan of intersectoral policies and mechanisms for action B.1 Scan of societal 'mega' trends D.2 Review and revise national plans
Identify supportive structures and processes	A.2 Scan of intersectoral policies and mechanisms for action C.1 Vision and leadership C.3 HiAP core team D.1 Models for governance and accountability
Frame planned actions	A.3 National consensus building B.2 Windows of opportunity C.2 Organizing the work E.1 Knowledge gaps and research agenda
Facilitate assessment and engagement	A.2 Scan of intersectoral policies and mechanisms for action B.3 Talking about HiAP C.3 HiAP core team E.1 Knowledge gaps and research agenda
Build capacity	B.4 Policy champions B.3 Talking about HiAP C.3 HiAP core team
Ensure monitoring, evaluation and reporting	C.2 Organizing the work E.1 Knowledge gaps and research agenda E.2 Monitoring and evaluation

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Chapter 2
Work stream A

Facilitating intersectoral collaboration: strengthening and creating networks across government

A.1 Analysis of health and determinants

Why and when?

One of the fundamentals of HiAP is a comprehensive understanding of the health status of the population in your country or sub-national area, the key contributors to the burden of disease (BoD), the risk and protective factors influencing health outcomes and importantly information on levels of inequity and the broad determinants of health and well-being. HiAP practitioners are often confronted with the need to provide an overview of the health status of the population and explain key health challenges including health inequities and the key determinants of health. Having this information at hand and in an easily shared form is important.

It is also critical to have a good level of knowledge about the evidence for interventions (policies, legislation, programmes, capacity building etc.) that impact on determinants and health outcomes.

This tool provides an introduction to using data and evidence in a way that will elucidate the pathways from the conditions of daily life to the BoD in your population. This enables the challenges or issues to be defined, including recognition of the social determinants involved, and highlights the overlapping roles that various sectors may play in contributing to appropriate policy and programmatic responses to address the issues.

It is often necessary to build the case for HiAP, through stakeholder, policy-maker and community advocacy, using both qualitative and quantitative measures to identify the need and rationale for HiAP actions. This analysis assists the HiAP team to start conversations with other sectors regarding their links to the determinants of health. It should facilitate stakeholder engagement and collaboration because it can help people see the mutual benefits that could arise from working together.

This information may also be needed to persuade others in the health sector of the merits of the HiAP approach.

The timing for the analysis of health and related determinants will depend on the country's needs and team capacity as well as factors such as the timing of the consensus building process (**A.3**), political or stakeholder windows of opportunity (**B.2**) or imperatives and planning processes underway.

Ideally the Analysis of health and determinants (**A.1**), Scan of intersectoral policies and mechanisms for action (**A.2**), and Scan of societal trends (**B.1**) tools would all be part of the initial base-line reviews prior to engaging with sectoral partners and stakeholders through the consensus building process (**A.3**) and discussions on specific strategies and setting a final HiAP agenda. However, it can also be progressed as part of implementation of priorities to provide in-depth knowledge about particular issues as work progresses and thus inform implementation of the HiAP priorities. The analysis will also identify knowledge gaps and thereby feed into establishing an agenda for research (**E.1/2**). This is the opportunity to develop partnerships with academics and other experts (both in the health field and beyond) who can support and inform the HiAP work over the longer term.

Rationale and scope

The tool is based on three premises. First, health inequities are avoidable and unfair, regardless of whether these manifest as gradients or gaps within or between population groups. Second, when a country's BoD situation is benchmarked against other countries at a comparable level of economic development, under-performance compared to the best-in-class becomes obvious. Third, health inequities and under-performance can largely be avoided through public policies addressing critical social, economic and environmental determinants of health.

The scope of the analysis will depend on factors including availability of data, HiAP team capacity and/or ability to contract in extra assistance, the time available and the level of understanding of key partners. This tool, therefore, includes suggestions for both an **introductory approach** and a more **in-depth analysis.**

An introductory approach can be undertaken where time is short and basic information on health and determinants will suffice to get started. The key message here is to ensure there is some robust evidence to describe the current health situation in your country and based on this, begin to make the case for HiAP as a mechanism for action on the social determinants of health.

For an **in-depth or comprehensive analysis** the tool needs a core team of at least two people able to devote considerable time during a period of three to four months to cover preparations, communication, intermediate analyses, and final analysis and reporting. The team must possess strong public health knowledge and skills in quantitative and qualitative analysis, preparing visual and narrative presentations of complex data, and have a solid knowledge of the 'evidence environment' of the country (researchers, statisticians, practitioners, etc.). If the analysis is completed in parts the personnel requirements will be less. You may also choose to partner with external consultants or research institutions with expertise in this area. The plan is to conduct a structured communication technique (Delphi method) to consult with a range of experts.

Frequently data required is not readily available in national and other reports. This tool caters for the common situation where evidence is in multiples sources, not always complete, and where the causal pathways between health, health inequity and the social determinants may or may not be well documented.

While these tools provide technical detail on data collection and analysis processes for HiAP initiation and implementation, it is recognized that not having exactly the 'right data' or 'breadth of data' from the outset should not deter you from starting your HiAP approach or trying to get HiAP on the political agenda in your country.

In addition, readers should understand that these tools are strategies which can be used at any time throughout HiAP activities (either as an intense analytical process or a more gradual process depending on the issue being explored), as part of a continuous cycle of building and enhancing the evidence-base for population health and well-being.

What to do?

Basic analysis

STEP 1 (introductory):

Review key health plans and reports to get an overview of the BoD

National reports to get an overview of the BoD describing the health situation in the country or region will provide information on the BoD profile for the country and the contribution of common risk factors and risk conditions. WHO regional offices produce health data reports that can be useful. See for example the European Region report *(1)*. The aim is to be able to summarise the main facts about the health of the population.

Hints!

In some instances it will be necessary, or desirable, to focus in on a particular health or policy issue and target your scan to this area. For example, the Health Lens approach used in South Australia focussed on particular state government targets in the beginning of their HiAP journey and gathered relevant data and evidence on health and the particular policy target, identifying evidence-based solutions or policy options *(2)*.

STEP 2 (introductory):

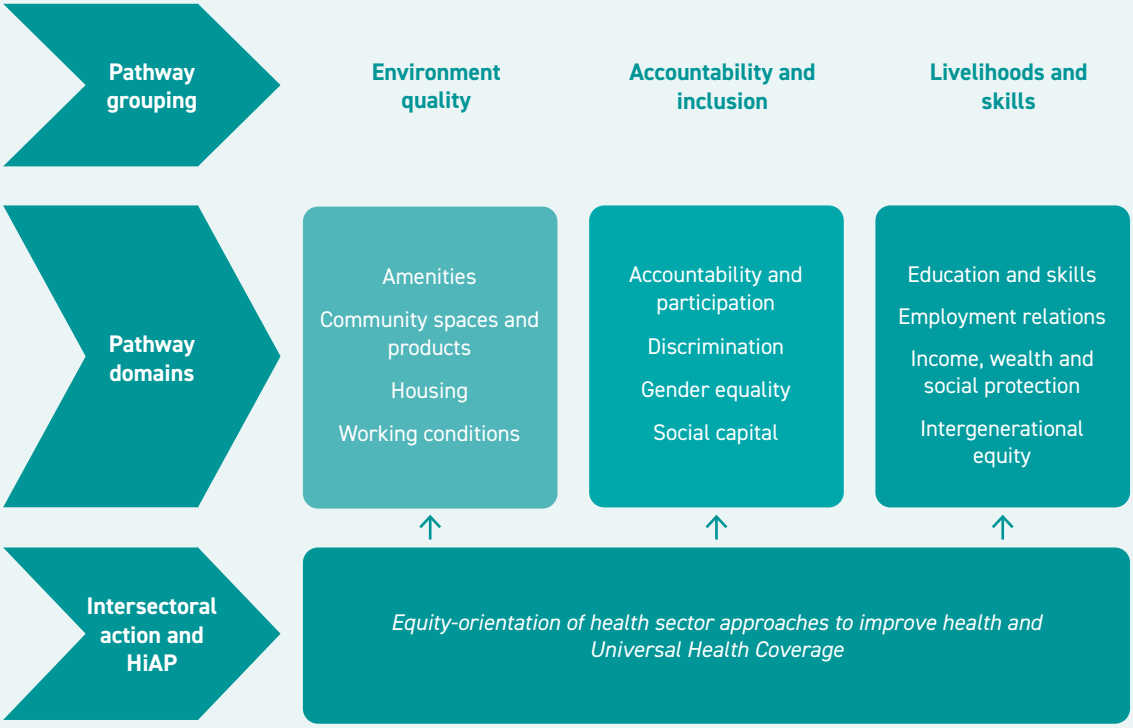
Scan health and other reports for information on determinants

HiAP is about addressing the determinants of health so it is essential to be able to show the pathways between the patterns of determinants and health outcomes across the population. Determinants information may be harder to find – if this information is not available, the national and international scientific literature will provide information on what research studies say about the determinants of the most common diseases and inequalities in diseases and health problems in the country.

Hints!

While there is no single list of all the determinants of health, there are several frameworks which include comprehensive listings. The EQUAL Framework (Figure 2-1) *(3)* provides a useful example for categorising determinants based on the evidence in the literature on the pathways between determinant and health outcomes, as does the Mega-trends report *(4)* and the European Region report *(5)*.

Figure 2-1 **The EQuAL indicator and monitoring framework for health: EQUity-oriented Analysis of Linkages between health and other sectors**



Domain scope
Amenities: includes access to adequate, affordable and reliable services such as safe drinking water, sanitation, waste disposal, electricity and transport.
Community spaces and products: includes the product market (e.g. availability of products, regulation on quality and safety throughout the supply chain, etc.) and public spaces, focusing especially on safety, environmental quality and accessibility/ affordability.
Housing: includes physical conditions (e.g. building design, space, crowding, ventilation, physical hazards, proximity to animals), and administrative issues (e.g. tenure, property disputes, formal address).
Working conditions: includes hours of work, time, occupational safety, stress (demand/control), risk/reward, rights awarded for special leave, parental leave, sick leave.
Accountability and participation: includes shared decision-making for health and determinants, ethical practices, confidentiality, transparency, accessible administrative procedures, adequate record keeping and data sharing (including registration), absence of institutional abuse and communication of information on rights, entitlements and obligations.
Discrimination: includes disrespectful or abusive treatment, stigma and related fears or shame on any grounds (e.g. health status, personal characteristics, irregular status, etc.) as well as the need for positive discrimination where needs are greater.

Gender equality: includes equality in gender norms, roles, relations and laws and in opportunities in different aspects of life (e.g. education, employment, household finances, access to energy and water, control over body). It also includes a participatory approach to involving men and women in health care decisions.

Social capital: includes supportive networks for information sharing and psychosocial benefit, and sometimes, financial support as well as social norms conducive to health.

Education and skills: includes access to opportunities to develop cognitive and literacy skills; access to information through mass media, outreach services and other sources; and knowledge on health and health care systems.

Employment relations: includes power of labour to negotiate contracts, contract security and fundamental rights at work (e.g. no bonded labour).

Income, wealth and social protection: includes the distribution and adequacy of resources, access to financial institutions, ability to purchase health-promoting products and related pricing policies, as well as cash and in-kind transfers that protect individuals from income shocks, inadequate resources, drastic coping strategies and life-cycle risks.

Intergenerational equity: includes access to opportunities to develop cognitive and literacy skills in early childhood, youth and early adulthood and to secure basic conditions for healthy growth and for work.

Source: Adapted from Valentine, Koller and Hosseinpoor *(3)*.

STEP 3 (introductory):

Compile an up-to-date summary

The information on health status and determinants is important and is likely to be used in multiple circumstances including briefings and workshops. This summary should be done in a format that is easy to read for an audience that may be unfamiliar with health-related information. It should be authoritative but user friendly and include graphics and references.

STEP 4 (introductory and in-depth):

Collect information on evidence-based interventions

Organise a literature review or collect key reports outlining evidence-based strategies that address the determinants and minimise the impact of inequities. Health colleagues will have many of these reports and journals and they will provide a key source of information. Annex 1.1 (Table A-1) gives two lists of strategies as a starting point but it will be important to compile your own examples relevant to the current circumstances and challenges of your country.

STEP 5 (introductory):

Develop a few strong narratives

Making clear the connection between health outcomes, the determinants of health, potential interventions and why it is important and necessary is essential. Practice this within the team.

In-depth, comprehensive analysis

Should time, funding and capacity allow a more in-depth and consultative process, progress the following steps. Further information on how to guide a Delphi process is provided in Annexes 1.2 – 1.6. The Delphi process may run over several months.

STEP 1 (in-depth):

Analyze the BoD profile

For the country to identify the 15 largest contributors to the BoD *(6)*, comparator countries (benchmarking) as well as the largest exposure and attribute risk factors.

The Institute for Health Metrics and Evaluation (IHME) website is a valuable starting point. The Country Profiles provide an overview of findings from the Global Burden of Disease (GBD). These profiles are meant to be freely downloaded and distributed (refer to http://www.healthdata.org/). The IHME, part of the University of Washington, makes available high-quality information and datasets on population health and risk factors.

Hints!

Be aware of not mixing exposure and attribute risk factors. Rationales for taking the BoD profile as the starting point include: to avoid biases from availability of data and/or specific programmes' interests; to benchmark with other countries and to identify knowledge gaps. However, the links of these risk factors to social determinants of health need to be drawn based on in-depth studies.

The sheet (Figure 2-2) considers the rank order for 15 leading causes of BoD, however the top leading causes of disease burden you wish to illustrate can be more or less than 15.

Figure 2-2 Example of overview planning sheet for assessing the BoD, health equity and the narrative on the social determinants

Ranking of BoD in [insert country name]		Disease / condition source of data				Population attributable risk factor				Producing graphs			Producing narratives			Quality checked		
GBD Profile: [insert country name][a] (groups[b])		Rate per district	Rate per wealth quintile	Rate by ethnicity and sex	Rate by other stratifier, e.g., education, occupation, etc.[c]	Rate per district	Rate per wealth quintile	Rate by ethnicity and sex	Rate by other stratifier, e.g., education, occupation, etc.[c]	Who - name	Planned date	Delivered date	Who - name	Planned date	Delivered date	Name and date	Name and date	Name and date
1	HIV/AIDS (Ia)																	
2	Stroke (II)																	
3	Preterm birth complications (Ib)																	
4	Ischemic heart disease (II)																	
5	Self-harm (III)																	
6	Major depressive disorder (II)																	
7	Road injury (III)																	
8	Diabetes (II)																	
9	Iron-deficiency anaemia (Ib)																	
10	Low back pain (II)																	
11	Neonatal encephalopathy (Ib)																	
12	Congenital disorder (II)																	
13	Lower respiratory infections (Ia)																	
14	Chronic kidney disease (II)																	
15	Adverse medical treatment (III)																	
Potential focused diseases / conditions that are not among the above 15																		
A																		
B																		
C																		

EXAMPLE RANKING

[a] The development of Country Profiles will enable an overview of findings from the Global Burden of Disease (GBD) to be illustrated. See www.healthdata.org.

[b] Burden of disease groups

Group Ia: Communicable diseases

Group Ib: Maternal, neonatal and nutritional conditions

Group II: Non-communicable diseases

Group III: Injury

[c] Note: If there are difficulties with disaggreating data according to wealth then look at data sources with alternative social stratifiers in mind. A related stratifier is 'educational attainment' but there are others.

STEP 2 (in-depth):

Prepare the template for each disease and the guidance for a participatory process

For the top 15 contributors to the BoD complete a briefing paper to summarise the key information and messages (Figure 2-3). Also refer to Annexes 1.2 - 1.6 for the participatory process.

Figure 2-3

Template for each BoD (2-page briefing/Information sheet)

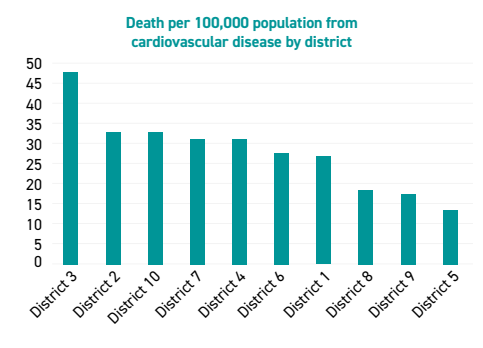
Short briefing template *(Annotated template with mock graphics)*

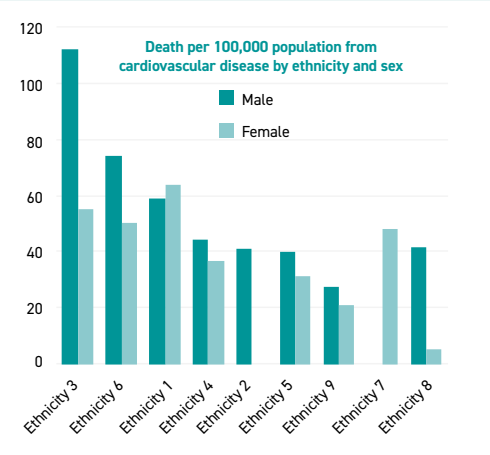
COUNTRY: (insert country name)
DISEASE: cardiovascular disease

Narrative: Should be written with a non-medical reader in mind. Start by stating the rank in BoD in Country X[a] and explain that burden quantifies the years of life lost due to premature death and years lived with disability. Explain what that means for this particular disease in a language understandable by the target reader.

Main risk factors: The main population-attributable risk factors, e.g., smoking, low immunization coverage, obesity, unhealthy diet, physical inactivity, etc.

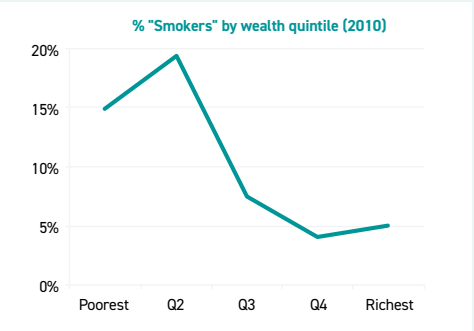
Missing data should be indicated by place-holder "n.a". Not all data for the graphs below need to come from the same source. The end-note should indicate what the data represents and whether it is population-based or service-based. A separate log should be kept with comments on the data.





Disease/condition (per 10,000) by wealth quintile[b]

This quick assessment has not found data on the distribution of cardiovascular disease by wealth. However, data on various risk factors was able to be accessed from other studies in Country X. The patterns found in distribution of risk factors in Country X closely follow the distribution of cardiovascular disease risk in countries with similar income, and suggest that the BoD for cardiovascular illness is largest among the poorest and poorer quintiles, compared to middle and higher quintiles.



Social determinants

The narrative on the social determinants should come out in the second part of the briefing, making links to the BoD information.

Try to group the social determinants under larger sub-headings – all should be referenced.

One option of sub-headings and categorization is shown below.

Society – context and position:

For example rights, status and registration would fit here

Social and economic environment:

For example gender and social norms, marketing of unhealthy products would fit here

Physical environment (and infrastructure):

For example water, sanitation, town and road planning, housing would fit here

Vulnerability, family and community:

For example education would fit here

Health care system:

For example availability, access, acceptability, quality would fit here

a Build a BoD profile for your country. See www.healthdata.org as a starting point, which provides Country Profiles from the GBD.
b Include your source/s of data.

Hints!
HiAP case studies in the WHO and Government of South Australia case study book *(7)* provide useful examples of the processes discussed in Tool A.1. See also Chapter 12 on Intersectoral planning for health and health equity from the WHO book, Strategizing national health in the 21st century: a handbook *(8)*. Sometimes there are country surveys that have not been fully analysed from an equity perspective, including, e.g., Demographic and Health Surveys (DHS) *(9)*, STEPS non-communicable disease (NCD) surveys *(10)*, Multiple Indicator Cluster Surveys (MICS) *(11)*, etc.

STEP 2.1 (in-depth):

Undertake four iterative Delphi-rounds by email

To gather further information on the leading disease burdens, health inequalities and social determinants of health, you might consider undertaking an iterative Delphi process *(12)* with key experts and other participants. This is just one example of how one might go about collecting more detailed data for the Analysis of health and determinants. The four Delphi-rounds might include the following sequence:

First round – limited number of expert-participants aiming to complete the description of the level and inequities in health of the 15 top BoD conditions as well as to identify any burden that is known to be very unevenly distributed across population groups but is not in the top 15 conditions.

Second round – larger number of participants, including others from academia, civil society, programmes and services that can help interpret what the data might mean to continue completing the

evidence base of the first round. This will now also include suggestions for the causes or determinants for the level of health and risk factors and the related inequities in the population – referenced if possible – as well as inequity dimensions such as income, gender and ethnicity.

Third round – the number of participants might be further expanded if deemed relevant based on the second round to continue complementing and supplementing the knowledge base of the second round. Now also include proposed policy domains capturing the social determinants across the 15 BoD Information Sheets with current policy and policy implementation gaps, proposed policy options, including expected health benefits (level and distribution) and benefits to other sectors.

Fourth round - the list of remaining issues, minority opinions, and items achieving consensus are distributed to all the participants for final comments and input.

Hints!

It is important to have quick turnarounds (maximum 10 days). This builds credibility and transparency so those providing input and feedback can recognize their contributions; or provide an explanation why their views are not included, if this is the case. After round two it might be feasible to focus on four inequity dimensions only, to be pursued in round three and four informing the work of the first cycle. This reduction should be explained and justified in the feedback from rounds one and two.

The results from the Delphi-rounds should be consolidated in a presentable format conducive for further distribution at any workshops (e.g. national consensus building workshop) to facilitate the identification of the problem and help set the HiAP agenda. The product of the in-depth analysis of health and determinants (e.g. Figure 2-2 and 2-3, and information collected the in Delphi process) should be as complete a picture of the health and health equity situation including the key social determinants and the main inequity dimensions. Equally important is that the gaps in knowledge are clearly identified. Important gaps in knowledge that are identified in the Delphi process should be considered in the research agenda (**E.1**).

At the end of the Delphi-rounds, you might expect to have completed a high-level briefing note summarizing the main BoD and risk factors, and information sheets on each of the leading disease burdens, highlighting social inequalities where data was found, and narratives on the social determinants of health causally related to the patterns of inequalities.

STEP 3 (in-depth):

Prepare policy domain sheets

The idea of the policy domain sheets is to orientate the information from the BoD towards the different policy sectors or areas. While the information summarizing the BoD is easy to use for public health actors, experts from other sectors may find it too health focussed. The same information can be presented according to policy domains. This information can be useful as background for facilitating discussions/workshops at, for example, a national consultation.

The policy domain sheets are an attempt to group the determinants identified in the BoD Information Sheets into actionable policy domains – in a tangible way feeding into a National consensus building process (**A.3**) and to help *'set the agenda'*.

The example in Figure 2-4 is for a policy domain labelled as 'physical infrastructure'.

Figure 2-4 Example of a policy domain master sheet/briefing for 'physical infrastructure'

Physical infrastructure as a policy domain for health

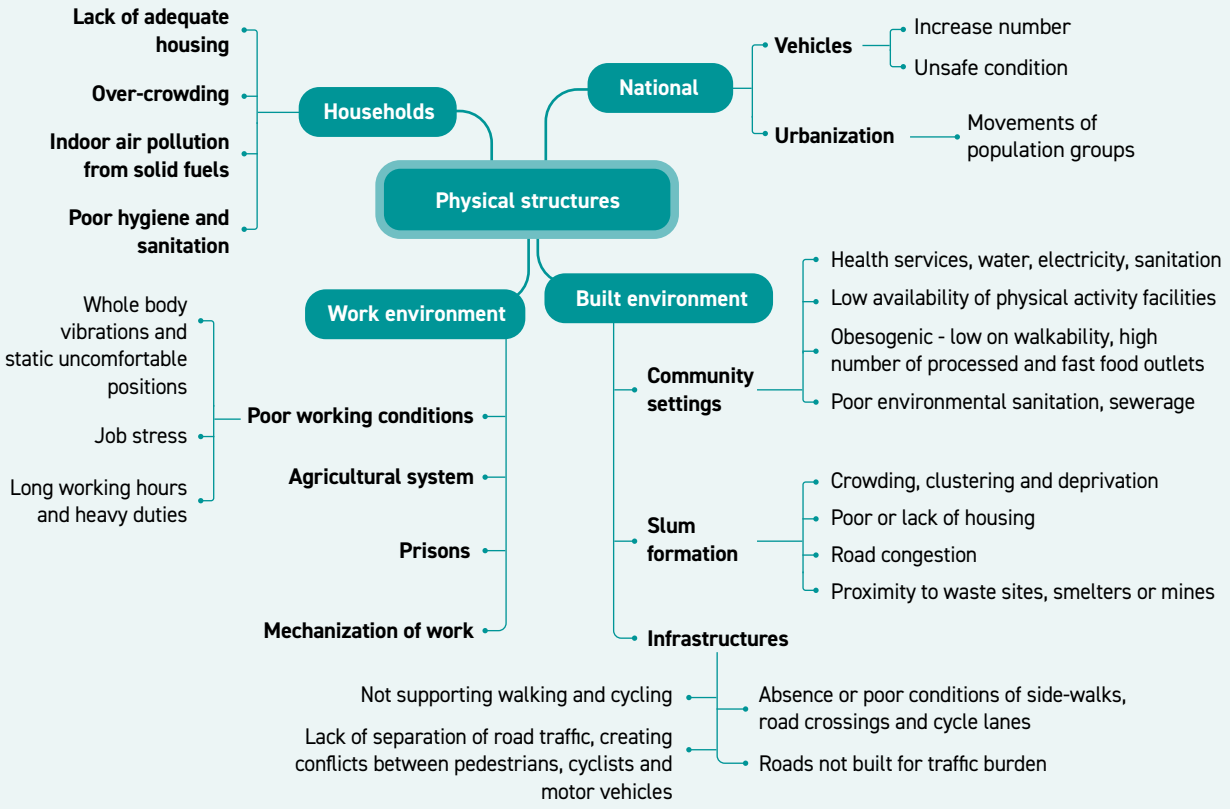
Narrative: The development of physical structures in a community is important for the social and economic advancement of a country. Development is a key target for the economic, planning and transport sectors. However, it also has an effect on health.

The analysis of the health situation in the country (refer to your Information Sheets) revealed a large number of physical structure determinants at play in shaping the level and distribution of health in the population, in particular for NCD and injuries. These can be arranged into four sub-domains: **national, built environment, work environment,** and **households** (*see diagram below*).

Appropriate policies that are sensitive to health will help to reduce the BoD and improve health equity, including for NCD and injuries. Health harming or non-optimal policies for health might, however, hinder action or reduce the effectiveness of efforts for improvement in health and well-being.

Who is working in this domain?

- Ministries of Regional Development, Labour, Health, Public Works, Physical Planning, Justice and Police
- Police Corps (traffic police)
- Also identify any United Nations agencies, Non-government organizations, and private companies that might have an interest.



Current policy situation for the physical infrastructure domain as a whole

The equity and social determinants analyses carried out during the Delphi process and described in the information sheets and short briefings (e.g. Figures 2-2 and 2-3) suggested a large number of diverse determinants at play in the physical infrastructure domain in particular for the 'built environment' and 'work environment' sub-domains – but also for 'national' and 'households'. However, the number and diversity is not reflected in the suggestions from Delphi III, in particular with respect to 'work environment' and 'household'. This is surprising given the importance of addressing NCD and poor housing conditions in this country.

The following table captures suggestions from the participants in Delphi round III where there might be policy gaps and policy implementation gaps for each of the four sub-domains. These will be discussed with critical stakeholders, for example during the National Consensus Building process, before proceeding to make recommendations on priority policy options.

Critical gaps by sub-domain

Policy gaps: *Missing policies or insufficiency of current policies*	**Policy implementation gaps:** *Where a policy exists – but is not adequately implemented*
National: • Legislation: pass the new Environmental Framework Act; adjust and design relevant laws; ensure coordinated physical planning. • Legislation on physical planning.	**National:** • Support for improved social cohesion through urbanization and physical planning policies.
Built environment: • Inventory of harmful facilities in and near towns and communities. • Inventory of the current situation and state of sports facilities and needs in the communities. • Attune all parts of the institutional and legislative field with regard to physical planning and decisions to be made based on a transparent verification strategy; foster public support in the planning and implementation process of physical planning. • Develop a coordination structure for physical planning to synchronize all plans and activities; and build capacity to gather and analyse data and information on physical planning.	**Built environment:** • Although the National NCD action plan contains a number of activities to improve the built environment, it is not always clear whether or how these will be supported by policy or legislation towards implementation. • Strengthen capacity and responsibilities of relevant institutions and sufficient competent personnel; intensify green sector education. • Reduction in the number of (illegal) mining, logging and other concessions issued without prior knowledge and consent of communities, and thus also the (illegal) use of mercury, pesticides and other chemicals, and a decrease in the immediate destruction of the environment.
Work environment: • Address the impact of climate change and other forms of environmental degradation on jobs, worker productivity, and decent working conditions.	**Work environment:** • Encourage corporate environmental responsibility.
Household: • Review of the housing system to reduce overcrowding and other housing problems.	**Household:** • Encourage environmentally responsible behaviour and healthy lifestyles.

STEP 4 (in-depth):

Prepare a summary 'Health of the population – health of the country' briefing

A succinct brief summarizing the findings from the analysis thus far should be prepared as a high-level briefing to senior decision-makers beyond the health sector. You may wish to review the briefing again after the National Consensus Building process (Tool **A.3**) to incorporate any new findings and information.

It should link health and development, identify the main dimensions of inequity (e.g. geography, ethnicity, sex and income) and give examples of how diseases, conditions and risk factors are distributed across these dimensions.

The briefing should call for intersectoral policy action, and provide examples of potential policy entry points for further exploration when developing detailed *options and strategies*.

An example brief is shown in Figure 2-5 for Country A.

Figure 2-5

High-level Briefing Paper motivating for using the Health in All Policies approach to address the social determinants of health

Country A - Health in All Policies brief

Health of the population – health of the country

Health and development

Poor health and health inequities cause personal suffering and missed opportunities for social and economic development. Each year, Country A loses 170 000 productive life-years due to ill-health and premature death. "*Communicable diseases, maternal, neonatal, and nutritional disorders*", "*Non-communicable diseases*" and "*Injuries*" account for **27%**, **58%**, and **15%** respectively.

Benchmarking against comparator countries[a] shows that for all Country A's 15 largest contributors to the BoD, there is considerable room to improve compared with other countries of similar income per capita (see table below).

Benchmarking		**The 15 largest contributors to the BoD in Country A** *(listed according to size of burden)*														
Comparator countries *(similar level of income per capita)*	**Overall rank**	**1. HIV/AIDS**	**2. Stroke**	**3. Preterm birth complications**	**4. Ischemic heart disease**	**5. Self-harm**	**6. Major depressive disorder**	**7. Road injury**	**8. Diabetes**	**9. Iron-deficiency anaemia**	**10. Low back pain**	**11. Neonatal encephalopathy**	**12. Congenital anomalies**	**13. Lower respiratory**	**14. Chronic kidney disease**	**15. Adverse medical treatment**
Serbia	1	5	14	2	11	13	1	6	4	1	13	1	2	1	2	3
Cuba	2	4	3	1	9	12	12	4	3	7	2	3	3	6	5	9
Macedonia	3	2	15	6	14	5	6	2	7	2	14	2	4	2	4	2
Montenegro	4	1	13	3	13	14	13	8	2	3	12	6	1	3	3	1
Panama	5	11	2	4	4	10	4	9	8	5	9	5	11	7	12	5
Jamaica	6	12	11	5	1	1	5	1	12	11	5	12	6	4	10	13
Columbia	7	9	1	8	5	8	14	7	1	9	10	8	12	10	6	4
Iran	8	3	6	9	15	4	15	15	5	6	15	4	15	5	1	7
Brazil	9	6	8	10	7	9	11	12	6	4	11	11	9	11	7	6
South Africa	10	15	10	11	3	2	3	3	12	8	8	14	5	15	13	8
Dominica	11	7	4	12	2	3	10	10	11	10	7	13	10	12	8	11
Saint Vincent and the Grenadines	12	10	7	14	8	7	7	5	14	13	3	9	8	9	9	10
Dominican Republic	13	8	9	13	12	6	2	14	9	12	1	10	13	13	11	15
Belize	14	14	5	7	10	11	9	13	15	15	4	7	7	14	14	12
Country A	**15**	**13**	**12**	**15**	**6**	**15**	**8**	**11**	**10**	**14**	**6**	**15**	**14**	**8**	**15**	**14**

Individual health care only explains 20% of the level and inequity in population health. The remaining 80% is shaped by a range of social determinants (50%) and individual health behaviours (30%). Health behaviours, in turn are also shaped by social determinants.

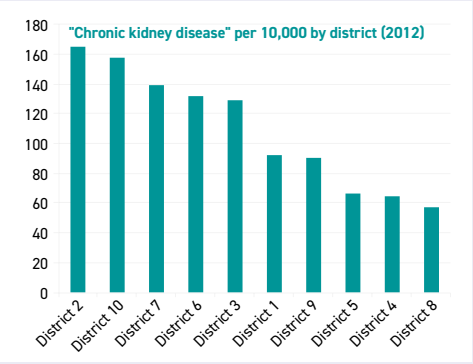
a Mock table comparing Country A with comparator countries for disease burden. Refer to the Institute for Health Metrics and Evaluation (IHME) website (www.healthdata.org/) for data presentation ideas and data on country profiles.

Dimensions of inequity

Social determinants are the conditions, in which people are born, grow, work, live, and age. Key forces at play are: social, economic and political systems; development agendas; and social norms. Social determinants cause health inequities and influence health and development via several pathways. They can be addressed through public policy and intersectoral action. The three main dimensions of inequity in Country A are: geographic location, socio-economic status, and population group and gender.

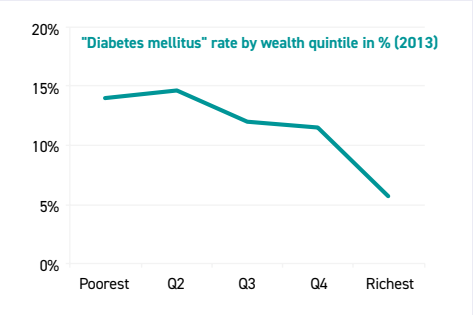
Geographical location – For each of the leading causes of BoD with data available, there are marked inequities across districts. However, not the same district is 'worst off' in all cases. E.g., for diabetes, it is District 10, for cardiovascular disease it is District 3, etc. It is likely that inequities also exist across locations within each district and urban/rural areas.

Social determinants include: population composition, clustering of disadvantage, poor infrastructure and housing, proximity to waste sites, smelters or mines, obesogenic environments, etc.



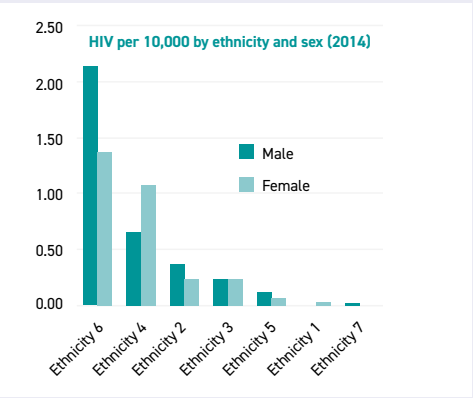
Socio-economic status – For diabetes there are clear inequities according to wealth with the poorest being four times more affected than the richest. In Country A, it is only for diabetes such data is available. However, inequities could, with data available be shown for most of the other major diseases also by level of education, age, and migratory status.

Social determinants include: lack of jobs and educational opportunities, low knowledge, lack of social capital in families and communities, etc.



Population groups and gender – HIV is unevenly distributed across ethnic groups and between men and women. There are different inequity patterns for different diseases. E.g., for stroke and kidney disease the blunt of burden is borne by Ethnicity 4 and for cardiovascular diseases by Ethnicity 1 women. Limited data exist for groups such as drug users, sex-workers, and LGBT.

Social determinants include: social and cultural norms and gender roles, access to social and health services, social stigma and discrimination, marginalisation, intersection with poverty, etc.



Risk-factors – Such as smoking, harmful use of alcohol, unhealthy diet, physical inactivity, co-existence of other health conditions, etc. are also unevenly distributed across geographical locations, socio-economic status, population groups and gender. However, limited concrete information on population-based risk factors is available.

Social determinants include: marketing, pricing and availability of tobacco, alcohol and unhealthy food products, nutritional transition, social and gender norms, lack of knowledge, poverty, etc.

Potential policy entry points

Health inequities are avoidable and can be reduced by addressing the social determinants causing them. The government, communities, and public and private sectors share the responsibility for action. The National HiAP Consensus Building process (refer to Tool **A.3**) identified potential entry points for the first-wave of policy action.

1. Education and jobs – Poor education and transition into adulthood are strong determinants for health inequity for oneself and for one's children, and for responsible participation in society. *Proposed policy options include:* compulsory education (4 to 16 years); second chance education; aligning education to labour market needs; improve teaching on health, nutrition, water and sanitation, good traditional practices, environment, physical education, entrepreneurship and innovation; and strengthen labour planning, adherence to labour law and health in the workplace.

Sectors: ***Education,*** regional development, district councils, labour, trade and industry, agriculture, environment, private businesses, civil society organizations, and ***health***

2. Spatial planning and management – People who are already disadvantaged, e.g., poor or marginalized are more affected by weak spatial planning and management than those better off. *Proposed policy options include:* coordinate physical planning; strengthen district level structures and capacities; neighbourhood planning and community centres; recognize communal land rights; reduce illegal mining; inventory of harmful facilities and activities; decrease destruction of the environment; etc.

Sectors: ***Planning office,*** regional development, district councils, public works, environment, physical planning, trade and industries, natural resources, agriculture, education, civil society, and ***health***

3. Built environments – Roads, transportation systems, settlements, housing, and appropriate and adequate infrastructure provide the physical frame for how people live and move. *Proposed policy options include:* formulate and implement infrastructural norms that consider health and well-being, including for safe walking and physical activities; coordinated policy on low cost housing; adequate and affordable housing as part of district plan; etc.

Sectors: ***Public works,*** regional development, district councils, housing authority, home affairs, transport, planning, police, home affairs, environment, civil society, social affairs, and ***health***

4. Integrated approach at community and household levels – Disadvantage tends to cluster in certain communities and households where they are mutually reinforcing. *Proposed policy options include:* increase political and administrative responsibility and accountability at local and community level; multidisciplinary action on gender and domestic violence and child abuse; early child development; link integrated planning at community level to regional and national planning; conditional cash transfers; etc.

Sectors: ***Regional development,*** district councils, public works, education, justice and police, social affairs, planning, spatial planning, sports and youth, gender bureau, civil society, and ***health***

5. Consumables – There are close links between food, smoking and alcohol consumption patterns and the level of disease and health inequity. *Proposed policy options include:* taxation according to nutrition and health value; regulation of advertising and marketing (*including targeting of children*), content of processed food (*salt, sugar, trans-fats, and additives*), labelling, alcohol and fast food outlets; and promotion of local healthy food production and distribution.

Sectors: ***Trade and industry,*** finance, agriculture, regional development, spatial planning, education, vocational training institutions serving the food sector, private food and beverage sector, civil society, and ***health***

6. Training and employment of staff – often staff of public and private organizations do not know how their 'business' influences health and how they can work with each other to reduce inequity. *Proposed policy options include:* assessment and revision of curricula of training institutions (*health and others*); include HiAP in generic and specific post descriptions; incentives and rewards for "desired" behaviour; integration of inequity and social determinants knowledge and skills into in-service training and career paths; integrated training for community workers; etc.

Sectors: ***Education, professional and higher learning institutions,*** regional development, district councils, spatial planning, public works, trade and industry, agriculture, justice and police, social affairs, professional associations, civil society, and ***health***

7. Health system governance – influences how it operates, its ability to work with other sectors, how priorities are set, who benefits; and participation, transparency and accountability mechanisms. *Proposed policy options include:* make inequity reduction part of the system's ethics code, budget allocation and success criteria; make contributions of all relevant sectors visible in policy, budget and reporting; structure for participatory, multi-sectoral and culturally appropriate planning and implementation; safe systems for protecting patients' rights and handling malpractice.

Sectors: ***Regional development,*** district councils, social affairs, insurance, Non-government organizations and private health care providers, justice, civil society, and ***health***

8. Health system organization and management – may cause the system to perform below its potential for reducing health inequities due to e.g.: fragmentation, weak administrative and managerial capacity. *Proposed policy options include:* enhanced and coherent coordination of the different subsystems of the national health system; enhanced evidence-based managerial effectiveness towards health inequity reduction goals; enforcing Primary Health Care, including intersectoral action, referral system, telemedicine and the integration of preventive services.

Sectors: ***Regional development,*** district councils, social affairs, insurance, Non-government organizations and private health care providers, professional associations, civil society, and ***health***

Next steps

- **Intersectoral working groups** on each of the above eight potential policy entry points to feed into sectoral policy-making action and the next National Development Plan.
- A comprehensive rights-based **HiAP monitoring strategy** for health and equity with four business lines: (1) administrative data, (2) repeated surveys, (3) *ad hoc* surveys, studies and research projects, and (4) policy adequacy, implementation and effect.
- An **annual population health report** presenting the newest knowledge on the BoD, inequity, risk factors, social determinants at play, and policy action in country A.
- The first annual **national health forum** providing the opportunity for politicians, sectoral managers, researchers, private sector and civil society to review the newest knowledge and policy and implementation progress, share experience, innovate and discuss the way forward.

A.2 Scan of intersectoral policies and mechanisms for action

Why and when?

The *Scan of intersectoral policies and mechanisms for action* will aid in identifying cross-cutting mechanisms and structures that may support a HiAP approach, how they function, and what opportunities and challenges they provide, as well as assist in getting to know potential collaborators in other sectors. It will also pick up relevant policies that are, or could be, multisectoral and supportive of health.

Together with **A.1** Analysis of health and determinants and **B.1** Scan of societal/mega-trends, the scan of intersectoral policies and mechanisms is part of the initial baseline review that needs to be done prior to a national consensus building process (Tool **A.3**) and before deciding on the final HiAP strategy and governance structure. It informs future engagement with sectoral partners and stakeholders (within health and beyond) for specific action. The exercise may lead to intersectoral dialogue workshops that test out ideas for appropriate structures and scope people's experiences of working intersectorally. These are all useful processes to precede and inform the development of more formal structures and accountability lines.

The political, social, economic, commercial and environmental determinants of health and health equity span across multiple sectors and thus call for concerted intersectoral action. This is not new. Numerous disease specific health programmes have pursued intersectoral action e.g. malaria and childhood malnutrition and many policies have been cross-sectoral in nature e.g. tobacco control. Mechanisms for intersectoral action for development in general have also been tried in many countries, however the experiences with respect to efficiency and durability have been varied.

Rationale and scope

The rationale for the scan of intersectoral policies and mechanisms is two-fold: first to learn from actual experiences with intersectoral collaboration and action in the country regardless of whether these are concerned with health or not; and second to start engaging key sectoral stakeholders from government and non-government sectors in HiAP and better understanding their policies, positions and values. This can be a labour-intensive exercise but experience shows it is usually worthwhile. However, if the HiAP team deems that it has the knowledge but not the time, some shortcuts may be made.

Intersectoral action is inherently challenging because, by nature, it falls between sectors and therefore often between organisations, structures and hierarchies as well as between budget allocations, access to resources and accountability lines. The practice of intersectoral action can differ from the theory and aspirations.

The input to the scan will be through meetings or interviews with key stakeholders guided by an interview sheet. These discussions provide an opportunity to inform the way HiAP will be described and explained into the future (see **B.3** Talking about HiAP), the positions and values of stakeholders and their experiences. This approach supports snow-balling (expanding to a wider group of potential stakeholders) and might include different viewpoints on current and previous mechanisms for governance, coordination and collaboration in intersectoral action.

STEP 1

What to do?

Table 2-1 identifies two tracks (one health, one outside of health) and Annexes 2.1 to 2.3 provide detailed tools for use in the **intersectoral scan**. Such a comprehensive scan of intersectoral action will take from one to three months with up to about 20 interviews each lasting two or more hours. This scan should be in parallel with and completed at the same time as the Analysis of health and determinants (**A.1**) and Scan of societal trends (**B.1**) and in advance of the National consensus building process (**A.3**) and finalizing the HiAP Strategy.

Nevertheless, at times there is no alternative but to undertake a more rapid scan and this can still be useful though it may narrow the number of stakeholders you engage with and the level of understanding of their positions and values. Annex 2.4 presents a tool for implementing a more limited scan.

The scan of intersectoral action will have two parallel tracks and a concluding strategic analysis.

Table 2-1

Intersectoral scanning approaches

Track one:
Interviews – health programmes
(guide for focused interviews – Annex 2.1)

1) Identify programme managers for interview
   - Disease specific programmes addressing one or more of the top 15 contributors to the BoD in the country.
   - Disease specific programmes addressing diseases that are not among the top 15 burden but are focused in certain geographical areas or population groups – this could include certain tropical diseases and/or some vaccine preventable diseases.
   - Non-disease specific health programmes e.g., health systems, health promotion, healthy cities, etc.
2) Identify who within the HiAP team will do which interviews – review and confirm common interview guide (Annex 2.1)
3) Conduct interviews, including SWOT* analysis (Annex 2.3)
4) The interviewer writes a brief report for each individual interview

Track two:
Interviews - other sectors
(guide for focused interviews – Annex 2.2)

1) Identify sectoral managers for interview
   - Sectors identified during *A.1* Analysis of health and determinants, e.g. education, agriculture, social services
   - Sectors emerging from health programme interviews (Track One)
2) Identify who within the HiAP team will do which interviews – review and confirm common interview guide (Annex 2.2)
3) Conduct interviews, including SWOT analysis (Annex 2.3)
4) The interviewer writes a brief report for each individual interview

Strategic analysis
(qualitative analysis done by the HiAP team as a group)

1) General immediate reactions to the concept of HiAP among interviewees (*including which questions are asked by the interviewers*)
   - From health programmes
   - From other sectors
2) Positions and values (*who is responsible for individuals' health, population's health, roles of sectors, equity, co-benefits, etc.*)
   - Health programmes
   - Other sectors
3) Experiences with intersectoral action (*including whether they address health, well-being, and equity*)
4) Mapping of concrete experiences to: top 15 diseases, risk factors (exposure and attribution), social determinants, inequity dimensions and by sectors
5) Consolidate SWOT analyses where there are more than one for the same approach

* SWOT = Strengths, Weaknesses, Opportunities, Threats

STEP 2

Having completed the SWOT take the opportunity to assess the results against the Framework (Table 2-2) originally developed by Shiffman and Smith*(13)* to analyse the determinants of political priority for global health initiatives. The Framework is equally applicable at the country or sub-national level in relation to assessing support and readiness for implementing HiAP and determining priorities.

Table 2-2

Framework on determinants of political priority for global initiatives

Category	Description	Factors shaping political priority
Actor power	The strength of the individuals and organizations concerned with the issue	1. *Policy community cohesion:* The degree of coalescence among the network of individuals and organizations centrally involved with the issue at the global level 2. *Leadership:* The presence of individuals capable of uniting the policy community and acknowledged as particularly strong champions for the cause 3. *Guiding institutions:* The effectiveness of organizations or coordinating mechanisms with a mandate to lead the initiative 4. *Civil society mobilization:* The extent to which grassroots organizations have mobilized to press international and national political authorities to address the issue at the global level
Ideas	The ways in which actors understand and portray the issue	5. *Internal frame:* The degree to which the policy community agrees on the definition of, causes of and solutions to the problem 6. *External frame:* Public portrayals of the issue in ways that resonate with external audiences, especially the political leaders who control resources
Political contexts	The environments in which actors operate	7. *Policy windows:* Political moments when global conditions align favorably for an issue, presenting opportunities for advocates to influence decision-makers 8. *Global governance structure:* The degree to which norms and institutions operating in a sector provide a platform for effective collective action
Issue characteristics	Features of the problem	9. *Credible indicators:* Clear measures that demonstrate the severity of the problem and that can be used to monitor progress 10. Severity: The size of the burden relative to other problems, as indicated by objective measures such as mortality levels 11. Effective interventions: The extent to which proposed means of addressing the problem are clearly explained, cost-effective, backed by scientific evidence, simple to implement, and inexpensive

In relation to this Scan of intersectoral policies and mechanisms for action (**A.2**), Table 2-3 sets out factors that may be elicited through the consultations. This will also be relevant in subsequent tools.

Table 2-3

Application of the Shiffman and Smith framework to the scan of policies and mechanisms

Category	Factors shaping political priority *(number from Table 2-2 in parentheses)*
Actor power	The degree of policy cohesion amongst stakeholders from the various sectors; where this is lacking it may be wise to avoid or put energy into developing a more cohesive approach *(1)*. The existence (or otherwise) and effectiveness of organizations or coordinating mechanisms set up to lead collaborative work. This is also relevant to Models for governance and accountability (**D.1**) *(3)*.
Ideas	The degree to which the policy community agrees on the definition, causes and solutions to the problem including understanding the determinants of health and their impact *(5)*.
Issue characteristics	Indicators that demonstrate the severity of the health issue or the determinants and that can be used to monitor progress. This also relates to Monitoring and evaluation (**E.2**) *(9)*. The size of the problem relative to other issues, determined through your initial Analysis of health and determinants (**A.1**) and potentially informed through the process of consultation *(10)*. The extent to which there are means to address the problem/s and which are clear, evidence based, cost-effective etc. This information may arise from consultations and also be part of the National consensus building process (**A.3**) *(11)*.

A.3 National consensus building

Why and when?

Having a common understanding and working across sectors towards a common purpose is at the heart of HiAP. However, building consensus for intersectoral collaboration is particularly demanding. Not only because people may have different interests, priorities and imperatives but also because they often view the same issues from different perspectives and may use terminology unique to their own professional or community group.

The National consensus building tool is intended to bring together the results of the Analysis of health and determinants (**A.1**), Scan of intersectoral policies and mechanisms for action (**A.2**), Scan of societal trends (**B.1**) and Review and revise national plans (**D.2**) to build interest and support in other government sectors and in civil society for a HiAP approach to be adopted.

The expected results include:

- Agreement on the overall picture of the health of the population and associated determinants, from Analysis of health and determinants (**A.1**)
- Agreement on the findings from the Scan of intersectoral policies and mechanisms for action (**A.2**) and Scan of societal trends (**B.1**) and the implications for HiAP priority actions, policy development and reform and working groups
- Recommendations to government to express national commitment for moving ahead with HiAP, including integrating into national plans, governance, steering, participation and accountability
- A political brief describing the national HiAP purpose, approach and immediate priorities.

National consensus building is a process that is on-going covering different issues, sectors and opportunities over time. A national consensus workshop may be held at different points during the HiAP lifecycle but will be useful once initial research is completed and as a step in developing a national HiAP strategy.

Rationale and scope

The intention of the consensus building process is to bring people together, from diverse sectors and within health, to determine what can be achieved using the HiAP approach. This may involve one large consensus workshop or a series of smaller workshops, forums or round table discussions. The format will depend on factors such as resources available, strength of political will for HiAP and level of engagement from policy-makers in different sectors. There is no one correct model or method.

A national consensus workshop unlike a classic consensus conference process does not distinguish between expert and lay-panels. Participants in intersectoral work will, almost by definition, be experts in some areas while at the same time lay in other aspects of the same issue. It is the essence of intersectoral work that each contributes his or her knowledge and expertise while benefiting from those of others.

The following step-by-step tool describes a generic process for a national consensus workshop (up to around 75 participants) designed to analyse and interpret information on health and its determinants; review societal needs and trends; consider options for intersectoral collaboration and as a result, ways to develop an actionable HiAP agenda. The tool should be adapted by the HiAP team to serve the specific needs of the country and the level of engagement. It is assumed that the HiAP practitioners using the tool have some general experience in preparing and conducting workshops or forums as well as a general knowledge about HiAP.

The national consensus workshop might also be preceded by other smaller and more focused workshops, meetings or training programmes for example, involving key collaborations. The below "what to do?" is provided for guidance and inspiration.

What to do?

Before initiating step 1, the Analysis of health and determinants (**A.1**), Scan of intersectoral policies and mechanisms for action (**A.2**), Scan of societal trends (**B.1**) and Review and revise national plans (**D.2**) (in particular the national development plan), and any other information to be considered at the national HiAP consensus workshop should be well underway to be certain that they will be completed in time for the workshop.

STEP 1

Objectives, scope, and expected results

The HiAP team should carefully draft objectives, scope and expected results considering the above. A key factor for the process logistics and the main driver of costs is the number of participants. At this time, the HiAP team should also prepare a first budget, assign responsibilities within the team and estimate the work-load week by week, including for the post-workshop activities (STEP 10).

Hints!

Preparations for the national consensus workshop (STEP 1) should begin four to six months before it is expected to be held. The number of participants can easily become quite large. With less than 50 participants, it might be possible to squeeze the workshop into a packed one-day event – carefully time-controlled. However, if the number exceeds 50, it is advisable to hold the workshop over two days. The workshop outline (STEP 9) does not foresee more than 75 participants. If a higher number is desirable, the outline needs to be modified accordingly.

It should be reiterated that depending on your resources and capacity, smaller forums or round table discussions can serve a similar purpose to a larger workshop, and the context you are operating in will dictate what is required for an optimal consensus building process.

STEP 2

Funding, venue and dates

The venue must have a plenary room large enough to seat all the participants so they can see, hear and participate in plenary discussions. Ideally this will include tables around which 10-15 people can be seated. Break-out rooms for other discussions will also be useful. The budget can now be finalized, funding ensured and a final decision on venue and dates taken.

Hints!

The venue will often be decisive for the workshop dates and constitute the largest cost item. Depending on the available funding, it may be necessary to go back to step 1 and adjust objectives, scope and expected results.

STEP 3

Advisory group and moderator

While the responsibility for organizing the workshop lies with the HiAP team, it can be useful to establish an advisory group to provide advice on issues including: key opinion-leaders, invitees, on information packages for participants and the moderator. The moderator should be a respected and knowledgeable person with excellent skills in handling workshops and meetings of similar size. The moderator will have key roles in STEP 8 (training of facilitators) and STEP 9 (consensus workshop), but ideally should also take part in some or all of the meetings of the advisory group.

Hints!

The advisory group would typically consist of five to six people drawn from public and private sectors, including civil society. It should meet about once per month (or as required) and continue until the evaluation (STEP 12) has been completed. The HiAP team should be prepared for advisory group members to have diverse viewpoints and interests and perhaps pursue agendas that are not fully commensurate with the HiAP approach. However, it is better to discuss these issues in advance rather than being taken by surprise in the workshop itself.

STEP 4

Publicity, sponsors and opinion-leaders

The national HiAP consensus workshop can provide an excellent opportunity to raise awareness, in both political spheres and the community, about population health, determinants and health equity. This may trigger a window of opportunity for influence (see **B.2** Windows of Opportunity). A communication plan should be prepared and implemented from early on, including media information packages, pre-briefing of journalists, recruitment of a government sponsor (e.g., prime minister or finance minister) and opinion-leaders to address the workshop.

Hints!

The findings from **B.1** Scan of societal trends will have identified opportunities and threats helping you to design publicity, select and brief sponsors and opinion-leaders so that you can engage likely supporters. Sponsors and opinion-leaders are like magnets for the media (see also **B.3** Talking about HiAP). Sponsors lend their power and commitment to the HiAP approach and can give participants the feeling of contributing something important to the nation and the people. Having the right opinion-leaders with the right messages in the context of the National HiAP Consensus Workshop can advance the agenda for intersectoral collaboration on population health and health equity in the public and private spheres. However, they need to be well chosen and briefed. The context you are operating in will help define how 'big' or 'small' you go with using sponsors and publicity.

STEP 5

Participants and facilitators

During the Analysis of health and determinants (**A.1**) and Scan of intersectoral policies and mechanisms for action (**A.2**) most of the potential participants will have been identified, either as active contributors or key players in the relevant policy domains. Participants will mainly come from across public and private sectors and civil society, whom the HiAP team will potentially be working directly with to develop, promote and implement intersectoral policies for improving population health and health equity. Facilitators should be recruited from among the participants in advance of the workshop (see also STEP 8).

Hints!

As a guide, count one facilitator per maximum 15 participants. Facilitators should be people who are respected in their own right and positive about the HiAP, experienced in facilitating workshops and small and large group sessions, and present balanced group views. Avoid facilitators known to have strong or particular opinions which they might push on the group.

STEP 6

Preparing materials

Preparing and refining resources including high quality handouts, presentations, briefings and speeches for sponsors and opinion-leaders, and drafting workshop statements and instructions for facilitators and participants (see samples in Annexes 3.1 and 3.2) is paramount for the success of the workshop and future work of the HiAP. When participants leave the workshop they should feel inspired and part of a greater good. That will not come about with poor quality materials and uninspiring or boring presentations and speeches. The HiAP team is in full control of the preparations, and advice should also be sought from the advisory group, if in place.

Hints!

The respective HiAP focal people should present the findings of Tools **A.1, A.2, B.1,** and **D.2** in the workshop. Many of the participants will have had contact with the HiAP team during the consultation and prior to the Workshop. Having the responsible HiAP focal point present will enhance the sense among the participants that they are part of, and have ownership of, what is presented and will help timekeeping. Any handout should be short and concise; there is no time in the workshop for people to be reading and trying to digest large amounts of information. What people need to know during the workshop should in essence be what is shown and explained in the presentations. In some cases a short background paper could be distributed prior to the workshop, though it should not be assumed people will have read it.

STEP 7

Workshop logistics

This includes everything from writing and sending out invitations, to seating arrangements, visual and audio systems, timing and flow of sessions and people, registration, catering, writing pads and pens and preparing reports. A workshop is a huge investment of both money and people's time. People expect the logistics to function well.

Hints!

It is indispensable to prepare detailed check lists with tasks, responsibilities and timelines. The more participants, the more time everything takes and the more can go wrong. It is very easy to underestimate the time things take such as registration of participants and morning tea. It is also often difficult to control presenters and group-rapporteurs that are passionate about what they say. Poor time management is as bad as poor materials. Make a detailed script for the workshop and session flow together with the moderator. For the routine logistics, consider hiring a professional company so the HiAP team and the moderator can concentrate on those aspects only they can do.

STEP 8

Training of facilitators

Facilitators have been identified because of their skills and role (STEP 5), however they may not be fully conversant with HiAP and the consensus workshop process. A facilitators' instruction sheet provides guidance (STEP 6). To be confident about the facilitators, it is advisable to call them together about one week before the workshop to consult with them about their role in the event and provide further information on your expectations.

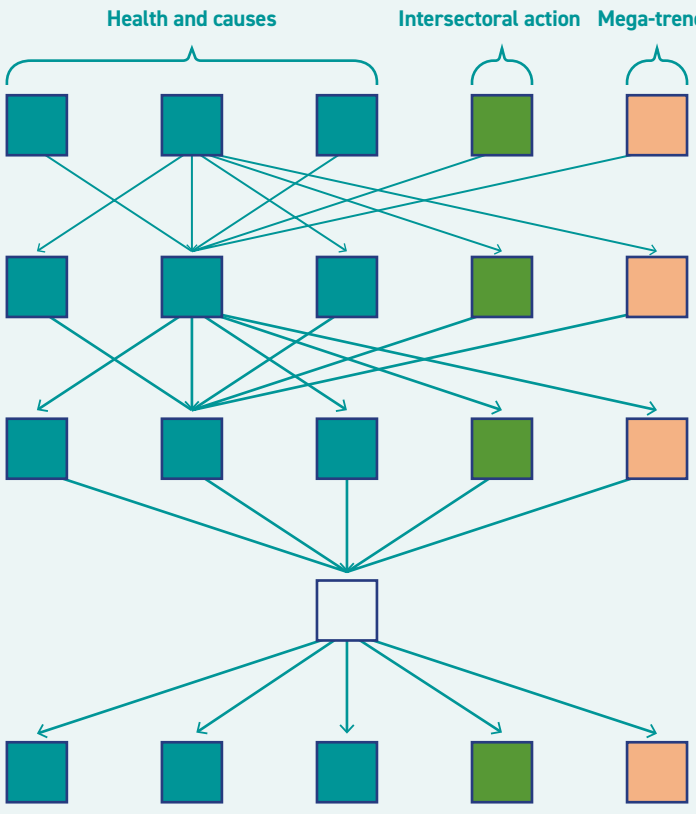
Hints!

You are the organizers of the consensus workshop. You have decided how it should be run. However, the facilitators may have some valuable perspectives and suggestions to improve the process so be prepared to make adjustments to the instructions for facilitators and participants.

STEP 9 Consensus workshop

For many of the participants, the workshop will be the first time they meet people from other sectors to find common group and intersectoral synergies. To support participants in getting to know each other and their work, a workshop flow is suggested to ensure optimal structured and informal interaction for learning and linking, while producing concrete outputs, including high-level HiAP statements with recommendations to government. Shifting participants between ***base groups, cross-sector groups*** and having a ***facilitators meeting*** with the HiAP team (see Figure 2-6) will optimize interaction across groups and help move towards the expected results of the workshop.

Figure 2-6 Consensus workshop process

Days	Time	Action	Notes
Day one	60mins	Opening: welcome, speeches by sponsors and opinion-leaders	**Notes on workshop flow**
	30mins	Introduction to concepts, purpose, process and expected results	
	60mins	Presentation of main findings from the scans (A.1, A.2, B.1) and the review of national plans (D.2)	
	45mins		**Base groups** review conclusions and draft priority actions from A.1, A.2 and B.1
	45mins		Participants disperse into **cross-sector groups**. Facilitator + one circulate. Exchange views, test priorities and recommendations
	60mins		Participants go back to **base groups**. Priority recommendations reviewed and comments on draft statements
	120mins		**Facilitators** meet with HiAP team to review priority actions/finalize draft statements
Day two	30mins		**Base groups** meet to quickly review final draft statements and priority actions
	60mins	Presentation and plenary confirmation of findings and priority action and endorsement of final statements	
	60mins	Closing: commitments from sponsors and opinion-leaders, farewell and next steps	

Hints!

The national consensus workshop in Figure 2-6 outlines a high-level process for one and a half days (9:00 – 16:00 and 9:00 – 12:00) with 30-minute morning tea breaks on day one and two, 30-minute afternoon tea break and a 60-minute lunch break on day one. It is a good idea to have a separate room where the facilitators can meet with the HiAP focal points at the end of day one as it often takes quite some time before all participants have left the main room. The outline is shown with three parallel base groups addressing health challenges and causes – each group addressing different policy domains.

With less than 50 participants, it might be possible to have one or two groups. One group could review the Scan of intersectoral policies and mechanisms for action (**A.2**) and the other group the Scan of societal trends (**B.1**). It may also be better to have two sessions with facilitators meeting with the HiAP team to review priority actions and finalize draft statements between the two sessions or share them electronically.

STEP 10

Post-workshop consultation and consolidation

Immediately following the workshop finalize any outstanding issues. Continue electronic consultations if required. Thank the participants, the sponsors and opinion-leaders and do not forget the facilitators. Confirm the next steps. Also consider the development of a workshop summary report to be made publicly available and distributed to all the participants for their records.

Hints!

The first week after the workshop is not the time to relax – it is the time to act and keep the momentum going. It is important to capture the reflections from the workshop process and document what was achieved and the agreed next steps. This should be shared with participants as soon as possible following the workshop.

STEP 11

Action

Workshops such as the national consensus workshop raise expectations and trigger opportunities. However, too often expectations are disappointed and opportunities lost because workshop organizers do not follow up, are too slow in following up or do not communicate further. As a consequence, participants return to 'business as usual'. This can be avoided by swiftly implementing decisions and keeping people informed:

- Establish priority working groups.
- Institutionalize governance, monitoring and accountability structures.
- Finalize and seek/gain approval of the national HiAP strategy.
- Draft, consult on and gain approval for the HiAP work plan and implementation of priorities.

Hints!

The workshop can be an excellent basis for starting and growing a 'HiAP community'. Consider the development of a HiAP mailing list to send regular updates. This can include links to relevant national and international publications, update on research programmes and findings, analysis of monitoring reports and surveys, achievements by the HiAP working groups, a monthly one-page HiAP newsletter, etc.

STEP 12

Evaluation

Evaluate the preparations, workshop logistics and conduct, meeting objectives and results. The evaluation can be done by the HiAP team with the moderator and the facilitators and include a debriefing meeting.

Hints!

It will not be the last time that the HiAP team organizes a large event. Therefore, it is a useful idea to safeguard all the documentation from the workshop and to be quite formal about evaluating and writing down the lessons learned. This should include what would be done differently should the workshop be repeated. A workshop summary report could include some of this information and two versions developed - one for internal use by the HiAP team and another for external distribution.

Summary

This tool (**A.3**) suggests a very comprehensive and ambitious method to hold a national or sub-national workshop. This will not always be possible and there are many different ways of building consensus for your HiAP strategy and approach. It depends very much on local circumstances including the level of commitment from other agencies, level of political support, and the workforce capacity to consult and run a workshop and implement actions. Caution is needed not to raise expectations that can't be met. It is important to adapt your process to local circumstances.

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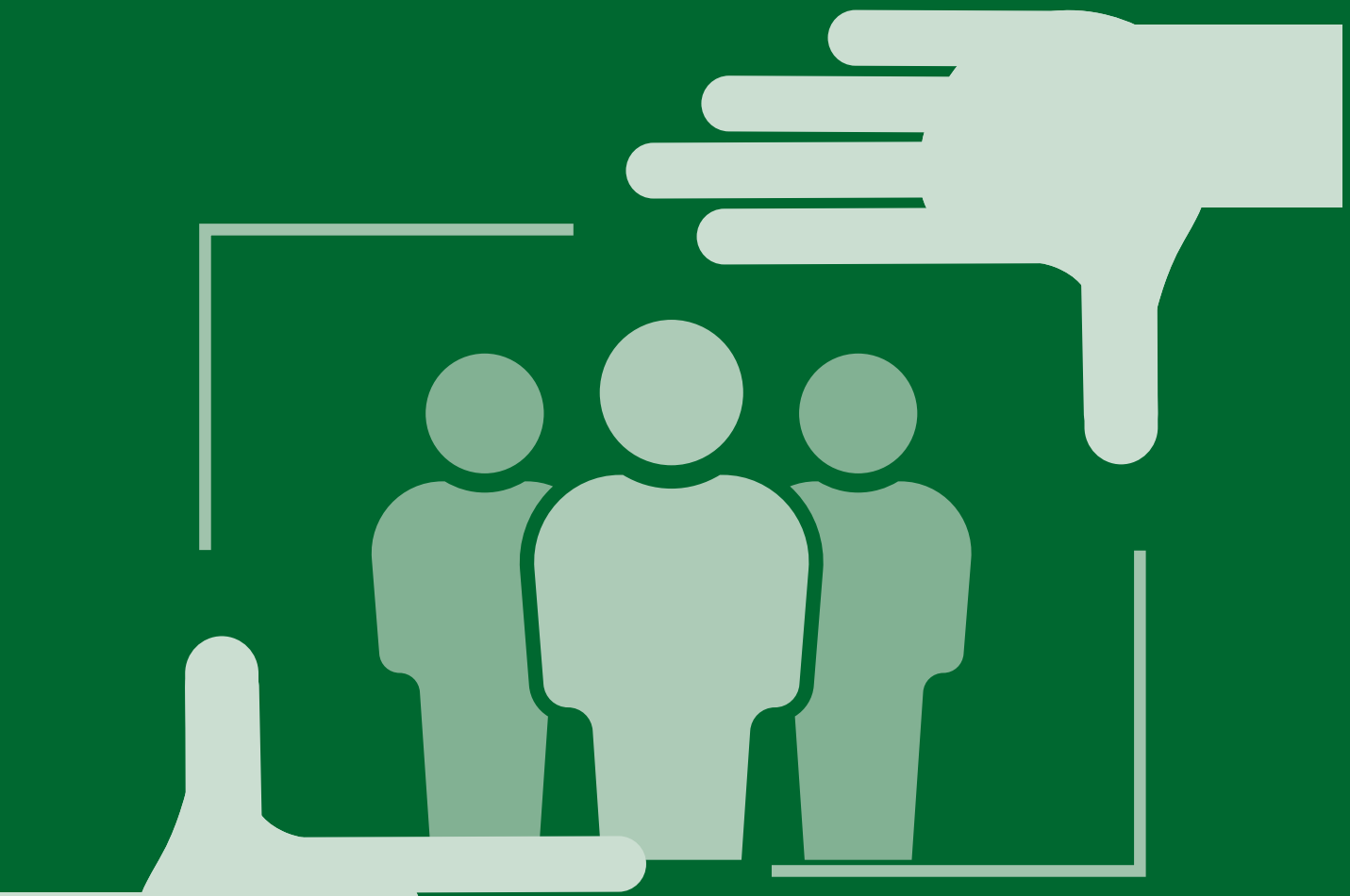
Chapter 3
Work stream B

Framing and scanning the political and policy environment: connecting with broader society and influencers



B.1 Scan of societal, 'mega' trends

Why and when?

Understanding the overall mega-trends in society is of paramount importance to understanding how population health and health equity is shaped and should be acted upon through healthy public policy to achieve long-term outcomes in population health.

The Scan of societal trends (**B.1**) is, together with Analysis of health and determinants (**A.1**) and Scan of intersectoral policies and mechanisms for action (**A.2**), part of the initial baseline reviews that need to be done prior to a national consensus workshop (National consensus building **A.3**), to help facilitate the development of a HiAP strategy and engagement with sectoral partners and stakeholders for specific action. However, continuous scanning of societal trends is a vital task of HiAP; understanding the political, social and economic context is essential to improving population health and health equity and the success of the approach. This includes what Shiffman and Smith (see Table 2-2) refer to as civil society mobilization (Actor power: the extent to which grassroots organizations have mobilized to press political authorities to address issues) and external frame (Ideas: public portrayals of issues in ways that resonate with external audiences, particularly political leaders who control resources) *(1)*.

Realizing the HiAP vision to sustainably improve population health and health equity requires a long-term perspective and changing the way people understand and respond to the causes of good or poor health, beyond disease and behavioural determinants; how people think, talk and act in relation to health and well-being and the way public policies are formulated and enacted. It means addressing "the causes of the causes" of health inequities, i.e., both the determinants of health and health equity and the political, social and economic forces that shape them *(2)*.

The SDGs illustrate the interrelationship between health and a range of social, economic, cultural and political factors. Whilst SDG 3 aims to "ensure healthy lives and promote well-being for all at all ages" health is influenced by, and influences, all other goals and targets *(3)*.

These many and varied determinants provide the context for the HiAP results-chain (see Figure 1-2). Some act as enablers while others act as blockers thus creating opportunities that can be seized or threats that must be avoided or handled. This requires a rich understanding of these trends.

The societal trends scan tool adapts tools used in the corporate world to assist HiAP practitioners in "painting" or developing the big picture, i.e., identifying the important macro trends in society and the opportunities they provide as well as the threats they pose in taking forward HiAP to realize its long-term vision.

Rationale and scope

The scope of the tool is the trends in the whole-of-society in which HiAP operates and the strategic opportunities and threats these provide. The macro perspective of this tool makes it different from the more micro-level focus of the SWOT analysis, for example as seen in Tool **A.2**.

The scan of societal trends tool:

- Helps identify opportunities for action and offers warnings about significant threats
- Reveals direction of change (trends) in the circumstances in which HiAP operates – helping to shape your priorities, so that you can *work with change, rather than against change*

- Helps avoid starting projects that are likely to fail for reasons beyond your control
- Helps develop an objective view of circumstances, avoiding unconscious assumptions.

It is also important to monitor 'big picture' issues and trends (e.g. climate change, growing inequities, megacities, migration, connectivity etc.) that form the context for your HiAP and may well impact on opinions and priorities. It also includes major reports reviewing and forecasting social, economic, cultural, commercial and environmental changes related to the determinants of health and which may change the way people live. This provides the important context for your HiAP work.

What to do?

STEP 1

Collect information on overall context and societal trends

The following seven external factors provide examples of many of the key determinants of health and inequities, which may be considered in the scan of societal trends. When completing this exercise you may wish to apply a time perspective of ten years and beyond. It is likely that much of this scanning has already been done, for example in connection with the United Nations 2030 Agenda for Sustainable Development *(4)* and your country's plans for meeting the goals and targets. The desk-top scan can be done by the HiAP team or delegated to experts for those of the seven factors that cannot be covered through review of readily available existing materials. These examples are not comprehensive:

1. *Political* – changes in political balances and values, government leadership, corruption, government stability, trade restrictions or reforms, bureaucracy issues, employment and operational laws, tax regulations, redistribution measures and stability of neighbours;
2. *Economic* – finance and credit, cost of living, inflation, production systems and work practices, GDP/GNP and sources of national income, taxes and duties, exchange rates and globalization influences;
3. *Social* – social values, social mobility, ethics and religion, lifestyle tastes and preferences, education, historical issues, attitudes and beliefs, demographics, cross-cultural communications and urbanization;
4. *Technological* – knowledge and information management systems, network coverage, research and development, production forms and efficiency, transportation and entertainment;
5. *Legal* – citizens and consumer rights and protection, health and safety, taxation, advertising, compliance, employment conditions, import and export and regulatory bodies;
6. *Environment* (physical) – climate and climate change, soil degradation and eco-systems, air and soil pollution, infrastructure, fresh-water availability, waste management, food content and chemical standards;
7. *Industry* (health) – structure and governance of the health care industry, alliance between public and private health care, how the industry copes with the changes in the BoD (epidemiological and demographic transition), payment and incentive systems, health care technology and pharmaceuticals, costs, financing and productivity controls and lobbying.

Hints!

Keep the HiAP vision and the 'big picture' in mind. Focus on long-term trends not short-term fluctuations or descriptions of current state. Be analytical rather than just "ticking" or listing. Summarise down to a one to two pages narrative and one summary slide for each of the seven factors. At least for the initial scan, it may be useful to commission short papers on each of the seven factors from relevant experts. Retired politicians, senior bureaucrats, policy-makers and scientists may have both the knowledge and the big-picture perspective required to quickly come up with such analyses.

However, the HiAP team may choose to do the scanning and analysis work themselves, drawing on expertise from others as necessary.

The papers developed from this exercise need to be useful in identifying opportunities for action and trends that are important for your HiAP work so undertake the task in a form which is meaningful for your context and within any capacity constraints.

STEP 2

Validate findings and brainstorm

Review the findings and brainstorm what they may mean for implementing the HiAP approach. This may be done during a dedicated meeting with key people from various sectors and areas of expertise or alternatively in ad hoc discussions with partners and stakeholders, remembering that scanning societal trends will be an ongoing HiAP activity.

Some key considerations during your brainstorm might include focusing on:

- *Opportunities* – which societal trends within each of the seven external factors can open up opportunities to progress the HiAP agenda and vision and help make the HiAP processes and results more effective if seized at the right time? Knowing and understanding the 'big picture' will help to capitalize on windows of opportunity and work with, rather than against change.
- *Threats* – which societal trends in each of the seven external factors could potentially undermine the HiAP results-chain (Figure 1-2), including processes, outputs, outcomes and impacts? Knowing and understanding the 'big picture' might help to avoid the problems or to act early by making adjustments and taking a different course of action.

Hints!
Keep the 'big picture' focus and long-term perspective and do not get trapped in micro-level and short-term issues. Be concise in describing the findings from your scanning analysis and condense these to three to five major bullet points of opportunities and also threats for each of the seven factors.

STEP 3 Synthesize and strategize

In order to come up with solutions or ways to deal with each major factor, opportunity and threat one must be strategic in how the findings and information are used. This is the work of the HiAP team – possibly in consultation with relevant partners or the advisory group.

In synthesizing the findings:

- *Rate each factor/opportunity according to*: relative importance to the HiAP vision realization, likelihood of occurring, and implications if occurring.
- *Decide which of the top-rated opportunities* you will pursue in your strategy and how.
- *Rate each factor/threat according to*: relative importance to the HiAP vision realization, likelihood of occurring, and implications if occurring.
- *Decide which of the top-rated threats* you will have to actively manage in your strategy and how.

Hints!
You could rate the factors to help prioritize. For solutions, concentrate on the three to five top-rated opportunities and threats. Solutions may mean supporting others who are better positioned to address issues and take eventual risks. Do not forget those factors, opportunities and threats that do not come up in your top-rating, as things evolve over time.

STEP 4 Institute continued monitoring of societal trends

Continued monitoring of the seven external factors is necessary to enable early warnings on the direction, strength or speed of change in regards to societal trends – or if disruptive events occur. Include updates of the analyses in the national population health report (see Tool **E.3**).

Hints!
Remember the external factors and in particular the threats work along the entire HiAP results-chain (see Figure 1-2): *processes, outputs, outcomes* and *impacts*. Even the best of processes and outputs (policies) may fail as the contextual factors may influence directly at the outcome or impact levels. Continued scanning of societal trends should be routine for the HiAP team. Sources of information also include media, opinion leaders (see Tool **B.3**) and collaborators in other sectors (e.g., Policy champion peer group (or group of change agents) – see Tool **B.4**).

Note: Societal trends mean 'big picture' trends confirmed by several sources of information pointing in the same direction.

The scan of societal trends described here is comprehensive and extensive. In many cases your HiAP focus will be more specific or contained in which case the scan can be focused on factors related to your policy priority. For example, if your priority determinant/policy issue is road safety you can narrow your focus within each of the seven areas to gather evidence on the trends and factors that will impact directly on this determinant.

B.2 Windows of opportunity

Why and when?

Knowing when it is time to act is just as important as understanding population health issues and determinants (Tool **A.1**), intersectoral policies and mechanisms (Tool **A.2**) and broad societal trends (Tool **B.1**).

A 'window of opportunity' is a short time during which there is an opportunity to do something favourable after which the opportunity will be lost. In HiAP, some windows of opportunity present themselves at regular intervals, for example during the annual finance bill or the release of national household surveys. Others come at longer but still predictable intervals, such as during the development of national strategies and plans while some are less predictable in terms of timing for example, sectoral and programme specific development plans. Others may be once in a lifetime, including a favourable political constellation in parliament or municipal council. The challenge is to identify opportunities and be ready to act.

Rationale and scope

HiAP practitioners must be highly tuned to policy opportunities; this is one of the key skills. The windows of opportunity tool is focused on policy change but can also be adapted to different uses in the other HiAP work steams (Tool **C.2**) and is likely to be used regularly. With time and experience the tool may be fine-tuned to the specific context and circumstances of the country.

According to John Kingdon (an American political scientist), public policy formation is the result of three kinds of process streams: *the problem process stream* regards public matters requiring attention; *the policy process stream* regards proposals for change and availability of solutions; and *the politics process stream* is composed of political issues including election results, changes in administration, interest group campaigns or changes in public opinion *(5)*. Kingdon notes the three processes are for the most part unrelated, but when they couple, a window of opportunity may open and facilitate policy change. The HiAP team rarely controls the three processes. However, there is certainly a lot that can be done to steer through and influence the three processes to increase the chances they come together to create the window of opportunity for policy change that is conducive to population health and health equity.

The HiAP team must know how to read the signs in the environment and act appropriately at the right time. This tool attempts to provide a practical structure for learning and acting rather than providing all the answers. These must be developed in each context and circumstance by the HiAP team and its collaborators.

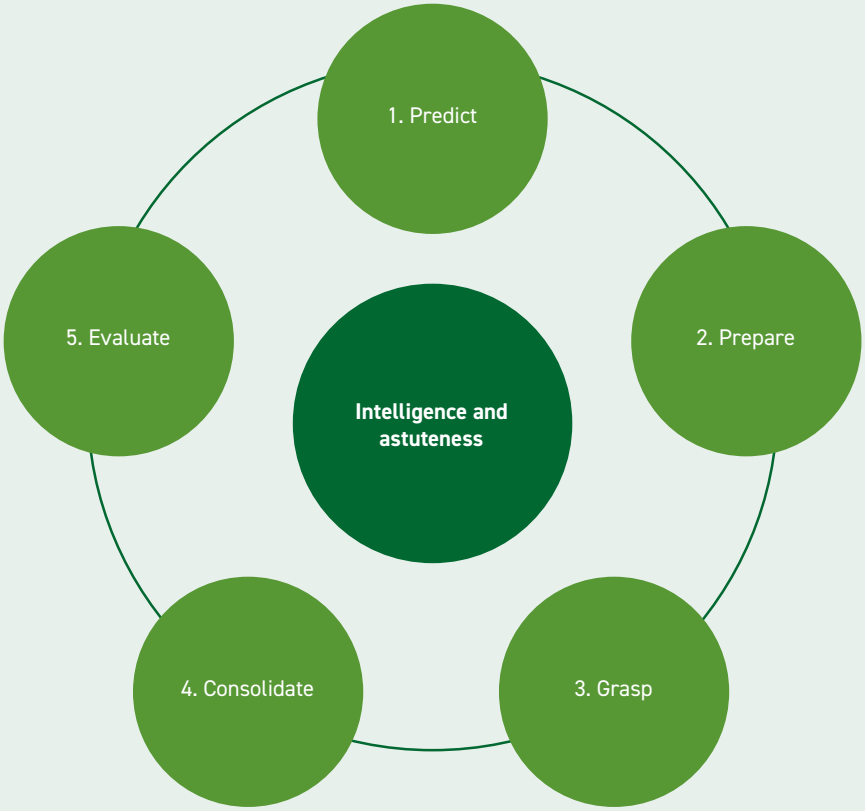
Taking advantage of and creating windows of opportunity for HiAP promotes health issues to be placed on policy agendas, enables the proposal of solutions with co-benefits, and generates professional and public allies that embrace HiAP and support the value of the approach.

What to do?

The tool is closely associated with and benefits from a range of other HiAP tools including: Analysis of health and determinants (**A.1**); Scan of intersectoral policies and mechanisms for action (**A.2**); National consensus building (**A.3**); Scan of societal trends (**B.1**); Talking about HiAP (**B.3**); Policy champions (**B.4**); Vision and leadership (**C.1**); and Review and revise national plans (**D.2**).

Intelligence and astuteness underlies all attempts to create and exploit windows of opportunity for policy change (Figure 3-1). It involves being able to predict, prepare, grasp, consolidate and evaluate multiple processes within public policy-making.

Figure 3-1 HiAP windows of opportunity tool



Hints!
The HiAP team must possess a thorough knowledge about the problem and its causes, the intersectoral collaboration environment as well as the 'big picture' opportunities and threats in order to work with, rather than against the trends. However, intelligence and astuteness at the organizational or institutional levels from key sectors will be crucial. Here the policy champions peer group (**B.4**) will be a useful source of information and analysis.

STEP 1

Predict

Timing is absolutely essential to success. Windows of opportunity are short and pass quickly. Missing a window of opportunity might mean wasting enormous amounts of work; and potentially missing out on the opportunity to get the policy in question right.

Hints!
Remember, windows of opportunity are not like deadlines cast in stone. They open when the three process streams couple. You therefore need to monitor each process stream (problem, policy, politics) carefully (**A.2** and **B.1**) to foresee sufficiently in advance when your moments of influence will come.

STEP 2

Prepare

If you are not prepared, you might be taken by surprise when the window opens, sometimes sooner than you expected, and it might close again while you are busy mobilizing.

Hints!

You may influence the *problem process* through analysing and documenting the population health situation and explaining its causes (**A.1**) and the *policy process* through proposing and co-designing solutions (**A.3** and **B.4**). Remember – most decision-makers like to have alternatives to choose from – with pros and cons. You may influence the *politics process* by shaping the way health is talked about in the public and political debates, including during election periods (for example see Tools **B.3** and **C.1**). Windows of opportunity may further be triggered by providing facts and holding policy-makers accountable for past decisions or lack of decisions (**D.2** and **E.3**).

STEP 3

Grasp

Once the window of opportunity is open for the policy changes to be progressed, the HiAP team and policy champions need to be ready with an understanding of what is required and have enough knowledge to be able to navigate and improvise as the final policy decision-making processes evolve.

Hints!

Sustain the pressure and keep the policy decision-makers informed and focused on the causes of the problem, the values, the solution, the benefits and the co-benefits. It is at this step that the HiAP vision and leadership (**C.1**) and the policy champions (**B.4**) will stand their test.

STEP 4

Consolidate

The first six months after a policy decision is made is critical. If policy roll-out and implementation measures are not institutionalized or at least on a firm track within these six months the likelihood that it will never happen is considerable.

Hints!

The primary responsibility for consolidation and implementation rests with the policy-owner. However, the job of the HiAP team is not over. During this step, close contact should be kept with the policy champion including through the policy champion peer group for experience sharing and momentum-keeping (**B.4**). Particular focus areas for the HiAP team will include: to ensure that data for measuring the indicators, e.g., for disaggregation by inequity dimensions, are actually being generated (**A.1**); to update the research agenda to assess the effect of the policy on population health outcomes and impacts, including equity and why or why not expected effects or unexpected effects occur (**E.1**); and to integrate into the national population health report (**E.3**).

STEP 5

Evaluate

As usual for all HiAP processes and tool-uses, the experience should be evaluated: what worked, what didn't work and what should be done differently next time? The purpose of the evaluation is to learn, grow and improve – not to blame.

Hints!

STEPS 1–3 should be evaluated immediately after STEP 3 and in parallel with STEP 4 while memories are still fresh and people still in place. STEP 4 should be evaluated six months after the policy decision. The evaluation could be done in two stages: firstly, internally by the HiAP team and then through the policy champions peer group (**B.4**) with clear proposals for improvements in the future. The evaluation should be documented and actioned by HiAP management and leadership and the windows of opportunity tool made ready for its next use.

Consideration

Vertical and horizontal collaboration across sectors and policy domains needs to be nurtured to maximize beneficial outcomes when policy windows open. Horizontal communication between different policy domains needs to be strong in addition to the usual vertical, hierarchical ways of working. Multisectoral work is at the core of HiAP practice and for HiAP to be effective, multisectoral processes need to be embedded in systems to enable windows of opportunity to be seized.

B.3 Talking about HiAP

Why and when?

How health is talked about in the public discourse shapes how politicians and institutions deal with health issues. This tool can aid HiAP teams to take the conversation beyond health care service provision to the causes of population health and health inequities – an element of universal health coverage sometimes overlooked – and thereby prepare the ground for intersectoral policy responses.

The Talking about HiAP tool is an iterative and continuous process, characterized by constant learning and refinement. The way we talk about health and HiAP can create an ambiance that is conducive to intersectoral collaboration and formulating policies that make better outcomes for the collaborating sector as well as fostering better population health and health equity.

Health in All Policies (HiAP) is about saying that the health of the population is not merely the sum of the health of the individuals and not just a matter of individual lifestyle choices and health care system capacity. Rather health and its distribution within the population is the result of forces that operate at the level of the society – political, economic, social and environmental decisions and circumstances. It is also about saying that poor health is not just a concern for the individuals affected and the health care sector. It is equally a concern for the political, economic, social and environmental sectors in terms of lost opportunities and lost productivity for example. HiAP brings a vision and hope. Poor population health and health inequity can and should be avoided to the benefit of all.

Getting different actors, sectors and stakeholders on board who are not aware of potential co-benefits of joint action and who do not necessarily have population health and health equity as their primary interest is paramount to HiAP. They may hold a range of interests: share the primary interest to make a positive change to social determinants and health risk factors; have a different, but not opposed interest; or have an opposed interest. They may simply not be aware of the major factors shaping population health and how sectors other than health influence the risk factors and determinants of health and health equity. They may also not be aware of the benefits, including the economic benefits that improving the determinants of health and population health can have for their sectors. Sometimes, even within the health sector itself such understanding can be limited.

This tool is designed to assist in changing how population health is talked about i.e., to foster a way of talking with greater focus on the causes of and the solutions to the health challenges and inequities; a way that fits the context and the needs of each individual country; a way that is conducive to working across sectors and disciplines; and a way that brings about the sense of shared responsibility, joint action and co-benefit.

Rationale and scope

The tool is based on the premise that improving health and the causes of poor health will require a change of mindset. How we think of health is intimately related to how we talk about health. The tool will potentially be useful to attune thinking and communication at all stages and steps of the HiAP cycle to the fact that potential partners and stakeholders often have their own understanding, interests, objectives and language. The tool will be equally useful for public and political debates as well as for interactions with individual collaborators and stakeholders.

Each HiAP team must create its own way of talking about HiAP that fits its own local conditions and culture. In doing so, much inspiration drawn, and many approaches borrowed, from HiAP models in other countries, and health and development programmes in general.

The tool has the HiAP team at its core extending to opinion-leaders and sectoral collaborators, and to the public at large.

What to do?

The HiAP team should get familiar with and follow closely the public and political debates, understand who the HiAP target audiences and stakeholders are, foresee reactions and continuously develop and rehearse its relationship and communication approaches, including systematically assembling a catalogue of examples to use. It is an iterative and continuous process. Steps in the process are suggested in Annex 4.1.

Unprompted, many people will hold individuals accountable for their own health outcomes, especially when these are related to certain risk factors such as smoking, unhealthy eating, alcohol consumption, physical inactivity, drug abuse, etc. Unprompted, many people will also point to medical solutions – more hospital capacity, more health care staff and better drug therapy. Unprompted, few people will refer to the causes of the causes for the situation – the economic, social and environmental determinants for health and health inequity *(2)*. To make the case for HiAP, it is important early on and repeatedly to provide an alternative to the default frame and keep a few key concepts in mind. The instructions in this section are described in terms of "considerations".

Consideration 1

Framing

Framing refers to how an issue is defined, which can in turn influence how the issue is viewed and understood (non-issue, problem, crisis, etc.), who is considered responsible, and the cause and possible solutions (see Table 2-2 internal and external frame). People, organizations and policy stakeholders can own or disown a public problem through the way they define it. Owning a problem can be an advantage to groups and organizations – it may allow for increased credibility, funding and legitimacy. Health problems frequently remain defined in purposely "fuzzy" terms because no stakeholder can see a benefit of owning complex problems. This often means that the ownership falls onto the "default" health actor: the ministries of health or other institutions that are mandated to deal with health, even if they are not in positions to handle the root causes. Redefining or reframing the problem allows for new ways of understanding, which can encourage new stakeholders to engage in the policy process.

Consideration 2

Values

People usually connect with issues through values. Commonly held values often include: fairness, efficiency, opportunity, equality, etc. A good starting point for HiAP is to understand and be able to express the commonly held values that align with the HiAP approach. The core values of HiAP are: "*Health equity*", i.e., avoidable health inequalities are unfair and unjust; and "*The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition*" as expressed in the WHO Constitution *(6)*.

Consideration 3

Opinion or thought leaders

Popular societal figures have more influence on people's opinions, actions, and behaviours than the media and direct HiAP communication. They are seen as trustworthy and non-purposive and people do not feel they are being tricked into thinking in a certain way about something if they get information from someone they feel they 'know'. The media and direct HiAP communication can be seen as forcing a concept on the public and therefore might be less influential. While the media and HiAP communication certainly may act as reinforcing agents, opinion leaders have more potential to change or determine an individual's or a population group's opinion or action. Channelling your message through such leaders can be effective. Combinations of the below factors make noteworthy opinion leaders:

1. expression of values;
2. professional competence/personal credibility;
3. nature of their professional/social network;
4. obtain more attention/media coverage than others; and
5. seek acceptance of others and are especially motivated to enhance their professional/social status.

Opinion or thought leaders are different to Policy Champions (**B.4**) who have a specific focus on recognising and advocating for policies that have the potential to support health improvement and address the determinants. Their role is more specific to the policy process.

Consideration 4

Basic messaging

This is about how messages and communication about HiAP related issues are constructed. An effective model is to trigger the *frame* first, state the *values*, state the *evidence*, and then state the *solution* clearly. Be sure that the solution gets at least as much attention – or more – than the problem. This model can be used in different ways for different topics, purposes and audiences. The following two examples are deliberately kept simple to be illustrative.

Example 1 (Health centred):

- *Frame*: The number of diabetes cases has tripled in the past 20 years. Health care costs are escalating and hospitals overburdened. It is diverting resources from other uses and sectors, and ruining individuals' lives.
- *Values*: The increase in diabetes hampers the health system's ability to provide the best possible health care to all those who are in need (are sick).
- *Evidence*: The rise in diabetes is (among other things) associated with increases in overweight and physical inactivity. Poor and vulnerable population groups are suffering in two ways – higher diabetes rates and fewer resources to pay the medical bills.
- *Solution*: Health, urban planning and transport working together to reduce the need for individual car transportation and make physical activity the easy and preferred choice.

Example 2 (Cause centred):

- *Frame*: Our streets are getting more and more congested and difficult to navigate. Our politicians prioritize running hospitals and the street maintenance budget cannot keep up with the deteriorating conditions. This means that our streets get worse every year.
- *Values*: Our cities are for all. While individual motorized traffic has its justification, it should neither be the escape-solution for those who can afford nor crowd-out other users of the cities. Further, individual motorized traffic is not sustainable in the long run.
- *Evidence*: Poorly planned and designed land use patterns (residential, commercial, office, industrial, etc.) and a transportation system favouring motor vehicle usage (i.e. does not promote walkability, cyclability or convenient and reliable public transport) are well-known determinants for street congestion, physical inactivity, overweight and diabetes.
- *Solution*: Urban planning, transport and health working together to reduce the need for individual car transportation and make physical activity the easy and preferred choice.

Consideration 5

HiAP messaging catalogue

This is a systematic collection of questions, sample answers, explanations and statements made by the HiAP team and others. This collection of main messages are used to foster intersectoral collaboration and shared responsibility. Each item entered into the catalogue is carefully analysed, e.g. what worked; what didn't work; and why? Growing the catalogue is an evolving process pursued with rigour and with all HiAP team members participating. The HiAP messaging catalogue can form the basis for continuous learning, and introducing new staff to the approach.

B.4 Policy champions

Why and when?

A champion is a person who takes an interest in, and advocates for, the adoption, implementation, and success of a cause, policy, programme or project. HiAP policy champions recognise and advocate for policies that have the potential to support health improvement and address the determinants of health. They recognise both the potential for better policy and the value of the HiAP approach to deliver better outcomes. As advocates they will typically try to push the idea through internal resistance to change and promote it throughout the organization.

Policy champions are needed from very early on in the HiAP processes, when the approach and priorities for policy action are first being considered. If there is no suitable policy champion, even the best intended policy change process risks stalling. They are also important when there is a loss of momentum in HiAP or obstacles to achieving milestones.

Policy champions are different to opinion- or thought-leaders (Talking about HiAP **B.3**) who contribute to framing how health, equity and its causes are discussed and thought about in more general terms i.e. shaping the context within which policies are revised and developed.

Rationale and scope

Policy champions proactively promote policy reforms and foster the support of others, therefore they are needed at all stages of HiAP implementation. Their roles include harnessing collaborative opportunities, identifying and exploring windows of opportunity, and helping to initiate new policies.

Policy champions will usually be in sectors other than health and be able to see win-win opportunities within their sector, and across government, for collaboration and policy integration. They may be working on or playing a key role in making or adopting policies relevant to population health and health equity and are likely to be leaders and senior officers and importantly 'change agents' helping to garner momentum and political will for change.

In identifying policy champions you will be seeking people who tend to have a holistic view of public policy, be influential in their field, willing to talk through issues and learn, and who are prepared to lead. When new territory such as Health in All Policies is being navigated, it is very helpful to have such a champion in the forefront. Not only can they push a particular policy in the right direction but they also serve as a role model for others who follow. Importantly, policy actors may also approach the HiAP team to be involved, especially once HiAP is gaining traction across sectorsand a network of policy champions is more established.

Policy champions are different from the HiAP team though almost certainly HiAP team members will also be policy champions. A HiAP team champion may have many of these same skills but will also be an advocate for the HiAP approach including within the health sector.

This tool is designed to assist the HiAP team identify, engage and support policy champions.

What to do?

STEP 1 Identify policy champions

HiAP processes including the national consensus workshop, interviews and meetings provide an opportunity to identify, observe and assess potential policy champions. Different priority policy actions will benefit from different champions so there are multiple ways in which champions can contribute. Table 3-1 lists the traits of potential policy champions and can inform the support needs that a 'given' champion may have *(7)*.

Table 3-1 Policy champion traits

Policy champion traits	
Category	**Trait and position**
1. Values and public speaking	Has made HiAP positive statements in official policy settings (workshops, administrative, policy or political forums) – expressing and recognizing the values of social determinants of health and equity
2. Understanding	Policy insight and skills, including of opportunities for synergies and co-benefits Level of understanding of the causes of population health and health equity
3. Policy formulation	Possession of interpersonal, networking, diplomacy, and negotiation skills Control or strong influence over a specific HiAP priority policy formulation process
4. Policy decision	Innovation and preparedness to take risks Influence on the specific HiAP priority policy adoption
5. Effectiveness	Track record of achievements and delivering on expectations

Hints!

Engaging policy champions is a continuous process serving the evolving needs of HiAP and covering new policy areas and sectors. There is no rush to identify the champions but it is an important role.

Depending on circumstances, a formal agreement may be developed to clarify the roles, responsibilities and expectations of the policy champion.

STEP 2 Engage the policy champion

Policy champions are likely to be busy people already engaged in a lot of different work but busy people are often also the people who get things done. There must be a fit between the individual's values and interests, work-capacity and job-position and the HiAP needs. Discuss this directly with potential champions as part of the engagement process.

Hints!

There is always some degree of uncertainty or risk in engaging a champion. They won't always be a perfect fit and you need to calculate the level of risk. Often the interest, willingness and capacity may be there but, for example the organization that employs the potential policy champion may not be supportive. The role might then need to be informal and advisory.

STEP 3

Nurture the policy champion

There are lots of ways that policy champions can be nurtured. Work with them closely to analyse and co-design policies and documents, let their role be known and publish their achievements. Provide opportunities for them to learn through conferences or visits to other HiAP initiatives. Consult regularly and draw on their expertise and experience. Give them credit and exposure and assist them in making presentations and publishing results and experiences.

Hints!

Remember, policy champions are few – they are the vanguards that make HiAP happen. Even modest investments in them will bring returns as they can be instrumental in getting policies through and also serve as role models for others. Continue to scan for potential new and emerging policy champions that may need a little encouragement and support to step up to the role (STEP 1). Policy champions are invaluable assets of HiAP and ideally you need a steady pipeline of new champions.

STEP 4

Monitor the policy champion

Champions may well move ahead pursuing their own agendas and drivers. They work in different sectors and organizations usually without hierarchical links to the HiAP team. Engaging with policy champions provides great opportunities but might also open up strategic risks. If they get too far off the HiAP course, it might be difficult to get them back on track again. Therefore, formal standard management tools may not work and informal personalized approaches for monitoring should be sought.

Hints!

Each HiAP team will need to explore and create its own approaches that fit to the local context as well as the individual policy champions active at a given time. Such approaches could include: personal individual contact and buddying between HiAP team members and each policy champion; a HiAP policy champion peer group (support network rather than working group) to share and learn from the experiences of each other and keep the HiAP course across different sectors and this could also provide an opportunity to introduce and test upcoming potential champions; a HiAP newsletter/website including pieces written by the policy champions providing opportunities for them to showcase their work – but also to be reviewed as part of the publication process.

STEP 5

What's next?

Policy champions may get new opportunities or be shifted to new responsibilities where they will no longer work with or be able to influence the relevant people and policies to the same extent. If a policy process has not reached maturity, all this might hamper your efforts for policy change. It is therefore critically important that the HiAP team is at the fore with such changes.

Hints!

If there is a buddy system in place, the buddy should sense where things are moving and get early informal warning about what is on the way. Capitalize on the champion's traits to see things accomplished (STEP 1). Challenge them on the values and push for policy decisions and institutionalization rather than relying on the next person in the job/position to be a true HiAP policy champion, regardless of what people may say. Even if policy champions move on to other roles or other sectors, they take with them the values and understanding and might still be useful to HiAP, possibly even more so.

STEP 6

Evaluate

Every HiAP process and approach needs evaluation in order to support greater efficiency, effectiveness, coherence with values, and direction towards improved population health and health equity. The purpose is to learn and adjust. This is particularly true when it comes to the work of and engagement with policy champions. Policy champions are the front-runners who serve as models and set the standards of others – not only by their personal example but also by the results they produce. Evaluation may take several different forms however, it should always have a structured formal format.

Hints!

The HiAP team could regularly set aside an internal meeting focusing on engagement with partners and in particular the policy champions to review processes, including STEPS 1 to 5. The HiAP Policy Champion Peer Group could do likewise. The frequency should be reasonably high in order to guide timely adjustments. Externally commissioned evaluations at longer intervals might also prove useful independent analysis.

Note: It can also be the case that a potential policy champion (they may not call themselves that but are usually aware that their skills can facilitate HiAP processes) approaches the HiAP team wanting to be involved – this is more likely once HiAP is up and running and traction is being gained across sectors.

Further reading

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Comment: The last two readings contain multiple examples on how to construct messages to support HiAP using the above principles as well as sample answers to common questions about HiAP. Some of these are context specific to California/USA and the UK. However, they provide excellent starting points for the HiAP team developing its own HiAP messaging catalogue relevant to its specific country and HiAP context.

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Chapter 4
Work stream C

Capabilities for HiAP: working with the HiAP team to facilitate action and progress policy priorities

C.1 Vision and leadership

Why and when?

HiAP is about a vision of a healthy population and a society that has public debates, decision-making processes, authorities, laws, and governance that are concerned with and systematically take into account population health and health equity; it is not just about intersectoral action or designing healthy public policies. Without this clear vision and great leadership, the HiAP approach will struggle to impact on population health and health equity.

Vision and leadership are fundamental to achieving change through HiAP. Many countries are facing an ever-increasing burden of noncommunicable diseases and significant inequities in health outcomes with many also dealing with widespread communicable diseases. This has enormous implications in terms of increasing health care costs and loss of economic and social productivity potential. To address this burden requires work across the political, economic, social and environmental sectors seeking win-win solutions.

"*Good business leaders create a vision, articulate the vision, passionately own the vision and relentlessly drive it to completion*" *(1)*. Leaders in governments, organizations and civil society also lead health and well-being related change based on a good understanding of complex public policy issues and a vision of policy solutions *(2)*. A powerful vision is one that can provide a sense of purpose, give direction, and unite people and organizations in moving towards a valued future. Leaders are essential to achieve the HiAP vision.

Caution – The political, corporate as well as non-corporate worlds tend to be fascinated with "strong" leaders and "grandiose" visions. However, even great leaders move on, and visions often fade with time. Keep nurturing future leaders with a vision, for future roles.

Rationale and scope

HiAP deals with political, economic, social and environmental issues in complex interplay with each other and with a multitude of population health and other impacts. An effective leader is someone who gets others on board to follow and be guided by the vision. HiAP leaders can be seen as policy entrepreneurs able to help understanding of an issue, frame it effectively and act as enablers and collaborators, visionaries and pragmatists bringing a sense of common purpose. They may not all be in the most senior positions; leaders with vision can emerge at all levels (see Tools **B.3** and **B.4**) and some may be managers. They may be providing leadership across sectors and/or within the health or another sector.

There is no blueprint on vision and leadership that fits all. Therefore, the following steps provide some general guidance and ideas on how vision and leadership may be developed in country contexts.

What to do?

STEP 1

Dual HiAP vision for the desired future

Envisioning is a process that generates a vision or a 'dream' of how the future could be. A good vision is sufficiently clear and powerful to arouse and sustain the actions necessary for that future to become a reality. HiAP envisioning is a collective process, not one person's ideas. It starts from knowing the current situation, a projection of the likely future without 'intervention' and a credible depiction of how the future could be with 'intervention'. The gap between the current and the desired future is the challenge and the vision is to fill this gap, i.e., solve the problem.

Hints!

A good HiAP vision has two components. The *first component* is about what the desired future population situation (health, economic and social development) would look like – expressed as credible states of achievement while highlighting the equity value intrinsic to HiAP. The *second component* is about how the desired population state would come about – expressed as ambitious yet feasible changes to how decisions affecting population health, economic and social development will be taken and governed. Table 4-1 provides some hints and examples for setting the vision.

Table 4-1 Examples of HiAP vision components

Future population situation	How decisions affecting population health will be taken in the future
• To have halted the increase in the three most rapidly growing burdens of disease	• New public health legislation requiring social, health and health equity impact assessment for all major policy decisions
• To have reduced the level of the attribute and exposure risk factor with the highest prevalence	• Cabinet holds ministries accountable for their impact on social determinants, health and health inequity
• To be among the three best-in-class countries with respect to disease 1, 2, 3... (GBD bench-marking)	• Parliament to consider and be guided by biennial national population health reports and hold government accountable
• To have reduced the equity gaps (health, economic and social participation) between population-groups A, B, and C compared to the most advantaged population-groups	• Culture and praxis of intersectoral co-design of new policies with potential impact on social determinants, health and health equity

STEP 2

HiAP leadership identification and growth

A cardinal role of leadership is to communicate the vision, to articulate why people should strive to create the envisioned future and to convince others about their individual and institutional roles and responsibilities in order to make the HiAP vision reality. A capable and inspiring leader is someone who can empower others to foster and enact HiAP principles and ways of working.

HiAP must identify and engage a number of individuals with leadership capabilities. Without such leaders, both within health and across sectors and in central government there will be no change; HiAP will not succeed, will lose momentum or may take an unwanted direction.

Hints!
Five checks for spotting HiAP-leadership potential:

- *Integrity* – honest and a strong belief in health equity and the right to health values;
- *Vision* – looking beyond tomorrow, seeing the necessity of working across sectors, and having a personal drive for a better future for the people;
- *Communication* – strong interpersonal communication skills, with regard to senior officials, peers, policy-makers and personnel and representatives at all levels, for conveying information and messages as well as for 'active listening';
- *Relationships* – high level of trust and respect among senior officials, peers, policy-makers and personnel and representatives at all levels, and ease of establishing new relationships;
- *Persuasion* – ability to influence others and cause them to move in a particular direction.

A good number of leadership capabilities can be learned and all leaders can improve their leadership capabilities – but leadership training alone will not be enough. Table 4-2 provides some hints for exercising and growing HiAP leadership.

Table 4-2 Enablers and inhibitors for HiAP leadership

Hints on potential enablers	Hints on inhibitors
• Clear HiAP vision providing common direction and underscoring values	• Lack of individual recognition from senior executives, including function not reflected in post description nor appreciated in performance appraisal
• Supportive organizational structures	• Sectoral and organizational silos in terms of both budget and success criteria
• Opportunities for cross-sectoral learning, peer-support, and joint problem-solving	• Weak high-level coordination and accountability across sectors (governance)
• Coaching and process consultation	• Minimal information sharing and transparency

STEP 3

Institutionalization and renewal

HiAP is about changing the way that population health is viewed and handled. HiAP, like most change processes, is very dependent on competent leaders but they will come and go, therefore institutionalization will be paramount for the long haul.

Hints!
Instruments for institutionalization include:

- HiAP strategy with a time frame of 10 to 15 years and endorsed by a high-level cross-sectoral body;
- biennial population health reports presented to and discussed in Parliament (**E.3**);
- HiAP Unit well-connected and visible in the government system (e.g., Ministry of Finance and Planning, Cabinet Office, etc.) (**D.1**);
- dedicated budget lines, however small, across sectors in the Finance Bill;
- succession planning and grooming of talents.

Special care should be taken during latter parts of election cycles and the last year of, for example, a WHO representative's term in office. Transitions can be difficult for vulnerable leaderships and HiAP that is not properly institutionalized.

The HiAP vision needs to be regularly reviewed to avoid it being out of date and to ensure it is consistent with new evidence and new circumstances. Opportunities for reviewing the vision include:

- national population health forums;
- the national population health report (Tool **E.3**) and its discussion in Parliament.

C.2 Organizing the work

Why and when?

Implementation of HiAP benefits from a strategic and planned approach even though progress may be uneven and uncertain at times. Having a thorough understanding of the determinants of health and the role of other sectors (Tools **A.1, A.2, B.1**); engaging with these sectors to find common ground (Tools **A.3, B.2**); navigating the politics of intersectoral work (Tools **B.3, B.4**) and ensuring effective governance arrangements (Tools **C.1** and **D.1**) must all be progressed to achieve change.

The Organizing the Work tool is designed to help develop the main streams of work. These will in due course feed into the HiAP Strategy and assist in determining such things as organizational structures, staff competencies and numbers, operational work plans and budgets and monitoring and reporting systems.

Rationale and scope

The tool proposes four streams of work, which together contribute to the realization of the vision: information and research, facilitating intersectoral collaboration, framing and politics, and governance and capacities. For each, a mission and a range of strategic activities are proposed for consideration (see Figure 4-1).

Figure 4-1 HiAP work streams

The **Mission** is a short statement of the purpose of the work stream. **Strategic activities** are high-level activities that are critical to achieving success and eventually realizing the HiAP vision. **Milestones** are critical progress points defined in terms of tangible results that must be achieved by a certain date in order to ensure the overall success criteria.

Key message: using the generic structure presented in Figure 4-1 as a way to think about HiAP work helps to systematically consider all the different elements required to realize the vision and to reduce the risk of erroneously leaving out important activities. The structure should provide a robust basis for planning and further developing HiAP in the country. Though the generic structure will be helpful in remembering important strategic activities and functions, different HiAP models might choose to group these under different headings.

What to do?

Typically, this tool will be developed by the HiAP core team (Tool **C.3**) which may be small but include public health, policy and management expertise. It should be developed in consultation with other key stakeholders and may be progressed through, for example, a strategy formulation workshop.

STEP 1

Missions for the four work streams

The **missions for the four work streams** are best considered together in order to distinguish the streams from each other and to ensure that together they capture the different types of work required to realize the HiAP vision.

Hints!

Examples of mission statements are provided in Annex 5.1.

STEP 2

Strategic activities

The **strategic activities** might usefully be considered for each work stream but cross-references will be required as there is likely to be cross-over. Examples of strategic activities for each stream are also suggested in Annex 5.1.

Hints!

- *Information and research* – some of these activities have long-term horizons and may require partnerships with people with expertise in research, service monitoring systems and national surveys for example.
- *Facilitating intersectoral collaboration* – this is about both benefiting from what other sectors are doing to support health and health equity as well as influencing them to support healthy public policy. It also applies within the health sector in relation to dedicated and disease-specific public health programmes.
- *Framing and politics* – note this is about shaping opinions and public debates consistent with the HiAP vision, values and benefits (see **B.3**).
- *Governance and capacities* – note that this is both a parallel and a cross-cutting stream of work; without robust leadership and institutionalization of governance, HiAP progress will be impeded.

STEP 3

Milestones

These should be set separately for each work stream and timeframes will need to be locally relevant. Think about short, medium and longer time periods with two to three milestones for each.

Hints!

Each milestone should be a marker that signifies a critical stage in development and illustrates progress towards the vision. Milestones can also be important for political 'announcements', engendering political support for HiAP.

STEP 4

Who in the HiAP team will be responsible

Now that it has been determined what needs to be done (Strategic activities) and how fast (the Milestones), it is time to consider who should do what. That is, **who in the HiAP team will be responsible** for all parts of the work plan including for reaching out to collaborators and partners to make things happen.

Hints!

While the strategic activities will guide the competencies needed for the HiAP team, the milestones set the pace and indicate the amount of work that must be undertaken within a given time period – thus the capacity (staff full-time equivalents) required in each work stream. As the HiAP matures, it will be necessary to adjust and fine-tune the plan including the milestones.

C.3 HiAP core team

Why and when?

Success in HiAP is dependent on having staff with sufficient authority, competence and time to move the processes forward. A review of the role of political leadership and bureaucratic change in the case of Norway's HiAP found that while competence is a must, capacity outperforms competence in terms of being the most important obstacle for HiAP work *(3)*. If staff are burdened with non-HiAP tasks, it does not matter how competent the staff are. A case study of HiAP in California (USA) describes how a central backbone staff of four full-time employees are fully occupied with convening meetings, researching relevant issues, engaging stakeholders, facilitating consensus, drafting policy documents and ensuring accountability. The study further stresses that to be effective staff must have access to high levels of government leadership and be allowed to speak freely on policy issues and be given the mandate to dedicate substantial time to HiAP work *(4)*.

National or international consultants can be a great help and may be necessary in many cases including, for example to initiate and guide the process forward or complete specific tasks. However, consultants cannot replace staff in the longer term. If there is not a commitment to assigning staff to HiAP, consideration should be given to deferring commencement. The time and goodwill of other sectors is valuable and may be compromised if the HiAP team cannot progress action in a timely manner. Depending on circumstances, size of country, degree of decentralization, local organizational cultures and experiences with inter- and intra-sectoral collaboration, experience suggests it will be necessary to have a formalized full-time HiAP Core Team for success, and ideally such teams should be in place within the first year of the HiAP and may grow over time.

The HiAP Core Team tool addresses questions such as:

- what kind of and how many staff resources are needed?
- what should be the reporting lines?
- do they need to be full-time?
- do they all need to be in a central unit or can they be distributed?

Rationale and scope

The tool is designed to aid translation of the HiAP work streams (Organizing the work **C.2**) into staff competencies, capacities and organizational structures. A key feature for all HiAP staff regardless of specific function is the collaboration and interaction with partners in different sectors and organizations. The collaboration can be so close that these partners could be considered part of a wider HiAP team.

While Policy champions (**B.4**), Vision and leadership (**C.1**) and Models for governance and accountability (**D.1**), are indispensable for institutionalizing and sustaining HiAP – and eventually improving health and reducing health inequities in the population, this tool focuses on the HiAP core team, an equally important HiAP component - recognizing those who make it happen, often behind the scenes.

Remember that only 20% of a population's health is shaped by clinical health services while the other 80% is shaped by social, economic and environmental factors that are influenced by public policy across a wide range of sectors. This should be recalled when staff resource allocation for HiAP is considered.

Key message: HiAP requires staff that are dedicated, competent, have the authority and time required to focus on the long-haul and cannot be diverted to 'fire-fighting' and other priorities. The way in which a HiAP team is set up and with how many people will depend on local conditions and decisions. However, the minimum core staffing is proposed as two full-time staff reporting directly to a senior executive. In all but the smallest countries it is probably justified over time to have maybe five to ten professionals fully dedicated to Health in All Policies.

What to do?

An interim HiAP lead person and an experienced consultant can be of great use to start work on HiAP, including addressing the first two steps below. However after formation, the HiAP core team should take responsibility for the subsequent steps.

STEP 1

Establish a HiAP core team

A minimum HiAP core team of two people should be defined and formed as early as possible in the HiAP process. Otherwise, the HiAP programme risks never gaining momentum or quickly losing the gained momentum. The drive to form the HiAP core team must come from the senior executive to whom the team will be reporting. Terms of reference for a minimum core team are proposed for consideration in Annex 6.1.

Hints!

It often takes considerable – and more than expected – time to establish posts and assign staff on a permanent basis. In the meantime, HiAP is vulnerable to change of temporary or part-time assigned staff and redirection of their attention. The aim should be to have a full-time core HiAP team in place well within the first year of HiAP. In most cases a team larger than the minimum HiAP core team will eventually be needed for effective implementation (see also STEP 5).

A person with strong public health experience will not always be the right person for the job. Different knowledge and skills are needed to address complex policy problems. Ensuring there are a mix of competencies in a HiAP team is essential.

STEP 2

Determine where best to place the HiAP team

It is tempting to place the HiAP team (or a HiAP unit that might be larger than the minimum core team) at the outset within the Ministry of Health. However, this can easily reinforce the perception that population health and health equity is a medical concern that should be left with clinicians and hospitals. Further, within ministries of health the tendency is to prioritize biomedical over societal and intersectoral solutions and to be focused on short-term imperatives. Ideally, the HiAP team (or unit) should be placed within a sector or office that already has an intersectoral mandate such as the prime minister's office, cabinet office, ministry of planning or finance.

Hints!

It might not be practical in the beginning to situate the HiAP Core Team at its final organizational place; often the budget is provided by the health ministry who will want the team to be located in the health ministry and there are examples of this working well *(5)*. It could be decided to incubate the HiAP function within the Ministry of Health or another institution for a *predetermined* period, perhaps two years, during which the placement should be reviewed, decided and a dedicated budget made available according to final placement and the financial year. Effective functioning of HiAP teams requires them placed near the top rather than lower down in government hierarchies.

STEP 3

Consider the advantage of virtual teams

In all circumstances, the HiAP Core Team (unit) will work with a variety of colleagues across sectors and organizations. It may be argued that the HiAP team should be a virtual team where people are based in different organizational units, have different reporting lines and are funded from different budgets.

Hints!

There are examples of both working well:

- Advantages of virtual teams include that it might be easier to mobilize the funding, the capacities and the wide range of competencies required for HiAP;
- Disadvantages of virtual teams include increased vulnerability to competing and changing priorities and lack of direct command lines. This is particularly the case if HiAP work is not sufficiently anchored in the individual's terms of reference. A virtual team structure is much more demanding for the HiAP Coordinator as well as the individual virtual team members.

STEP 4

Consider the issue of decentralization

As decentralized countries set up HiAP in their sub-national states (or similar) and formulate their own policies and interpret central policies, HiAP will require dedicated staff at this level with considerations similar to those mentioned under STEPS 1 and 2.

Hints!

In decentralized countries there is often no direct command line between the central Ministry of Health and the health sector at the sub-national or local level. For example, sectors at the district level often report to a District Executive, who in turn may report to the Prime Minister or a Ministry of Local Governments.

STEP 5

Functional teams

Regardless of the size of the team, whether it is physical or virtual, central or decentralized, the functions to be undertaken and the associated competencies remain the same and must be taken into account. These functions and thus competencies call for – in all but the smallest countries – having **functional teams** comprising at least one professional for each of the four HiAP work streams (see Organizing the work **C.2**).

Hints!

- *Information and research* – requires strong competence in quantitative and qualitative research and data analysis; ability to translate and distil complex data and analyses into knowledge for policy-making across social and economic sectors; and have or be able to establish strong links with academia and knowledge management staff in other sectors.
- *Facilitating intersectoral collaboration* –requires very strong negotiation and collaborative skills and deep understanding of policy and political processes. Competencies will need to include and go beyond public health to embrace social, economic and environmental planning, development and policy formulation in order to identify co-benefits and credibly engage in co-design of policies.
- *Framing and politics* – requires deep understanding of societal and political processes and very strong communication skills and experience to 'market' the HiAP approach and guide the public and political discourses towards understanding population health drivers and to demanding multi-sectoral action. Competencies include the ability to understand what shapes public and political opinion and confidence to lobby decision-makers and opinion-leaders.
- *Governance and capacities* – requires a strong public health management background, leadership and networking abilities; having sufficient seniority, being results-focused, widely respected and politically savvy. This corresponds mainly to the HiAP Coordinator (see Annex 6.1).

Further reading

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Chapter 5
Work stream D

Governance and accountability: reinforcing the critical roles of decision-makers

D.1

Models for governance and accountability

Why and when?

The purpose of governance and accountability models for HiAP is to provide a mandate and high-level oversight for HiAP action. Governance enables an authorizing environment for intersectoral work, and provides the mechanism for action, through HiAP, on the social determinants of health. A key feature of HiAP, which distinguishes the practice from other forms of collaborative action is governance structures to facilitate intersectoral action. Accountability is an important aspect in the HiAP approach, emphasizing the role of governments for the health of its citizens. HiAP serves to strengthen accountability of decision-makers and policy-makers for health impacts in all sectors and at all levels. Thus, accountability is closely linked to governance for health. Also central to accountability is effective monitoring (see Tool **E.2**). Progress to improve health and reduce health inequities must be tracked with appropriate data to demonstrate impact and findings from monitoring used to shape corrective action for policies and practices which need improvement.

HiAP has been implemented differently in different contexts reflecting local social and political cultures as well as government structures. Nevertheless, it is possible to make some generalizations about the structures and mechanisms commonly used for HiAP governance and accountability. Thus, this tool focuses on the structures and mechanisms, from the perspective of government, which can promote governing and accountability for decision-making and public goals.

Shiffman and Smith (see Table 2-2) identify *Guiding institutions* (factor 3) as one of the key factors shaping the political priority given to action on determinants. Under the category of *Actor power* the strength of the individuals and institutions influences decision-making. Setting up effective governance arrangements and being aware of other institutions' *modus operandi* is therefore important. Similarly, the political context in which HiAP will be operating and the prevailing norms provide for effective collective action which is also recognised as important (factor 8).

It is usually the case that some sort of governance arrangement for HiAP will be established early in the initiation phase (if not in the planning phase) – either in a formal or informal capacity. It is critical to have the high-level drivers in place to progress HiAP from the outset and prevent early implementation failure. Consideration should also be given to ensuring a decision-making structure that is capable of withstanding changes in leadership and funding. It is important to remember that HiAP is a dynamic practice and so the governance model will need to evolve and adapt over time as the political and policy environment changes. Regular reflection and scanning of the political and policy environment can help to sustain efforts in times of change and find the right opportunities to re-shape and re-form governance arrangements, as necessary.

Rationale and scope

Governance for health is becoming of paramount importance in view of increasing complexity of health systems and changing epidemiological and demographic scenarios. Ministries of health and health systems cannot just be inward looking – improving the delivery and reach of their health services alone – they must reach out to policy-makers in sectors outside of health such as economic, transport, housing and food sectors and assist these sectors to develop policies and services that have a positive impact on health. Thus, shared governance models for health are needed, where all of government and society works towards improved health and well-being for their population. HiAP prioritizes governance for health and well-being; involving more than the health sector and working in all directions.

A mix of different models of accountability are appropriate for HiAP to keep track of action and policy delivery as well as the responsibilities of government for the health its citizens. These models include mutual accountability, accountability for the impact of policies, responsibility for implementation and monitoring and accountability to the public.

This tool supports the implementation of the most critical building block of a HiAP approach; the establishment of governance structures and accountability. It is difficult to progress action across sectors if there is no formal mandate, clear accountabilities or governance model in place.

The establishment of governance models:

- Helps to harmonize policy-making (i.e. efforts do not undermine other priorities);
- Enables conflicts of interest to be resolved in a timely and transparent manner;
- Provides an overarching supportive structure for sectors to work together on policy issues;
- Improves the accountability of policy-makers for health impacts at all levels of policy-making;
- Promotes collaborative decision-making and direction-setting with a wide range of partners and stakeholders;
- Encourages information sharing and understanding of multiple disciplines and sectors;
- Supports a systematic approach to working across a wide range of social determinants;
- Guides progress toward long-term commitments for population health.

Governance is a key condition which must be present to provide the mandate for cross-sector partnerships, engagement of cabinet committees, use of intergovernmental agreements, and to support the value of public health legislation. Governance ultimately provides the foundation to address the strategic policy imperatives of government and supports policy action on the social determinants of health *(1)*.

What to do?

STEP 1

Scan and analysis of the structural environment

An initial first step is to scan the structural environment to determine if a new governance and accountability framework is required to be established for HiAP purposes or if the accountability for HiAP can be linked to an already existing structure.

Attaching HiAP to an existing governmental framework can be beneficial and save time if the right people from across different government agencies are already at the table (e.g. ministers or senior executives) and the levers for intersectoral decision-making can be implemented or strengthened with the structure that is already in place. HiAP can then work with, and support, existing structures and decision-makers.

If your scan and analysis reveal that a new structure is required then you will need to consider how the new body will be formed and who the members of the group will be, recognizing that senior officials hold the decision-making power. It may be the case that the legitimacy for the creation of a new governance body comes from central government or the highest senior official in government (e.g. Governor or President), making it easier to make the case for a new governance arrangement.

STEP 2

Identify the most feasible and favourable governance option

Once the scan is complete, a decision must be made as to what the most feasible and favourable governance option will be so that it will enable buy-in from across sectors. While informal approaches may be a good first step in embedding a culture of collaboration into government processes, in the long run the goal of transforming government by embedding health in governmental decision-making is best supported by stable formal structures and accountability mechanisms.

Table 5-1 presents examples of the different formal structures for HiAP governance, including accountability, which can be established (note that these are high-level, senior groups).

Table 5-1

HiAP-related governance and accountability examples

Governance structure and accountability framework	Description
Cabinet committee	Cabinet committees allow ministers to engage with policy issues of cross-departmental significance and offer a mechanism for ministers to work with outside interests. Cabinet committees are recognized for being able to facilitate dialogue and reach agreement on shared policy issues. As cabinet committees are one of the highest decision-making bodies, they have the potential to promote and implement HiAP, especially in the presence of competent political leaders and policy champions.
Parliamentary committee	Parliamentary committees of elected representatives can play a role in promoting wider political ownership of issues and reviewing policy decisions. Committees consisting of multiple parties, including the opposition, can enhance the potential influence of findings and can support the longevity of an issue as a political priority even through a change of government.
Interdepartmental committee and units	Interdepartmental committees and units operate at the bureaucratic level and aim to re-orient ministries around a shared priority. They are mainly made up of civil servants, however, committees can include political appointees and units can include people from outside of government. The effectiveness of interdepartmental committees and units depends heavily on the context, particularly the relative importance of the issue and level of political support.
Incorporating health into an existing government framework	Incorporate a process for inter-ministerial consultation into a framework that already exists within the government's structure (e.g. over-sight of a national strategic plan which cuts across the different sectors of government). This enables efficiency and limits additional burden on senior officials who already sit on many high-level committees and groups.
Accountability model	Governance structures ultimately support the establishment of stronger and more concrete levers for holding all sectors accountable for health impacts and creating a shared responsibility for health. A mutual accountability framework can be embedded into governance arrangements so that all stakeholders assume an oversight role and an implementation role. Stakeholders agree on overall priorities and strategies and then on actions and measures of action that each sector or agency will take. The governing group as a whole holds individual agencies accountable for performance through agreed-on mechanisms, such as public reporting. Effective monitoring helps to facilitate accountability by tracking progress.

Hints!

If the political environment does not allow for a formal governance arrangement when you are starting-up the HiAP approach, an informal mechanism can also work, remembering that the goal will be to look for opportunities to implement a more formal and stable arrangement at a later stage. This is important, as the evidence strongly suggests that having formal over-sight for HiAP improves its sustainability and legitimacy to work across government and with other stakeholders.

STEP 3

Create the authorizing environment

Now that the most suitable option for a governance structure (including accountability) has been chosen, the authorizing body or group must come together to discuss and move forward on the HiAP agenda. Planning for the initial meeting will involve the development of concept notes, policy or background papers, or briefing notes to inform the group about HiAP, their roles and responsibilities, and begin to set a policy agenda for HiAP.

STEP 4

Formalize the model

Develop a written document which outlines the formalization of the governance and accountability arrangement. This can be by way of an executive order, strategic plan, resolution, interagency agreement, city ordinance, charter, memorandum of understanding or through legislation.

STEP 5

Develop supporting processes

The high-level governance and accountability structure for HiAP is best supported by a more operational group and processes to implement the HiAP work itself and the decisions made by the body overseeing HiAP.

Some of the different supporting processes which can be established include:

- **Intersectoral policy-making procedures:** these can include multiple measures that promote intersectoral collaboration (e.g. impact assessments, policy proposals). These procedures differ significantly between countries and can be mandatory or voluntary.
- **Joint budgeting:** promotes integrated budgets and supports the alignment of resources for common goals; agencies commit to pool financial resources for a common interest. Joint budgeting enables the allocation of appropriate budgets and alignment of those budgets with joined-up goals as well as dedicated resourcing. Joint budgeting can range from fully integrated budgets for the provision of a service or policy objective to loose agreements between sectors to align resources for common goals, while maintaining separate accountability regarding the use of funds. Another option can be to have jointly funded posts to help coordinate intersectoral policies. Agreements on joint budgeting can be mandatory or voluntary in nature and may be accompanied by legislation and regulatory instruments. Developing joint budgeting mechanisms is challenging as it requires careful planning, with clear objectives, roles and responsibilities.
- **Intersectoral sub-groups (project groups):** intersectoral sub-groups usually begin to organically formalize in the authorizing environment, as their establishment is necessary to commence and progress work on policy priorities. They are also useful for building capacity, skill development, and identifying policy champions and advocates for HiAP action.
- **The HiAP core team:** a dedicated HiAP team move processes forward, engage partners and stakeholders, research relevant issues, draft policy documents, and organize basic working arrangements, among other important tasks. The HiAP team are essentially the co-ordinators and facilitators of HiAP work, without which HiAP accountability would be difficult to attain (refer to Tool **C.3** for further information).
- **Non-government stakeholder engagement (including research institutions):** government engagement with non-governmental stakeholders is crucial for joined-up work and the HiAP approach. This is where government involves a range of actors in the development, implementation and monitoring of health and equity issues using a HiAP approach. In principle, a government's engagement with external stakeholders increases accountability to its citizens and is an indicator of good governance.
- **Responsibility for monitoring:** A monitoring framework should be established to facilitate accountability, which tracks process and impact outcomes (Tool **E.2**).

STEP 6

Reflect and adapt

Change is inevitable within a dynamic political environment so the HiAP governance and accountability model must adapt and move with changing government structures and functions, and priorities. When necessary, shift the governance and accountability for HiAP so it remains relevant to political and social circumstances, and the administrative and reporting environment.

D.2

Review and revise national plans

Why and when?

National development plans articulate the overall vision for achieving economic development and broader societal outcomes under which other national plans are formulated. In the era of the SDGs, they are increasingly being shaped around the five pillars of the global SDG agenda: Peace, Partnership, People, Planet and Prosperity. Health of the population is fundamentally linked to all of these pillars. First, healthy populations are key enablers for all the SDGs. Second, the social, economic and physical circumstances are strong determinants for the level and distribution of health (well-being, morbidity and mortality) across and within populations. The health goal (SDG 3) cannot be achieved separate from the other SDGs. Therefore, it is relevant to review all national plans – but the national development plan or similar overarching strategy provides a good starting point for identifying overall priorities, and how well-being is framed.

The purpose of reviewing (and/or informing revisions to) the national development strategy and related plans is to provide input and identify opportunities for working with other sectors to optimize their impact on health and capitalize on potential synergies (co-benefits). The review process enables a conversation about governance and accountability to be progressed potentially through new governance arrangements. Reviewing and revising national plans as part of HiAP can be a useful entry point to starting or furthering discussions about governance and accountability, especially if you are wanting to establish more formal structures for HiAP. Therefore, this tool is situated under Work stream D to help readers to identify the different processes across government that can be used to leverage opportunities for HiAP and create systemic impact. In addition, as national plans are usually anchored to objectives and targets across portfolio domains, accountability mechanisms can be promoted to ensure all sectors take account of the health impacts of their policies.

Reviewing and/or participating in the development of national plans are key components of HiAP. The earlier population health and health equity concerns are introduced into the development processes the better. Early introduction will help ensure internalization in process-thinking while late introduction may give the impression of 'control' and may meet resistance.

Ideally, all national plans of importance should be reviewed for potentially negative impacts on health and health equity and co-benefits before they are approved. If this is a stated requirement, e.g., in the Public Health Act of a country, it will encourage plan-developers to seek early advice and introduction of the HiAP perspectives. This is highly ambitious however, and the need to prioritize is recognised.

National plans for economic, social and environmental development that do not consider health and health equity may inadvertently have negative impacts on population health or fail to reach their goals or to be sustainable if the impact of health is not considered. Similarly, national plans for health development (dedicated programmes and systems) that do not consider the determinants of health and health inequity may fail to meet their objectives and targets, be unsustainable or inadvertently increase health inequity.

The focus of this tool is national, or sub-national level plans regardless of which sector 'owns' the plan.

Rationale and scope

The tool may also be adapted to the sub-national level. It can be used for assessing plans prepared by the health sector. While plans by the health sector by definition aim to have a positive impact on health, such plans do not necessarily consider the determinants or inequity and could inadvertently increase inequities or even have negative impacts for certain population groups.

The tool is primarily designed for reviewing finalized or nearly finalized plans in order to learn and prepare for engagement with plan-owners and sectors. However, it can also be useful for participating during plan preparations and can be a forerunner for doing prospective health impact assessments of plans and policies, when the HiAP is fully established. Plans also come up for review periodically offering another opportunity to provide input.

A key feature of the review is to establish plausible causal pathways from the determinants influenced by the plan to the health and health equity impact for different population groups (STEP 3). National evidence to support this may not always be available in which case international evidence should be sought.

It is suggested that all national plans – current and in preparation – should go through at least an initial screening (STEP 1) in which it is decided whether to go ahead with a full assessment.

What to do?

The review process is described below in seven steps and Annex 7.1 provides an overview matrix for the review once the screening commences. In practice of course, the review report may be more comprehensive than just a one-page matrix.

STEP 1

Screening and scoping

It should *a priori* be assumed that all national plans will have an impact on health and health equity. Begin by identifying relevant plans (this should be straightforward based on work undertaken in the Analysis of health and determinants (**A.1**) and the Scan of intersectoral policies and mechanisms for action (**A.2**). Determine timelines for their review, when there may be an opportunity to provide input. Schedule this in the workplan. Identify priorities for review.

The decision on whether to perform a formal review should be decided in the initial screening. The main factors include the capacity to perform a review combined with a judgement on the potential magnitude of negative impact on health and health equity. Ideally all plans should be reviewed however experience suggests this is unlikely. If there are capacity-constraints, priority should be given to those plans judged to have the most profound impact on population health and health equity.

If time allows use the following more in-depth process to assess priority. Examine each plan and write a concise description of what the plan intends to impact in different sectors, what it aims to change and how, and what could be unintended impacts on the social determinants of health. This includes if the plan explicitly intends to improve health and health equity.

Generally this will involve a *desk review* where there are sufficient national or international data and evidence available to assess the potential impact of the plan. Desk reviews are quicker and less costly than a *comprehensive review* which would require collection of data, consultations, research etc.

Hints!

For transparency and accountability, records must be kept of which plans were examined and decided to formally review, which were not reviewed, as well as the decision about the type of review and for what reasons. The record must include clear identification of who took these decisions.

STEP 2

Inequity dimensions

A key step in the review is the analysis across different population groups. Which groups or inequity dimensions are relevant for the analysis will vary from country to country depending on the specific context.

Hints!

The 2030 Agenda for Sustainable Development suggests: income, gender, age, race, ethnicity, migratory status, disability, geographical location and other characteristics relevant to national contexts. Usually, the inequity dimensions will be defined from the analysis of health and determinants (Tool **A.1**). All reviews of national plans should use the same list of inequity dimensions and definitions of the population groups.

STEP 3

Determinants and potential health impacts

Almost all plans, whether in health or other sectors, will in some way touch on economic, social or environmental determinants of health. This will require analysis of each individual plan. Sometimes, the determinants are explicit in, or even the very focus of the plans. Other times they are implied. To guide the analysis, it might be useful to consider the hierarchy of causes and examples of determinants in Table 5-2.

Table 5-2 Hierarchy of determinants and examples

Hierarchy of causes	Some examples of determinants potentially relevant in connection with reviewing plans
Society	Globalization, trade and international regulations; urbanization; tax and redistribution systems; pensions and social benefit systems; civil rights; etc.
Social environment	Social norms, practices and access to education; marketing and advertising regulations; social diversity, etc.
Physical environment	Chemicals regulation; physical settings and infrastructure; housing, transport, urban planning and spatial regulations; etc.
Population group vulnerability	Poverty and marginalization; access to, e.g., insurance and financial services, unemployment benefits, health care, social support, water, sanitation, and electricity; housing and food security; etc.
Individual health care	Ease of making contact with health services; quality of health care services; discriminatory treatment; provider compliance; patient interaction and adherence; etc.
Individual consequences	Social, educational, employment and financial consequences; access to rehabilitation; social exclusion and stigma; exclusion from insurance; etc.

Different determinants operate differently and may have differential relevance and effect across population groups. Therefore, the determinants must be considered separately for each inequity dimension (population group).

Hints!

We are here looking at the causes of the differential health outcomes and impacts across the inequity dimensions (STEP 2). Alongside these considerations, the potential positive and negative impacts, including beyond the stated objectives of the plan, should ideally be assessed, documented and referenced for each population group separately. Rarely will time allow this.

STEP 4

Mitigation

This step includes proposals for how the plan could be revised or new policies and activities added to avoid, reduce, remedy or compensate for the potentially negative and enhance the potentially positive health and health equity impact of the plan for the affected population groups. This is also an opportunity to suggest governance arrangements to be put into place to assist in meeting the targets in the relevant plan through HiAP ways of working.

Hints!

This will require going back to the causes (STEP 3) and proposing how they could be addressed in the plan being reviewed. STEP 4 should also include defining adequate indicators and may usefully involve consultations with the plan-owner or people from the concerned population groups.

STEP 5

Co-benefits of mitigation

The co-benefits of mitigation includes identification of the potentially positive effect of mitigation (STEP 4) for the assessed plan's primary objectives for each of the population groups.

Hints!

This is a critically important step in making the plan's owner take real ownership of the plan's consequences and enacting mitigation and monitoring. Note, the plan-owner (in other sectors) would have a shared interest – according to the 2030 Agenda for Sustainable Development – in reducing inequities and monitoring differential effects of the plan across population groups.

STEP 6

Monitoring

The responsibility for monitoring the population health and health equity consequences of the plan is with the plan-owner. The monitoring system should integrate the above indicators for monitoring the potentially negative impacts on health and health equity of the plan for each of the relevant population groups. The system should be designed to capture unanticipated effects and provide early warning to alert if negative impacts are evolving unacceptably for population groups.

Hints!

The result of STEP 6 is to make recommendations to the plan-owner on how to integrate the health and health equity concerns into the plan's monitoring framework and system. The monitoring information should be analysed and documented in the biennial national population health report (**E.3**).

STEP 7

Evaluation

The responsibility for progress review and impact evaluation is with the plan-owner. However, the review of the plan should lead to making recommendations for how the plan's evaluation component can integrate evaluation of the efforts made to avoid the negative health and health equity impacts and consequences as well as what the results of these efforts have been.

Hints!

The HiAP team should keep track of scheduled evaluations of national plans in order to feed into the terms of reference for such evaluations and subsequent revisions in a timely way.

The above steps are generic and each country HiAP should develop its own protocol for reviewing national plans. Such protocol if seen as a live document will be useful for quality assurance, ongoing learning and continuity.

D.3 Public health legislation (legal tools)

Why and when?

This tool is yet to be fully developed and so it follows a different format to the other tools; it is positioned as a briefing note rather than a tool. Following is a brief discussion about the role of public health legislation as an important tool for institutionalizing an infrastructure for HiAP, and some examples where legislation is being used to co-ordinate and facilitate HiAP and integrate health into other sectors. Based on HiAP experiences around the world, it is usually the case that law to support HiAP is enacted well after HiAP has started and has achieved proof-of-concept. In most cases, it has been used as a way to sustain HiAP efforts well after the practice has been implemented. However, it is increasingly important to develop this tool on legal mechanisms, as in some countries legislation for action on the social determinants of health comes first and provides the important framework for action. This is particularly the case in countries where there are weaker political systems in terms of governance, which helps to promote the longevity of HiAP approaches beyond short-term political cycles, and where civil society demands action. As the evidence for the enabling conditions for HiAP grow, greater consideration should be given to how law-based strategies can be used to support HiAP from the outset, which will strengthen accountability and buy-in across sectors. Careful planning and consultation are required as legal mandates for HiAP should not over-prescribe processes at the expense of flexibility or damage the intention of good-faith collaboration on which HiAP action is premised. As the complexities for developing and using a legal framework for HiAP are challenging and heavily context specific, developing a tool on this topic requires further evidence and analysis of the different legal tools available and how they can foster intersectoral collaboration for acting on the social determinants of health.

Rationale and scope

The role of the law in fostering collaborations to achieve a HiAP approach for the development of public policy has in recent years received growing recognition. Law can support intersectoral collaboration around health in many ways. For example, law can require collaboration, authorize collaboration, establish institutions for collaboration, prescribe collaborative processes, assign responsibility, prioritize a public health issue, coordinate government efforts, provide for funding, and foster informal relationships.

Fostering intersectoral collaboration through law signals that government agencies must work together regardless of budgets, politics and competing priorities. In this way, legal requirements can further embed collaborative norms and decision-making. Laws that 'authorize' rather than 'require' collaboration, can be more conducive to HiAP ways of working by providing agencies with discretion to decide when and how to collaborate. Thus, the use of legislation for HiAP requires care and cannot guarantee genuine collaboration, especially if the powers provided through the legislation are executed in a way which is detrimental for building trust and relationships. HiAP is underpinned by the concepts of mutuality and reciprocity so "forcing" stakeholders from outside of the health sector to collaborate and implement and enforce policies in a certain way goes against the HiAP ethos and will ultimately be damaging for HiAP implementation.

This, however, should not deter the use of legislation as a valuable HiAP tool, especially because HiAP supported by legislation, with clearly defined mandate and authority, is more likely to function despite changes in government or in technical staff and provides an avenue to advocate more effectively for resources.

In testing and refining this pilot toolkit, a key priority will be to examine the scope and importance of legislation for HiAP in different societies and what that scope might mean in different contexts.

Practical examples

Following are some examples of how different jurisdictions are incorporating HiAP into laws.

Québec Public Health Act 2001 – acknowledges that various laws and regulations of other government agencies can affect population health and well-being. It empowers the Health Ministry to undertake intersectoral action to support public policy development favourable to health. It specifies that decision-making for all government activities must take into account potential impacts on the population's health and well-being of all legislative and regulatory actions *(2)*.

Thai National Health Act 2007 – enabled the establishment of a new form of governance, the National Health Commission, to be an advisory body to the Cabinet on health policies and strategies. The National Health Commission facilitates the process of developing public policy using intersectoral collaboration. In addition, a National Health Assembly (NHA) is legislated as an instrument to develop participatory public policies on health. The NHA is one of the tools the National Health Commission applies to achieve HiAP *(3)*.

South Australian Public Health Act 2011 –

- Section 17 of the Act provides the power for the Health Minister to provide expert advice to Cabinet on matters which may impact public health. This provision is being implemented as a way of systematizing HiAP across the South Australian Government, taking care to adhere to HiAP principles through the use of soft measures.
- The establishment of Public Health Partner Authorities through section 51 of the Act enables the health sector to work with other sectors to achieve mutually beneficial outcomes. The formalized partnerships are developed with the intention of improving population health through action on the social determinants of health, whilst achieving the goals of the partnering agency *(4)*.

Norwegian Public Health Act 2012 – aimed to further equity in the domain of health by addressing the social gradient in health. The legislation included policy measures to delegate responsibility to the municipal level for identifying and targeting vulnerable groups and stipulating that health impacts be taken into account in all areas of policy-making through a HiAP approach. In addition, the act recommended municipalities employ a public health coordinator to support action, create municipal health overviews and monitor progress *(5)*.

Well-being of Future Generations (Wales) Act 2015 – establishes the provision requiring public bodies to work to improve the economic, social, environmental and cultural well-being of Wales. Each public body must set and publish well-being objectives and take action to make sure they meet the objectives they set. In addition, the legislation outlines seven well-being goals that provide a shared vision for the public bodies captured under the legislation and specifies that they must work together to achieve all of the goals, not just one or two *(6)*.

Further reading

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5. Norwegian Public Health Act 2012. (https://www.regjeringen.no/globalassets/upload/hod/hoeringer-fha_fos/123.pdf, accessed 1 July 2020).
6. Well-being of future generations (Wales) Act 2015. (https://www.futuregenerations.wales/about-us/future-generations-act/, accessed 10 December 2019).

Chapter 6
Work stream E

In-depth analysis to grow the scientific knowledge base: linking with academics and research institutions

E.1 Knowledge gaps and research agenda

Why and when?

The Analysis of health and related determinants (**A.1**), Scan of intersectoral policies and mechanisms for action (**A.2**), Scan of societal 'mega' trends (**B.1**) and Review and revise national plans (**D.2**) tools will have revealed what is known and what is not known about the health situation of the population, and the key priorities in sustainable development and well-being and its context, including in relation to implementing intersectoral policies.

These scans enable identification of knowledge gaps informing the development of a HiAP research agenda. At the same time, taking stock of knowledge gaps and setting the HiAP research agenda is not a one-off thing. It needs to be done upfront and then be maintained. The research community needs to be alerted, kept interested and engaged. This can be done through strategies including stimulating interest and entry, providing formal and informal partnership opportunities and through establishing platforms for dissemination and debate.

This tool is designed to assist the HiAP team to encourage and guide research towards serving the needs for policy action without necessarily having the resources itself to fund research on a large scale. Dissemination of the research is also important.

Readers should be aware that the two areas that are key challenges for HiAP in terms of data, which will influence the ability to fill knowledge gaps relate to: (1) the link between policies and the determinants of health in other sectors and their health impacts in real time; and (2) disaggregated data on health inequalities (i.e. it is difficult to know the distribution of the impacts because there is not enough disaggregated data in the data systems of the health sector and in other sectors).

Rationale and scope

HiAP requires and is fuelled by multidisciplinary knowledge and research cutting across multiple sectors. HiAP broadens the concept of research and who can do research. HiAP research is not solely an academic undertaking but helps to inform and trigger societal action and helps find evidence-based policy solutions.

HiAP practitioners are often asked to research and develop health and equity measurement tools and metrics *(1)* and are recognised as a resource with content expertise and experience in policy research and translation *(2)*. This kind of research comes easily to those with population health experience but not necessarily to those from other sectors.

STEP 1

What to do?

Analyse knowledge gaps

The scans (**A.1, A.2, B.1**) will inevitably reveal gaps in knowledge about issues such as the whole BoD, distribution within the population, the causes for the inequitable distribution and why intersectoral collaboration might have failed. These gaps need to be analysed and broken down into researchable questions. Table 6-1 provides a template for analysis and categorizing each question into different types.

Table 6-1 Knowledge gaps and research questions

Breakdown of knowledge gaps into questions	Types of [research] questions						
	How?	Why?	Who?	What?	Where?	How many?	How much?

Hints!
If a question appears to fall in "how and why" *as well as* in "who, what, where, how many, or how much" categories, it is probably too broadly formulated and could be broken down further.

STEP 2

Research strategies

HiAP research applies the full spectrum of research strategies and methods – qualitative and quantitative as well as combinations thereof. However, the strategy must be right for the type of question asked.

- *How and why* – experiment, case study, focus groups, literature reviews or historical study strategies;
- *Who, what, where, how many, how much* – survey, archival analysis including analysis of monitoring data strategies.

Hints!
Different researchers often specialize in and have preferences for certain research methods. Therefore it is important for the HiAP team to carefully analyse the gaps and questions (STEPS 1 and 2) before moving on to the next steps. Further, in many cases HiAP research analysis and interpretation will require multi-disciplinary research teams.

STEP 3

Existing repeated surveys

Many countries have a considerable number of surveys repeated at regular intervals including: national census, budget and household surveys, demographic health survey, etc. These surveys are owned by different agencies. The national bureau of statistics is in many countries a key player. Some of these surveys might already collect data needed for answering the knowledge gaps/research questions identified in STEP 1. However, in some cases the survey instruments might need certain modifications in order to generate the desired data. As most large population surveys have long lead-times, it is important to keep track in order not to miss a window of opportunity for getting the survey-owner on board and making modifications – an opportunity that might not come again for another five to ten years.

Table 6-2 will assist in making an overview of the various repeated surveys of relevance in the country.

Table 6-2 Overview of surveys

Existing repeated survey (owner)	To provide data for research question	Modifications		Next survey		
		Not required	Some required	Deadline for input	When conducted	When results expected

Hints!
In addition to the information in Table 6-2, it will be useful to note the limitations to each survey with respect to factors such as sample frame and options for disaggregation of data required for answering questions of inequity between population groups or geographical areas. Conducting representative population-based surveys that provide sufficient granulation (disaggregation of data) is extremely expensive so be sure not to miss any opportunity to hook onto on surveys that will be carried out anyway.

STEP 4 Prioritization

Not every research question can be answered, and every knowledge gap covered at once. Resources – human and financial will normally not permit this, so it is necessary to prioritize. Three prioritization criteria are suggested:

- *Importance* for political action, including complexity and potential magnitude of the problem;
- *Feasibility* considering costs and available capacity;
- *Urgency* in relation to decision-making requirements and opportunities identified in STEP 3 and Tool **B.2** Windows of opportunity.

Hints!
The loss by missing windows of opportunity is potentially so great that it suggests giving a high weight to 'urgency'.

STEP 5 Encouraging and supporting research

HiAP teams will rarely command the resources and organizational capacity to undertake the required research itself – nor is it desirable. Instead, the HiAP team should encourage and facilitate research on population health, health equity and the root-causes. This can be done through a range of activities and considerations for example:

- Take a longer-term perspective, while recognizing some research may need to be done quickly depending on the HiAP needs;

- Provide technical support and link researchers with policy actors outside of the health sector who can be useful as part of research processes or with other researchers themselves (the nature of the HiAP work exposes the HiAP team to a range of technical experts and academics who may not necessarily know each other but the HiAP research would benefit from a multi-disciplinary approach);
- Encourage training institutions (covering fields such as public health, public administration, business, urban planning, engineering, economics, health and social work, etc.) to make students interested in building skills for multi-sectoral and multi-disciplinary action and research on the pathways between economic, political, environmental and social determinants and population health;
- Establish a small grants scheme with a focus on the identified priority research questions open to masters and PhD students, community groups, secondary schools and others;
- Guide research funding – many countries and international organizations have relatively large amounts of funds available for research – encourage these to have funding windows aimed at research on the identified priority research questions; and
- Provide platforms for disseminating and debating research findings, see Tools **E.2** Monitoring and evaluation and **E.3** National population health report.

Hints!

Quality is paramount and research does not necessarily have to be academic. However, all research needs to be quality assured right from proposal writing and selection, conduct, write-up and presentation. Peer-review and other review mechanisms are well-established. It might be a good idea for the HiAP team to assemble a group of experts from different disciplines and sectors to form a HiAP research steering and support group.

Where resources are available, the HiAP team should consider splitting funding costs with HiAP partners in different sectors to fund research. This also promotes multi-disciplinary research and co-benefits to be realized.

STEP 6

Research timelines and work plan

The work plan should be planned backwards rather than incrementally, i.e., start from when the answers are needed, including for monitoring requirements (**E.2**), national health forums and political windows of opportunity where relevant. The right blend of new findings at the right time can make the difference. Preparation of the National Population Health Report (**E.3**) also provides a milestone for taking stock of the knowledge base and thus for starting a new research agenda cycle from STEP 1.

Hints!

It is easy to underestimate the time it takes from when a research question is identified until research findings and possible answers are available. It is advisable to operate with a rolling four to five years HiAP research work plan. In connection with preparing the timelines, it might be necessary to go back to and revise prioritization (STEP 4). Further, as not all the research will be completed for various reasons or issues surrounding the quality or the usefulness of the results may lead to delays, it is important not to rely on a single piece of research and maintain diversity in your HiAP research agenda.

E.2 Monitoring and evaluation

Why and when?

The HiAP Framework (Figure 1-2) sets out enabling conditions for successful HiAP practice and includes monitoring, evaluation and also reporting **(E.3)**. There are two important approaches in monitoring and evaluation for HiAP practice: (A) management review (process monitoring and evaluation), and (B) impact assessment (monitoring impacts).

The immediate outcomes of HiAP will be policy and programme implementation, and community engagement. Evaluating the HiAP mechanisms which influenced the process of policy-making and government business refers to management review or process monitoring and evaluation. HiAP also requires monitoring and evaluation of the intermediate and longer term impacts to track the potential and/or actual contribution of HiAP to population health outcomes, which requires monitoring impacts. Process monitoring and evaluation is generally less complex, and thus can be undertaken more frequently, whereas monitoring impacts is more technical and cumbersome, and it would be expected to be undertaken less frequently, for example at key milestones. Together, management review and monitoring impacts can show how and why HiAP works and helps identify challenges and best practice (process monitoring), as well as enabling an overall assessment of the changes resulting from the HiAP work, i.e. examining the endpoints of interventions and policy changes expressed as outcomes such as mortality or unemployment (monitoring impacts). Monitoring impacts in the context of HiAP relates to health inequality monitoring. Health inequalities refer to differences in health status or in the distribution of health determinants (e.g. access to improved water and sanitation) between different population groups. The concepts of "health inequalities" and "social determinants of health" are inextricably linked. Health inequalities can only be eliminated through action on the social determinants of health.

The value of management review is often underestimated and is not simply about checking if a HiAP work plan is on track but also emphasizes the actions needed for bringing about mind-set change and relationship building to promote and eventually build-up to policy and institutional change. This is critical as concepts such as shared values, shared vision and shared responsibility for health are integral to HiAP process mechanisms, which are necessary building blocks to ultimately changing the distribution of the social determinants of health and health inequalities.

The 2019 Global Status Report on HiAP showed there is a clear link between maturity of HiAP practice and monitoring and reporting mechanisms as well as a positive relationship with formal governance structures. Further, different jurisdictions defined monitoring and evaluation in different ways *(3)*.

Ideally, monitoring and evaluation mechanisms in relation to management review should be set up from the beginning of the HiAP work with monitoring occurring routinely to see if HiAP activities, as outlined in the HiAP Plan, are on track allowing for correction if not. Evaluation will occur periodically at specific points in the process to measure success against the objectives set. Monitoring impacts should also be considered early, especially the availability of data to monitor health inequalities (including disaggregated data) and the technical capacity for analysis of these data and the interpretation of results for decision-making.

Furthermore, community participation is an additional element important in monitoring HiAP and particularly health equity. Participation should be inclusive, transparent, accountable and meaningful with an opportunity to redress problems identified. Increasingly community-developed indicators are being used and mobile phone technology and social media offer opportunities to collect information. Improving community participation in monitoring mechanisms will encourage community groups and organisations to take better ownership of health assessments and decision-making. In turn, this will open up channels for public participation, and raise the profile of health and social issues for major policy decisions more broadly.

Rationale and scope

In planning your monitoring and evaluation it is necessary to consider what is possible, what is important and what data is available. Ideally, you are seeking to examine the implementation of the HiAP programme (process evaluation) and measure and assess the long-term effects produced by the programme and its policy interventions (impact assessment). For example, questions one might explore include:

- How do HiAP mechanisms influence the process of policy-making and government business? (e.g. interventions and partnerships) – process evaluation
- What are the barriers and enablers? – process evaluation
- Is the model operating according to the work plan? – process evaluation
- What are the changes in the determinants of health and well-being as a result of the policy interventions? – impact assessment, and
- What is the impact on well-being, morbidity and mortality, including both level and distribution? – impact assessment.

There are a range of methodological approaches that can inform your monitoring and evaluation . This includes organizational learning and critical action research, realistic evaluation, programme logic , theories on policy agenda setting and implementation, systems thinking and network evaluation etc. As your HiAP approach becomes embedded and partnerships with researchers strengthened these can inform your monitoring and evaluation approaches.

The challenge in monitoring HiAP change (monitoring impacts) is that population health outcomes – the primary health related aim of all HiAP approaches – can take many years to show up, are distal to the intervention point making attribution extremely difficult, and are often across sectors where access to the data may be limited. This simply means that using a mix of monitoring and evaluation strategies is necessary.

Monitoring and evaluation enables a justification for the investment in establishing, fostering and sustaining HiAP. Monitoring and evaluation strategies are particularly important for policy-makers to make the arguments for HiAP action by having evidence of progress to show that HiAP has improved health and well-being and their determinants in the general population or in targeted population groups.

A. Management review
What to do?

STEP 1

Identify outcomes for your plan

Based on your overall HiAP plan identify the key changes being sought. For each action area identify the processes, outputs and outcomes you hope to achieve and the relevant timelines.

Hints!

Consider constructing a programme logic model for the HiAP approach as a whole. This will be useful to show to different partners and can be developed and revised with them; it will also change over time and need to be reviewed. See for example the South Australian model *(2)* which includes theory of change, strategies, implementation mediation factors, activities, impacts on the policy environment and outcomes within the context of an authorising environment for intersectoral partnerships. The evaluation model was built up on a logic theory where different elements in the chain of causation were analysed.

Hints!

For the HiAP team at the early stages, measurement and evaluation will be more feasible at the "intermediate" level. The type of results may include:

- increased awareness and understanding of social determinants of health;
- personal and collective learning;
- broadened perspectives on issues in different sectors;
- convergence of agendas and agreement on action;
- new and strengthened alliances and opportunities;
- increased organizational and personal capacity for intersectoral work;
- legitimising proposed actions;
- reduction in siloed mindset and processes;

- understanding each others' language and processes;
- forums for joint work;
- evidence of community engagement.

The kind of indicators that could be useful are:

1. Individuals in government and society
- knowledge of policy-makers about determinants of health, social determinants.

2. Network level
- increase in numbers of sectors involved;
- shared budgets;
- seniority/consistency of representation.

3. Results in policy and systems
- changes in policies according to evidence;
- health impacts assessed in decision-making.

STEP 2 Identify relevant monitoring indicators and data sources

For the processes, outputs and outcomes in each action area. You do not need indicators in all areas as it may become unmanageable. Focus on the key areas where you will be working and realistically hope to make a difference.

Data will be more readily available in some areas including health status, risk factors, access to services etc. and will have been identified through the initial analysis of health indicators and determinants and public health and sustainable development reports **(A.1)**. Ensure your actions are of sufficient intensity and duration to realistically have an effect on health impact data.

Other indicator sources include: intervention summaries from systematic reviews to illustrate established impacts of strategies; legislation databases; impact assessments; and education and training databases.

Data on determinants which are mainly outside of the responsibility of the health sector is likely to be less feasible to collect and proxy indicators will be needed.

Factors including the availability, timeliness and form of data will impact on what can be measured and monitored *(5)*. Data may not be available for equity analysis or it may not be disaggregated to a suitable level. Other actions will be more focused on processes rather than outcomes. This means alternative indicators will be needed such as: *governance structure established* (monitoring) and *governance structure achieving its purpose* (evaluation) or *equity is acknowledged as a goal in key documents*. Where relevant refer to the SDG targets, given countries will be reporting on these regularly.

Hints!

HiAP is often opportunistic and always collaborative so the actions will change and evolve over time. Monitoring and evaluation should not impede this approach and the requirement to be nimble and responsive.

STEP 3 Analyse the results

To assess the extent to which the HiAP programme has achieved what it set out to achieve, to what degree and where possible, why achievements were or were not reached. Collate the information into a report that clearly sets out the results. Remember what was not achieved is also important to note and share to assist others and inform reflection and programme redesign. Use the results to inform the required changes to the operation of the HiAP model.

Hints!

Remember monitoring is a process of repeatedly observing a situation to watch for changes over time so it will be important to embed monitoring into your approach *(4)*.

STEP 4 Evaluation

Of the HiAP programme as a whole and of specific initiatives may be required. Identify areas where this would be useful and how this might be done e.g. through a partnership with universities or other researchers who can independently assess achievements.

Hints!
Tools such as health impact assessment, cost-benefit analysis, environmental impact assessment and human health risk assessments can be applied for more formal evaluations and help build evaluation capacity.

STEP 5

Governance mechanisms

Such as a Monitoring Steering Group that meets periodically can help ensure monitoring and evaluation occurs and is not forgotten when the programme is busy and other priorities take over. Include people from health and other sectors to ensure commitment and ensure people with monitoring and evaluation expertise and responsibilities are included. Community representatives or community-based organizations should also be involved.

Hints!
Assign responsibility for collecting and monitoring relevant indicators to a HiAP team member or members and set timelines for doing so.

STEP 6

Share the results

With government, political leaders, partners, stakeholders and the community. The results can demonstrate the value of investment for health and well-being and policy collaborations and should be promoted allowing an opportunity to showcase activity and influence future HiAP action. They will also feed into national population health reports **(E.3)**.

B. Monitoring impacts
What to do?

There are three interrelated options to consider when monitoring impacts of your HiAP programme. Following, these are highlighted rather than providing step-by-step detail.

Option 1

Strengthening public health surveillance

The HiAP team will need to use health surveillance data to be able to track impacts of the HiAP programme and the implementation of its policy recommendations. Health surveillance is the responsibility of the data and statistics area of the health ministry and is used to identify public health problems, inform disease prevention strategies and immediate or long-term public health responses, which also target specific population groups. The data which is typically collected relates to (1) health indicators that make explicit reference to reductions in morbidity, mortality, or BoD, and (2) health-related indicators that provide information on health service performance, exposure rates (e.g. to pollution, chemicals etc.), and health states (e.g. malnutrition). The health systems monitoring functions rarely consider or extend to upstream health determinants, which is the type of data needed for HiAP impact monitoring. It is therefore important for the HiAP team to manage these data challenges but also create the opportunities for strengthening public health surveillance to extend its focus on upstream socioeconomic, environmental, and governance aspects determining population health and health equity. This highlights the clear need to base monitoring systems on a broader defined set of determinants that are important for health.

In addition, the HiAP team should also support efforts to have more health-related indicators included in the goals of other policy sectors. This requires methods for linking and reporting data from different sectors to understand their impact in reducing or exacerbating health inequalities.

Monitoring systems need to adapt and focus on the scope of indicators needed if they are to address the determinants of health equity, which means better sharing of data across different policy sectors and the inclusion of health determinants in monitoring frameworks within and outside of the health sector.

Option 2

Monitoring systems at the local and sub-national levels (monitoring beyond the national level)

It is important to be able to draw upon indicators which are relevant to your HiAP context and the level of government your approach is working within. Up-to-date and comprehensive surveillance data is often more readily available at the national level than at the local level. Robust indicators need to be available at the local and subnational levels, which also implies consistency between local, national and global monitoring efforts. As highlighted in OPTION 1, the HiAP team will need to champion the development or

strengthening of a localized monitoring system that takes account of a wider set of health determinants to support sufficient data provision about the conditions experienced by local population groups and understanding of the health impacts of HiAP action (i.e. policies and practices, including governance interventions).

Hints!

The Finnish monitoring system provides one example of health monitoring that captures local, regional and national data sources. The country's health monitoring system is based on national surveys, national administrative registers, and local patient registers. Finnish national health policy has relied on the HiAP approach for several decades, so the approach has been able to benefit from the sophisticated health monitoring model in the country, which covers a spectrum of indicators, including with the purpose of evaluating the effects of health policies and interventions. The availability of data on key health and social indicators is extensive.

The Finnish HiAP approach emphasizes the role of local authorities in promoting residents' health and welfare. It is through this recognition of action at the local level that the country has been able to introduce the use of indicators in local level policy-making through the development of user-friendly, web-based portals which have been filtered to include the most important indicators and data sources. In this way, municipal councils can better manage and plan health and welfare services and develop and evaluate prevention activities. The data is used by municipalities to fulfil their obligated monitoring and reporting of their residents' health. The welfare reports also act as an accountability mechanism for decision-makers to ensure the timely prevention of health problems in communities and the minimization of inequalities between population groups. In addition, these welfare reports are prepared in collaboration with other municipal sectors (e.g. environment, sport and leisure, culture) holding other sectors to account for the health impacts of their policies.

Option 3

National population health report

The development of a national population health report is likely to be the best starting point in an effort to monitor impacts, disseminate findings and promote political accountability. Health monitoring and the use of indicators in holding to account all stakeholders that contribute to the conditions for health in a community is a powerful tool, whereby findings should be presented through regular population health reports. Even a small indicator set that covers traditional summary measures of health and well-being as well as capturing some health determinants and including the ability to make an assessment of governance for health should be used to progress a measurement and reporting framework. This can be used as a basis to help build a strengthened public health surveillance system (as discussed in OPTION 1).

Hints!

Tool **E.3** (National population health report) provides more information.

Further reading

- Global status report on Health in All Policies, Global network for Health in All Policies. Government of South Australia, Global network for Health in All Policies. Adelaide: Government of South Australia; 2019. (https://actionsdg.ctb.ku.edu/wp-content/uploads/2019/10/HiAP-Global-Status-Report-final-single-pages.pdf).
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E.3 National population health report

Why and when?

Health of populations and in particular health inequities within populations are political issues. The shape of the population's health is a result of political decisions. Politicians tend to sub-optimize and focus on short-term solutions, e.g., on immediate bottlenecks in the health care system and increasing productivity – but without necessarily having a great impact at the population level. Politicians need to know and understand the health situation, what its causes are, what is being done, and what the effects of the efforts are.

Only then can the politicians (Parliament) take informed responsibility. Thus, the national population health report is a key HiAP leadership and governance instrument for facing the reality and stating accountability.

Although 'reporting' may be seen as appearing as the HiAP matures, it should be included in all stages and steps right from the beginning. The development of a national population health report is a highly recommended activity in the Health in All Policies approach.

Therefore, an outline for the National Population Health Report should be prepared early at the 'agenda setting' stage. In most cases, making comprehensive *annual* National Population Health Reports will overstretch the capacity, including of the HiAP team. Many of the HiAP processes and indeed the results have a longer timeframe to them. However, making the intervals too long (e.g. every four years), may run the risk of exceeding the political cycles, thus losing on the important political accountability *(6-8)*. A reasonable frequency would be biennial population health reporting.

Some countries have tried to include health and health equity indicators into overall national reporting – but without great success as the messages tend to get lost among other messages and the politicians often pay greater attention to the economic indicators. Ultimately, HiAP requires dedicated reporting though the data and findings might feed into other reports, including, e.g., reporting on the Sustainable Development Agenda, in particular with respect to *'leaving no one behind'*. HiAP action might also be reported as part of, for example, a report on public health. This can still be a way to achieve recognition of the HiAP achievements.

Rationale and scope

The national population health report should be designed for political and public audiences and presented to the Parliament, providing evidence first and foremost for social and political accountability. Evidence for bureaucratic and managerial accountability can usefully be done at a summary level, in a separate report, or in a web-annex. It is recommended to keep the report between 30 and 50 pages. Alternatively, make a full comprehensive report with an executive version of about 25 pages. Several additional products, such as press releases, feature or academic articles, policy briefs, etc. can usefully be made based on the national population health report.

In this tool, the report is titled National Population Health Report. However, a similar format can be used at sub-national levels.

Key message: The national population health report is a key instrument for informing and nurturing the public and political debates and ultimately policy-decisions and political accountability. The report should be scientifically based but popularly written, targeted and planned from the onset of the HiAP. It should analyse the situation going beyond descriptive statistics to include the causes for the level and distribution of health in the population as well as what is being done to redress the situation.

What to do?

Producing the national population health report is a collective project of the HiAP team. It will require inputs and contributions from a range of different sources and collaborators from across sectors, institutions, organizations and levels of government.

STEP 1

Outline of the national population report

As soon as the initial scans (Tools **A.1**, **A.2**, and **B.1**) and the national consensus workshop have identified the problems and solutions (Tool **A.3**), an **outline of the national population report** should be prepared.

Hints!

The national population health report is a key HiAP milestone setting both the pace and direction for many of the strategic activities (see Tool **C.2** Organizing the work). The report could include information relating to:

- BoD and inequalities;
- Policies and outcomes (risk factors and social determinants);
- Latest research and monitoring findings;
- Implementation experiences (intersectoral collaboration, flagship projects); and
- The way forward including further research needs.

STEP 2

Map out the timeline

For when the different parts of the inputs for the report should be available.

Hints!

For the first national population health report, a lead time of about three years should be allowed as it will take time to orient research, information systems and surveys towards beginning to deliver the required inputs – including on missing and disaggregated data.

STEP 3

Who contributes what

Based on the outline (STEP 1), it should be decided **who contributes what** to the report.

Hints!

It will probably be useful to have a half- or full-day workshop with the key contributors every six months. This will facilitate learning from each other, resolving issues and keeping direction and momentum.

STEP 4

Extensive peer review

Schedule an **extensive peer review** to ensure the quality required for this HiAP flagship product and prepare a **detailed production plan** (see also STEP 5).

Hints!

The detailed production plan should be prepared about one year before the publication date. All parts of the report should be ready for the extensive peer review about six months before the final publication date in order to allow for revisions, editing, lay-out and the production of additional materials.

STEP 5

Launching reports in Parliament

Are a powerful step towards engaging non-partisan commitment. A parliamentary, or some similar launch, takes the debate into the public forum involving key opinion-leaders, policy champions, partners and other stakeholders.

Hints!

To produce and launch the national population health report is work of the wider HiAP community orchestrated by the HiAP core team. The report is the evidence platform for shaping the public and political debates and for holding politicians and the government accountable for population health and health equity.

Practical examples

- Norway produces its "Public Health Political Report – Indicators for Cross-sectoral Public Health Work" addressed to Parliament (Stortinget) annually. The 2015 report focused on seven policy domains corresponding to seven working groups: economic living conditions; social support, participation and involvement; safe and health promoting environments; healthy choices; child development; work-life; and local public health work *(5)*. (https://www.regjeringen.no/contentassets/ce1343f7c56f4e74ab2f631885f9e22e/en-gb/pdfs/stm201220130034000engpdfs.pdf).
- Health in All Policies as a priority in Finnish health policy: A case study on national health policy development http://journals.sagepub.com/doi/pdf/10.1177/1403494812472296 *(6)*.
- In Finland, the Public Health Act (2006, revised in 2010) imposes local governments to monitor health and health determinants and they have a legal obligation to produce a comprehensive welfare report every four years with a compressed version every year. The Finnish monitoring tool at the local level, given the devolution of health and social services is informative: https://teaviisari.fi/teaviisari/en/tulokset. It shows how well the capacities needed for Health in All Policies are being taken up. See also the paper https://journals.sagepub.com/doi/full/10.1177/1403494817743895 *(7)*.
- Monitoring social well-being to support policies on the social determinants of health: the case of New Zealand's "Social Reports/ Te purongo orange tangata" http://socialreport.msd.govt.nz provides an example of integrating indicators for social determinants of health and health inequity into comprehensive social reports produced by the Ministry of Social Development. However, it also highlights the challenge that government agencies concerned with economic development make negligible use of the reports *(8)*.

Further reading

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ANNEXES

Annex

Annex 1 - Work stream A Analysis of health and determinants (Tool A.1)

Annex 1.1: Examples of interventions to address inequity and determinants

Table A-1 Evidence-based strategies to minimise the impact of social hierarchy on health

Invest in children	• Early child development enrichment programmes • Intensive parent support (home visiting) programmes • Enrolment of all children in early childhood education
Get the welfare mix right	• Regulate markets as necessary • Implement income transfer policies that redistribute resources (i.e. progressive tax and benefit regimes) • Optimise balance between targeted and universal social protection policies through benefit design that minimises both under-coverage and leakage • Eliminate child poverty through monetary and non-monetary support for families with dependent children
Provide a safety net	• Provide income support or tax credits • Provide social housing • Subsidise childcare • Provide free access to health care (especially preventive services)
Implement active labour market policies	• Provide job enrichment programmes • Democratise the workplace (involve employees in decision-making) • Provide career development and on-the-job training • Provide fair financial compensation and intrinsic rewards • Promote job security • Discourage casualization of the workforce
Strengthen local communities	• Foster regional economic development • Promote community development and empowerment • Encourage civic participation • Create mixed communities with health-enhancing facilities

Provide wrap-around services/integrated services for the multiple disadvantaged	• Coordinate services across government and NGOs • Provide intensive case management when necessary • Foster engagement of the targeted families and individuals
Ensure universal access to high quality primary health care	• Subsidise practices serving high need populations • Provide additional nursing and social worker support for practices in disadvantaged areas • Assist patients with clinic transport and childcare • Provide services free at point of use • Provide conditional cash transfers (to increase demand for clinical preventive services)

Source: Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice).

Table A-2 Examples of social determinants of health interventions using the concept of targeting within universalism

Entry point	Strategies	
	Universal	Selective
Social Stratification: Policies to reduce inequalities and mitigate effects of stratification.	• Active policies to reduce income inequality through taxes and subsidized public services. • Free and universal services such as health, education, and public transport. • Active labour market policies to secure jobs with adequate payment. Labour intensive growth strategies. • Social redistribution policies and improved mechanisms for resource allocation in health care and other social sectors. • Promote equal opportunities for women and gender equity. • Promote the development and strengthening of autonomous social movements.	• Social security schemes for specific population groups in disadvantaged positions. • Child welfare measures: implement Early Child Development programmes including the provision of nutritional supplements, regular monitoring of child development by health staff. Promotion of cognitive development of children at preschooling age. Promote pre-school development.
Exposure: Policies to reduce exposure of disadvantaged people to health damaging factors.	• Healthy and safe physical neighbourhood environments. Guaranteed access to basic neighbourhood services. • Healthy and safe physical and social living environments. Access to water and sanitation. • Healthy and safe working environments. • Policies for health promotion and healthy lifestyle (e.g. smoking cessation, alcohol consumption, healthy eating and others).	• Policies and programmes to address exposures for specific disadvantaged groups at risk (cooking fuels, heating, etc). • Policies on subsidized housing for disadvantaged people.
Vulnerability: Policies to reduce vulnerability of specific groups.	• Employment insurance and social protection policies for the unemployed. • Social protection policies for single mothers and programmes for access to work and education opportunities. • Policies and support for the creation and development of social networks in order to increase community empowerment.	• Extra support for students from less privileged families facilitating their transition from school to work. • Free healthy school lunches. • Additional access and support for health promotion activities. • Income generation, employment generation activities through cash benefits or cash transfers.
Unequal Policies to reduce the unequal consequences of social, economic, and ill-health for disadvantaged people.	• Equitable health care financing and protection from impoverishment for people affected by catastrophic illness. • Support workforce reintegration of people affected by catastrophic or chronic illness. • Active labour policies for incapacitated people. • Social and income protection for people affected with chronic illness and injuries.	• Additional care and support for disadvantaged patients affected by chronic, catastrophic illness and injuries. • Additional resources for rehabilitation programmes for disadvantaged people.

Source: Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice).

The following annexes contain sample invitation letters and notes that may inspire and guide during the Delphi process. It is suggested that you read these sample letters and guiding information and then formulate your own letters and information packs as appropriate to the particular circumstances and approaches in your country.

Annex 1.2: Getting ready for the Delphi process

The information presented in this Annex (1.2) may be useful in developing a general guide which outlines the rationale and background for the Delphi process that can be used as an attachment to invite letters or form the basis of a general letter informing participants of the process. Annexes 1.3 - 1.6 provide detail on specific invite letters relevant for each Delphi round.

There is an increasing recognition internationally as well as in <Country> of the interrelated nature of the multiple and complex challenges facing the world including climate change, the rise in chronic NCD, urbanization, globalization, migrating populations, economic and fiscal crises, threats to natural resources and increasing inequities. There is also increasing recognition of the crucial relationship between these issues and health outcomes and inequities, and thus the importance of intersectoral action for better health and well-being. Addressing the social determinants of health requires tackling issues related to housing, transportation, employment, urbanization, economic development, and the environment, to name just a few.

The Health in All Policies approach (HiAP) is an effective way of working across all levels and sectors of government and in conjunction with the private sector, civil society, and community-based organizations in the search for innovative and joint solutions to these complex interconnected problems. Whilst seeking to ensure all policies and programmes support better health and health equity, the approach involves co-design, co-production and collaboration to achieve shared goals and benefits for all sectors.

Initial base-line reviews have been undertaken comprising an Analysis of health and determinants (**A.1**). These preliminary scans have provided useful high-level information which will be used to inform the HiAP Strategy and priorities for action. However, it is important to have an in-depth understanding of the health of the population in our country, the inequities and the determinants contributing to this situation to inform our collective and collaborative search for solutions. To achieve this, the following is a process which aims to collect the necessary information in a timely and collaborative manner.

The process consists of four major STEPs:

STEP 1

Review the BoD profile

The purpose here is to identify the 15 largest contributors to the burden in <Country>, using comparator countries for benchmarking, as well as identifying the largest exposure and attribute risk factors *(led by the HiAP team)*.

STEP 2

Prepare guidance for a participatory process

Develop 'information sheets' and 'briefing papers' for diseases/conditions for the 15 top BoD and preliminary inequity dimensions filled with information readily available *(led by the HiAP team)*.

STEP 3

Undertake four iterative Delphi-rounds by email

(*led by HiAP team and with active stakeholder participation*)

1. *First round* – limited number (five to ten) of expert-participants aiming to complete the description of the level and inequities in health of the 15 top BoD conditions as well as to identify any burden that is known to be very unevenly distributed across population groups – but is not in the top 15 conditions i.e., very focalized health problems.
2. *Second round* – larger number of participants (10 to 20), including others from academia, civil society, programmes and services that can help interpret what the data might mean (continue completing the evidence base from the first round). This will now also include gathering suggestions for the causes for the level of health status and risk factors and the related inequities in the population, i.e., the determinants of health – referenced if possible.

3. *Third round* – the number of participants might be further expanded (up to 50) if deemed relevant based on the second round to continue complementing and supplementing the knowledge base of the second round. Now also include proposed policy domains capturing the social determinants across the 15 BoD Information Sheets with current policy and policy implementation gaps and proposed policy options, including expected health benefits (level and distribution) and benefits to other sectors.
4. *Fourth round* – the list of remaining issues, minority opinions, and items achieving consensus are distributed to all the participants for final comments and input.

In each round, the participating experts will have from seven to ten days to respond (it is important to have quick turnarounds to build credibility and transparency). The HiAP team will analyse the results and get back with more complete Information Sheets and additional questions within another ten days.

STEP 4

Consolidate the results from the Delphi-rounds in a presentable format

This is to ensure that results are conducive for presentation to different audiences, for example a national consensus workshop to support further work on identifying the problems and helping to set the HiAP agenda *(led by the HiAP team)*.

Hints!

Below is some text that can be inserted into invite letters regarding the Delphi-rounds. This may be used as a concluding paragraph in the invitation letters.

Don't forget to consider who is the best person to sign the invitation letters. The initial invitation letter should be addressed from someone with a higher authority than the HiAP team (e.g. an Executive Director). This demonstrates to potential participants that there is high-level buy-in for the work and that the work is supported within government.

Ideas for specific letter

We expect to have a range of initial policy recommendations on Health in All Policies finalized by <XXXX> in time for the HiAP national consensus workshop in <XXX>. These will form the basis for prioritization and strategy roll-out.

<XXX> from the HiAP team will be the focal point for the process through which you will be contacted for the above-mentioned Delphi rounds. For any questions, XXX can be contacted at XXX@YYY.ZZ. Further instructions will be shared with you in due time, as well as the tight deadlines which need to be observed. I would like to urge you to participate in this unique process, which will ultimately lead to more comprehensive policies for the health and well-being of everyone in <Country>.

Signed

AAA

Annex 1.3: Delphi round I

Ideas for specific letter

You are kindly invited to participate in the Delphi-process for a scan of the health situation for the <Country> Health in All Policies (HiAP). A roadmap of the full process is described in the attached background letter from ***AAA*** (see Annex 1.2). You have been selected to participate in the process due to your expert knowledge on quantitative data sources and analysis and to provide input to the documentation of the level and distribution of the burden of disease in <Country>.

Your role in this first round is to review the attached draft Information Sheets and provide comments and additional information. In some cases you will find that the Information Sheets are incomplete, e.g., some or all the quantitative information (graphs) is missing, or that there is no or incomplete disaggregation by inequity dimensions. We need your assistance in guiding us to any additional information in this respect – being it from large national surveys or from smaller surveys or studies. Kindly provide your feedback to me on (XXX@YYY.ZZ) by the latest ***day and date close of business.*** Please also get back to confirm if you have no further information or comments.

There are 15 two-page BoD Information Sheets representing the top-contributors to the burden of disease in <Country> and X Information Sheets with smaller contributors deemed to be highly focused or localized.

Each sheet contains a narrative section briefly describing the disease/condition and the main risk factors (exposure and attribute) by populations, i.e., rates, for example per 10,000 population, can be calculated if information is available.

- We would like to have your comments and any quantitative information/data from <Country> you may know of, including additional risk factors. This may be from large surveys or smaller studies.

In addition, each Information Sheet presents several small graphs, showing distribution of the disease/condition and risk factors across various inequity dimensions: income, gender, age, race, ethnicity, migratory status, disability, geographical location and other characteristics.

- We would like to have your comments and any quantitative information/data/data sources from <Country> you may know of or have on the missing data, including disaggregation. This may be from large surveys or smaller studies.
- We would also like to have your comments on and eventual data related to the above inequity dimensions – including any additional inequity dimensions you may suggest. Kindly provide relevant references.

On the Information Sheets you will find a brief list of specific additional information/data we are looking for in respect to the disease/condition in question.

- Please read carefully and provide any feedback, keeping in mind that some of the answers might be in data sources, studies and reports that only you are aware of.

We are looking forward to working with you during the Delphi-rounds and appreciate your valuable time and knowledge.

Signed

XXX

Annex 1.4: Delphi round II

Ideas for specific letter

You are kindly invited to participate in the second round of the Delphi-process for a quick health situation assessment for <Country> Health in All Policies (HiAP). A roadmap of the full process is described in the attached letter from ***AAA*** (see Annex 1.2). You have been selected to participate in the process due to your expert knowledge on quantitative and/or qualitative data sources and analysis and to provide input to the documentation of the level and distribution of the burden of disease in <Country>.

Each of the attached Information Sheets has been updated with feedback from the first Delphi-round and includes a narrative section briefly describing the disease/condition and the main risk factors by populations, i.e., rates per 10,000 population can be calculated if information is available.

- We would like to have your comments on the narrative and any information/data from <Country> you may know of, including additional risk factors. This may be from large surveys or smaller studies.

In addition, each BoD Information Sheet presents several small graphs, showing distribution of the disease/condition and risk factors across various inequity dimensions such as: income, gender, age, race, ethnicity, migratory status, disability, geographical location and other characteristics.

- We would like to have your comments and any quantitative information/data/data sources from <Country> you may know of or have on the missing data, including disaggregation. This may be from large surveys or smaller studies.
- We would also like to have your comments on the listed inequity dimensions, which you find are most relevant and which are missing. Please justify your feedback by including relevant references to studies, etc.

The Information Sheets outline some of the indications for the causes for the health situation and its inequities. Some of these are from international sources and may not be representative of the situation in <Country>.

- We would like to have your comments on the listed causes as well as suggestions for other [missing] causes that may be relevant for <Country>. Please explain your suggestions and provide references where available.

Please provide your feedback to me on (XXX@YYY.ZZ) by the latest ***day and date close of business.*** Do also get back to confirm if you have no further information or comments.

Signed

XXX

Annex 1.5: Delphi round III

Ideas for specific letter

You are kindly invited to participate in the third round of the Delphi-process for a quick assessment of the health situation and causes for the <Country> Health in All Policies (HiAP). A roadmap of the full process is described in the attached letter from ***AAA*** (see Annex 1.2). You have been selected to participate in the process due to your expert knowledge on quantitative and/or qualitative data sources and analysis and to provide input to the documentation of the level and distribution of the burden of disease in <Country>.

In the **first round of the Delphi**, we focused on getting more quantitative data for the Information Sheets, in particular for the graphs.

In the **second round of the Delphi** there was a dual focus: to continue getting quantitative data and, additionally to analyse what might be the social determinants for the level and inequities within each disease/condition making the largest contribution to the burden of disease in <Country>.

The results of Delphi I and II are comprehensive and greatly improved the Information Sheets (*attached*) – many thanks to all who contributed.

For the **third round of the Delphi** we have updated the Information Sheets. We have honed in on four inequity dimensions, deemed in the second round by the participants to be most important: ***aaa, bbb, ccc, and ddd.*** We have further added **X** policy domains (***aaaa, bbbb, cccc, dddd, eeee, ffff, etc***), each with four sub-domains. All of the determinants presented in the Information Sheets have been linked to one or more of the sub-domains.

- We would like to have any additional information and comments you may have on the Information Sheets.

The main focus of Round III is to get your feedback on the Policy Domain Sheets (refer to the in-depth STEP 3 in Tool **A.1** and Figure 2-4) and in particular suggestions to what might be policy or implementation gaps for each of the sub-domains.

Each Policy Domain Sheet includes a short narrative and a box suggesting who might be working within this domain (refer to Figure 2-4).

- We would like to have your comments on the narrative and suggestions for any additional actors within the domain.

In addition, there is a chart mapping the determinants on the Information Sheets to the sub-domains of each particular policy domains.

- We would like to have your comments on the chart, including any missing elements/determinants. When providing your comments please make reference to the specific disease/condition Information Sheet where the determinant appears or should have appeared. The reason being that the Information Sheets are the basis for the charts.

The enclosed sheets also provide a description of the policy situation of the domain as a whole. The purpose is to guide and trigger analytical thinking rather than providing a full and comprehensive account of all policies in the domain.

- We would like to have your comments on what is proposed and suggestions for change, while keeping in mind that the text should not be longer than 10 to 12 lines in total.

Furthermore, on the sheets there is a table with eight windows, two for each of the sub-domains. Apart from the title of the sub-domains, the table is empty.

- We would like you to suggest policy gaps that you consider are critical in relation to the determinants mapped to the sub-domain on the chart. Please think policy rather than intervention or direct action.
- We would like you to point to any gaps in implementation, i.e., where there are already policies in place – but these are not being implemented optimally.

Please provide your feedback to me on (XXX@YYY.ZZ) by the latest ***day and date close of business.*** Please also get back to confirm if you have no further information or comments.

Signed XXX

Annex 1.6: Delphi round IV

Ideas for specific letter

Thank you for participating in the quick assessment of the health situation and causes for <Country>, we have now come to the final Delphi round.

Attached please find the Information and Policy Domain Sheets containing the information and knowledge generated during the previous three Delphi-rounds.

Now is the final opportunity for commenting and providing any additional relevant input.

- We would in particular like to have your input to any missing information and information that you think is incorrect (kindly provide references if possible).
- In some of the sheets, we have asked some final questions. Please review these and provide any answers or comments to these questions.

Kindly provide your feedback directly in the attached Policy Domain Sheets [*and Information Sheet documents in case you have further comments on these*] **and return them to me** (XXX@YYY.ZZ) **by day and date close of business at the latest.**

Please also get back to confirm if you have no further information or comments.

Kindly note that the deadline is tight as we will need to analyse and consolidate the feedback in order to prepare and send out all documentation well in advance of the HiAP national consensus workshop which will take place on the ***DATE.***

Signed

XXX

Annex

Annex 2 - Work stream A Scan of intersectoral policies and mechanisms for action (Tool A.2)

Annex 2.1: Guide for focused interviews with health programme managers

Focused (or semi-structured) interviews are used to collect qualitative data by setting up a conversation that allows the interviewee (the respondent) the time and scope to describe their experience with intersectoral collaboration and provide information on relevant policies, positions and values that can inform future partnerships. The objective is to understand the respondent's point of view rather than providing your views. It uses open-ended questions (see below).

The interviewer (a HiAP team member) aims to build a rapport with the interviewee to make the interview like a conversation. The wording and order of the questions will not necessarily be the same in all interviews though the topics are likely to be consistent. Where a topic does not naturally arise during the conversation, the interviewer may use prompts and phrases such as "Tell me about..." or "You said a moment ago...can you tell me more?" in order to shift from one topic to another and to move the conversation forward.

Start the interview by very briefly explaining what HiAP is about; summarizing the history, purpose and status of HiAP in the country and that you have asked for the meeting in order to listen and learn from the interviewee. Stress that you appreciate the interviewee´s time and that it might take a couple of hours as you have a number of themes that you would like to cover and get the interviewees opinion on. It is good practice to have a written brief about HiAP to provide at the end of the interview.

Always record:

- The name of the interviewee(s) including if there is more than one person present
- Position of the interviewee(s)
- Start and finish of the interview (date and time)
- Who did the interview.

It is recommended you finalize the interview report immediately following the interview.

Topics and guiding questions

1) **General immediate reaction to the concept of HiAP** – prompts could include:
   - What do you think about what I just told you about HiAP?

2) **Positions and values** – prompts might include:
   - Who in your view is responsible for the health of an individual?
   - Who in your view is responsible for the health of a population?
   - The health situation is different in different parts of the country and in different population groups – why do you think that is the case? What factors do you think explain such differences?

- In your view what should be the role of the health sector in addressing these differences in health?
- What should be the role of other sectors in addressing these differences in health?
- What could be the benefits to health and other sectors in addressing the factors causing the health differences?
- Can you give some concrete examples of such co-benefits?

3) **Experiences with intersectoral action** – prompts might include:
   - Do you have any concrete experiences of intersectoral action where two or more sectors have worked together with a common objective? What are they?
   - What was your role in this intersectoral action?
   - Can you explain what the purpose was and how it worked?
   - How would you characterize the mechanisms of the intersectoral action: governance, coordination, project collaboration, common accountability framework?
   - Can you give some examples of concrete issues addressed in the intersectoral action?
   - Which other sectors took part in the intersectoral action?
   - Who initiated and who led the intersectoral action?
   - Are you aware of any health-related policies that have been developed intersectorally?
   - If there is a concrete experience – continue to STEP 4 (below)– otherwise move to STEP 5.

4) **SWOT analysis of the concrete experience(s)** – see Tool **A.2** and Annex 2.3.

5) **Ask the interviewee if he or she has any questions to you and don't forget to thank** them for their time and valuable input and describe what will happen to the input, including a realistic time frame. Hand out the HiAP brief.

Annex 2.2: Guide for focused interviews with managers from other sectors than health

Focused (or semi-structured) interviews are used to collect **qualitative** data by setting up a conversation that allows the interviewee (the respondent) the time and scope to express his/her opinions on a particular subject. The **focus** of the interview is informed by the information obtained in the scan of intersectoral action (see Tool **A.2**).

The objective is to understand the respondent's point of view rather than providing your views. It uses open-ended questions (see below).

The interviewer (a HiAP team member) aims to build a rapport with the interviewee to make the interview like a conversation. The wording and order of the questions will not necessarily be the same in all interviews though all the topics are likely to be consistent. Where a topic does not naturally arise during the conversation, the interviewer may use prompts and phrases such as, e.g., "Tell me about..." or "You said a moment ago...can you tell me more?" in order to shift from one topic to another and to move the conversation forward.

Note this guide is very similar to the one for the health programme managers (Annex 2.1). However, the order is different and there are more prompts in Annex 2.1.

Start the interview/conversation by very briefly explaining what HiAP is about; summarizing the history, purpose and status of HiAP in the country (*it is good to have a written brief about HiAP to provide at the end of the interview*) and that you have asked for the meeting in order to listen and learn from the interviewee. Stress that you appreciate the interviewee´s time and that it might take a couple of hours as you have a number of themes that you would like to cover and get the interviewees opinion on.

Always record:

- The name of the interviewee(s) including if there is more than one person present
- Position of the interviewee(s)
- Start and finish of the interview (date and time)
- Who did the interview.

It is recommended you finalize the interview report immediately following the interview (same or next day). Never attempt to do more than one interview per day.

Topics and guiding questions

1) **General immediate reaction to the concept of HiAP** – prompts could include:
   - What do you think about what I just told you about HiAP?

2) **Experiences with intersectoral action** – prompts might include:
   - Do you have any concrete experiences of intersectoral action, i.e., where two or more sectors have worked together with a common objective regardless of whether it included the health sector? What are they?
   - What was your role in this intersectoral action?
   - Can you explain what the purpose was and how it worked?
   - Did it include concerns about health or health risk factors and if so, how?
   - How would you characterize the mechanisms of the intersectoral action: governance, coordination, project collaboration, common accountability framework?
   - Can you give some examples of concrete issues addressed in the intersectoral action?
   - Which other sectors took part in the intersectoral action?
   - Who initiated and who led the intersectoral action?
   - Are you aware of any sector-relevant policies that have been developed intersectorally?
   - If there is a concrete experience – continue to STEP 3 – otherwise move to STEP 4.

3) **SWOT analysis of the concrete experience(s)** – see Annex 2.3.

4) **Positions and values** – prompts might include:
   - Who in your view is responsible for the health of an individual?
   - Who in your view is responsible for the health of a population?
   - How do you think your particular sector influences the health of the population?
   - In your view how is your particular sector influenced by the health of the population?
   - The health situation is different in different parts of the country and in different population groups – why do you think that is the case and which main factors do you think explain such differences?
   - In your view what should be the role of the health sector in addressing these differences in health?
   - What should be the role of other sectors in addressing these differences in health?
   - What could be the benefits to health and other sectors in addressing the factors causing the health differences?
   - Can you give some concrete examples of such co-benefits?

5) **Ask the interviewee if he or she has any questions to you and don't forget to thank** them for the time and valuable input and describe what will happen to the input, including a realistic time frame. Hand out the HiAP brief.

Box A-1 provides an example of a semi-structured questionnaire used for a pre-meeting HiAP-related survey in Namibia. A similar set of questions were used in face-to-face interviews at the start of the engagement period, preceded by a discussion of the concept of HiAP.

Box A-1 Example questionnaire based on Namibian HiAP work

Example invitation
National Stakeholder's Consultation Workshop on Health in All Policies

Pre-Meeting questions
Kindly complete the questions below and send to INSERT EMAIL by INSERT DATE

The Ministry of Health (or appropriate name) in partnership with/support from LIST PARTNERS IF RELEVANT is hosting a National Workshop to develop an implementation strategy on Health in All Policies. The strategy will be a roadmap on how health and other sectors can strengthen collaboration for intersectoral action with the aim of improving the health of the population. The Health in All Policies approach is premised on the fact that the determinants of health are largely outside the remit of the health sector and thus the need for increased intersectoral action to promote health and well-being and prevent poor health.

The questions below will guide the facilitators and inform the presentations. Kindly complete. Answers can be short, concise and bulleted.

Questions:

- What are the key goals of your Ministry?
- What key policies exist in the Ministry that may have an impact on health?
- What existing mechanisms does your Ministry have for working with the Ministry of Health and Social Services?
  - How well are they working?
  - What are the key challenges experienced when collaborating with other sectors?
- What key priorities has your Ministry addressed in INSERT RELEVANT NATIONAL OR REGIONAL STRATEGY?
  - What are the potential health outcomes of these priorities?

Annex 2.3: SWOT analysis

The SWOT analysis is a useful technique for understanding Strengths and Weaknesses, and for identifying both the Opportunities open to be exploited and the Threats faced. The technique can be useful in many ways but the guidance in this annex is specifically focused on analysing the strengths, weaknesses, opportunities and threats for existing intersectoral collaboration and coordination mechanisms in relation to HiAP, and potential public policy reforms, as part of the interviews with key individual stakeholders.

What makes SWOT particularly powerful is that, with a little thought, it can help uncover opportunities that a particular intersectoral mechanism or approach (in the following called the *approach*) is well placed to exploit. By understanding its weaknesses, one can manage and eliminate threats that could otherwise be problematic. By looking at SWOT analyses of different intersectoral approaches, you can start to craft a strategy that helps make HiAP intersectoral action successful.

How to use the SWOT analysis

Strengths and weaknesses are often internal to an approach, while opportunities and threats generally relate to external factors. For this reason, the SWOT analysis is sometimes called Internal-External Analysis and the SWOT Matrix is sometimes called an IE Matrix.

To carry out a SWOT analysis, answer the following questions in the four windows of the SWOT matrix (Table A-2).

Strengths:

Consider the strengths from the perspective of the interviewee, and from the point of view of others. Be realistic.

Weaknesses:

Consider weaknesses from all perspectives. Do other people seem to perceive weaknesses that the interviewee doesn't see? Are other approaches doing any better? Be realistic.

Opportunities:

Useful opportunities can come from:

- Changes in technological, political and economic development on both a broad and narrow scale.
- Changes in government policy and structure.
- Changes in social patterns, population profiles and lifestyle changes.
- Local events.

A good approach when looking at opportunities is to look at the strengths and ask whether these open up any opportunities. Alternatively, look at the weaknesses and ask whether they could open up opportunities if eliminated.

Threats:

Consider the threats from all perspectives.

Further SWOT tips

When using SWOT analysis make sure you're rigorous in the way you apply it:

- Only accept precise, verifiable statements.
- Ruthlessly prune long lists of factors, and prioritize them, so that you spend your time thinking about the most significant factors.
- Try to have a similar number of bullet-points – say five or six – in each of the four SWOT windows.
- Make sure that options generated are carried through to later stages in the strategy formation process.

SWOT summary and matrix

Approach (*name*):
Purpose (*20 – 35 words*):
General description (*30 – 75 words*):
Lead sector:
Participating sectors:
Dates of meetings in the past 12 months – if relevant:
Information from (*date of interview(s) and name of interviewee(s)*):

Table A-3 SWOT matrix with questions

Internal analysis

Strengths

- What advantages does the intersectoral approach have?
- What does it do better than any other approach?
- What unique, lowest-cost resources or power-structures can the approach draw upon?
- What do people see as its particular strengths?
- What factors mean that the approach delivers results?
- What is the unique comparative advantage of the approach?

Weaknesses

- What could be improved?
- What should be avoided?
- What are other people likely to see as weaknesses?
- What factors stop the approach from delivering results?

External analysis

Opportunities

- What good opportunities can the interviewee identify in the approach?
- What interesting trends is the interviewee aware of that could be furthered by this approach?

Threats

- What obstacles does the approach face?
- What are other approaches doing or doing better?
- Are the expectations of the approach changing?
- Are changing technological, political, economic, or structural situations threatening the position of the approach?
- Does the approach have a negative reputation?
- Could any of the weaknesses seriously threaten the approach?

Annex 2.4: Limited scan of intersectoral action

If for some reason the HiAP team cannot go through the comprehensive scan of intersectoral action as described in the main document and annexes 1 and 2, there are several options for a more limited scan. Each of these comes with pros and cons that need to be carefully considered. This annex provides a brief description of how the scan might be done through a desk review, a questionnaire survey or a workshop. In all cases, stakeholders need to be identified as described in the main document.

Desk review

STEP 1

Each HiAP team member will individually consider each of the identified stakeholders in terms of values and potential co-benefits, place them in the two-by-two matrix (Figure A-1) and make a short note on why they have been placed there.

Figure A-1 Stakeholder matrix

Level of potential intersectoral co-benefits	Degree of sharing equity values/concerns: *Low*	Degree of sharing equity values/concerns: *High*
High		
Low		

STEP 2 The HiAP team members share matrices and notes and reach a common agreement.

STEP 3 Collectively, the HiAP team does the SWOT analysis Tool **A.2** on a number of intersectoral governance and management mechanisms.

Pros: This takes only a few hours of each HiAP team member's time plus a session collectively going through the results.
Cons: The knowledge of the HiAP team will limit the scan, its value and opportunities to establish a personal contact to start engaging stakeholders, and potential collaborators will be lost.

Questionnaire

STEP 1 The HiAP team prepares questionnaires based on the interview outlines (Annexes 2.1 and 2.2 – different audiences).

STEP 2 The questionnaires are validated with a few representatives from the two target audiences (health and other sectors).

STEP 3 The questionnaires are sent out to the identified stakeholders.

STEP 4 The returned questionnaires are analysed including possibly placing the stakeholders in the above two-by-two matrix (see Figure A-1).

STEP 5 Collectively, the HiAP team does the SWOT analysis Tool **A.2** on the intersectoral governance and management mechanisms identified by the respondents.

Pros: Can potentially reach a large number and variety of stakeholders.
Cons: Questionnaires need to be validated before sending out and analysed when returned which is time consuming. Response rates may be low and the approach does not provide opportunity for 'follow-up' questions. Opportunities for establishing personal contacts will be lost.

Small workshop(s)

STEP 1 Introduce HiAP and the purpose of the workshop.

STEP 2 Depending on the number of stakeholders divide them into two (or more groups) by type of audience (see Table 2-1 in Tool **A.2** – track one and track two).

STEP 3 Ask each individual stakeholder to write a short rationale on a post-it note regarding potential intersectoral co-benefits and equity concerns together with their name and post it on a two-by-two matrix (see Figure A-1) for the group.

STEP 4 Each participant explains in a plenary why he or she has placed the post-it where it is in the matrix. A HiAP team member takes notes.

STEP 5 Each group does a SWOT analysis of one or two mechanisms Tool **A.2**.

STEP 6 Plenary presentation and discussion. A HiAP team member takes notes.

STEP 7 Summary and close of workshop, including short brief on next steps.

STEP 8 The HiAP team writes a report that is circulated to the workshop participants for comments.

Pros: can be done over a short duration with a short time for preparations through a one-day workshop. It will involve the stakeholders and start building some engagement.
Cons: differences in opinion and in values tend to get lost. While it might appear to be fast, the actual work-time-equivalents might be considerable involving one or two full days per HiAP team member and one full day per stakeholder.

The above approaches may be combined internally or with the comprehensive approach described in the main document.

Annex

Annex 3 - Work stream A National consensus building (Tool A.3)

Annex 3.1: Sample template for a facilitators' guide

Background

- **Why HiAP is now taking place in country:** international and national background.
- **What has happened in the lead up to the consensus workshop:** what were the processes and who participated?
- **Snapshot of findings**
  1. *A.1 Scan of health and determinants* – six to eight lines on the main findings, how and where the results are presented (report, information sheets, policy domain sheets, etc.)
  2. *A.2 Scan of intersectoral policies and mechanisms for action* – six to eight lines on the main findings, how and where the results are presented
  3. *B.1 Scan of societal trends* – six to eight lines on the main findings, how and where the results are presented.

Objectives and expected outputs

- **National consensus workshop objectives:** spell-out (see main body of tool)
- **Principal expected results:** spell-out (see main body of tool).

Key concepts

The Global Burden of Disease (GBD) Study

is a collaborative project of nearly 500 researchers in 50 countries led by the Institute for Health Metrics and Evaluation (IHME) at the University of Washington. It is the largest systematic scientific effort in history to quantify levels and trends of health loss due to diseases, injuries, and risk factors. GBD serves as a global public good to inform evidence-based policy-making and health systems design.

Disability-adjusted life years (DALYs)

quantify both premature mortality (years of life lost - YLLs) and disability (years of life with a disability – YLDs) within a population. DALY is thus a measure of lost opportunity for social and economic development in a population and a society.

GBD Profile: provides the key BoD numbers and trends for <country> and benchmarks the country against comparator countries.

In analysing health and its determinants, the top disease burden areas were analysed for disaggregated data for health inequities in specific disease symptoms or leading risk factors. A narrative on the causation, based on the scientific literature was developed to explain the pattern of morbidity or mortality or risk factor across the population. This led to the development of a policy brief, and could be used to inform expert discussions and intersectoral workshops.

Health inequities

are *avoidable* inequalities in health between groups of people within countries and between countries. These inequities arise from inequalities within and between societies.

Social determinants of health (SDH)

are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. The SDH are the causes of health inequities and influence health through a multitude of pathways. SDH are primarily addressed through public policy.

A policy

is a deliberate system of principles to guide decisions and achieve rational outcomes. A policy is a statement of intent and is implemented as a procedure or protocol. Policies are generally adopted by senior governance bodies whereas procedures or protocols would be developed and adopted by senior executive officers. Policies can assist in both subjective and objective decision-making. Policies to assist in subjective decision-making would assist senior management with decisions that must consider the relative merits of a number of factors and as a result are often hard to objectively test e.g. work-life balance policy. In contrast policies to assist in objective decision-making are operational in nature and can be objectively tested e.g. password policy. In the consensus workshop the focus is on policies for subjective decision-making.

Intersectoral action for health

refers to the inclusion of several sectors in addition to the health sector when designing and implementing public policies to improve quality of life. An important objective of intersectoral action is to achieve greater awareness of the health and health equity consequences of policy decisions and organizational practices in different sectors and through this move in the direction of healthy public policy and practice across sectors.

Health in All Policies (HiAP)

is a policy strategy which targets the key social determinants of health through integrated policy responses across relevant policy areas with the ultimate goal of supporting health equity. The HiAP approach is thus closely related to concepts such as *'intersectoral action for health'*, *'healthy public policy'* and *'whole-of-government approach'*. There are four types of HiAP strategies:[2]

- *Health at the core:* Health objectives are at the centre of the activity, for example tobacco reduction policies or mandatory seat belt legislation.
- *Win-win:* The aim is to find policies and actions that benefit all parties, such as providing healthy school lunches that promote learning and health.
- *Co-operation:* Emphasis is on systematic co-operation between health and other sectors which benefits the government as a whole. Health seeks to help other sectors meet their goals as a central aim and health is advanced through systematic, on-going co-operative relationships.
- *Damage limitation:* Efforts are made to limit the potential negative health impacts of policy proposals, such as restricting the sale of alcohol in a new urban development.

Consensus workshop process

The knowledge is with the participants – all have something to contribute

The purpose of the process is to harvest and translate that knowledge into agreed feasible policy recommendations using a systematic process.

The facilitators

are full members of the group who have received some orientation in advance of the consensus workshop in order to enable efficient work processes. Facilitators will:

- Introduce the task and the expected results.
- Ensure that relevant questions are collected and answered by the relevant HiAP team member.
- Lead discussions and ensure that all are heard.
- Summarize discussions and delegate who goes to which group in the second round.
- Take notes to ensure comprehensive feedback on the group's views when facilitators meet to review priority actions and finalise draft statements.
- Brief the group on the deliberations and output of the facilitators' meeting.

HiAP team members

will be available for the working groups to explain, clarify and answer questions.

Logistics of the consensus process

Insert model to be used based on the final chosen decision-making process – reference to/adjust diagram in main part of tool.

Pre-prepared draft statements

These could include:

1) Population health situation and its causes – risks of non-action, key determinants, etc.
2) Intersectoral collaboration – governance, accountability and establishment of priority policy domain working groups.
3) Societal trends, opportunities and threats – links with larger national development efforts, threats, and the need for monitoring and target-setting.

Separate one to two-page documents will be provided at the facilitators' orientation meeting (and possibly adjusted before handed out for consideration at the national consensus workshop).

Policy recommendations

It is crucial to stress that the consensus workshop is about analysing and recommending changes or additions to public policy not about proposing specific actions or interventions that somebody ought to do or carry out (*see definition of policy*).

Annex 3.2: Sample template for a participants' guide

Objectives and expected outputs

- **National Consensus Workshop objectives:** spell-out (see main body of tool)
- **Priority expected results:** spell-out (see main body of tool).

Key concepts

Health inequities
are *avoidable* differences in health between groups of people within and between countries.

Social determinants of health (SDH)
are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. The SDH are the causes of health inequities and influence health through a multitude of pathways. SDH are primarily addressed through public policy.

A policy
is a deliberate system of principles to guide decisions and achieve rational outcomes. A policy is a statement of intent and is implemented as a procedure or protocol. Policies are generally adopted by senior governance bodies whereas procedures or protocols would be developed and adopted by senior executive officers.

Health in All Policies (HiAP)
is a policy strategy, which targets the key social determinants of health through integrated policy responses across relevant policy areas with a goal of supporting health equity. HiAP aims to create win-win situations and co-benefits though policies that generate benefits for both the collaborating sector and for population health and health equity. The HiAP approach is thus closely related to concepts such as *'intersectoral action for health', 'healthy public policy'* and *'whole-of-government approach'*.

Consensus workshop process

The knowledge is with the participants – all have something to contribute
The purpose of the process is to harvest and translate that knowledge into agreed feasible policy actions and recommendations using a systematic process.

The facilitators
are full members of the group who have received some orientation in advance of the consensus workshop in order to enable efficient work processes. Facilitators will:

- Introduce the task and the expected results.
- Ensure that relevant questions are collected and answered by the relevant HiAP team member.
- Lead discussions and ensure that all are heard.
- Summarize discussions and delegate who goes to which groups in the second round.
- Take notes to ensure comprehensive feedback on the group's views when facilitators meet to review priority actions and finalise draft statements.
- Brief the base group on the deliberations and output of the facilitators' meeting.

HiAP team members
will be available for the working groups to explain, clarify and answer questions.

Annex

Annex 4 - Work stream B Talking about HiAP (Tool B.3)

Annex 4.1: Steps in "Talking about HiAP"

Talking about HiAP is an iterative and interactive continuous process, though it might for convenience be broken down into steps. Six steps are shown in Figure A-2. This is done in an attempt to illustrate both the cyclic nature of the process and the interdependence between the steps. In real-life several of these cycles may run simultaneously and the sequencing may not be as orderly as shown in the diagram.

Figure A-2 Key steps in talking about HiAP

STEP 1

Scan how health, equity and intersectorality are talked about in the media, political and public debates, and by different groups; undertake both an initial scan and continuous **monitoring. Evaluate**, analyse and document how new ideas are launched in the public debate and how messages, strategies and approaches are working.

Hints!

The environment is constantly changing and the HiAP team need to be agile in order to keep up. Scanning, monitoring and evaluation can be done at different levels of sophistication (and costs). As a minimum, the HiAP team must set aside dedicated time to follow and discuss the debates. Surveys and studies might be added if resources allow.

STEP 2

Identify and assess **opinion/thought-leaders** in public, political and professional domains – determine who they are, how they get their opinions across, who they influence (population groups, professions, etc.), what their value-base is, how they talk about health and equity, and their level of knowledge about health and its causes.

Hints!

Opinion/thought-leaders usually have strong minds and are not easy to sway. Those who share the HiAP values will be the easiest to get on board to embrace "Talking about HiAP" in a helpful way – with a bit of support and encouragement some might even be official or unofficial HiAP Ambassadors. Those who do not share the HiAP values will need to be provided with evidence or actively persuaded. Be aware that different opinion/thought-leaders have different audiences and followers and therefore different spheres of influence. Don't forget thought-leaders in the health sector. They can be very influential and it is important that they embrace HiAP from the outset.

STEP 3

Constantly **grow** the HiAP messaging **catalogue** with documentation of the lessons learned and knowledge gained from the other steps. It is important to reflect and share findings.

Hints!

The HiAP messaging catalogue should be an internal repository of challenges, approaches and experiences for shaping the talk and debate. It should at all times be kept up to date and reflect facts and the collective wisdom of the HiAP team. A team member should be assigned with the responsibility for getting input from the others and keeping the catalogue updated.

STEP 4

Based on previous steps **strategize** how you will change the way health is talked about to create the public and political debate ambiance necessary for HiAP. **Formulate** specific approaches and messages for media and opinion/thought-leaders as well as for targeting potential individual collaborators, e.g., in sectors and organizations.

Hints!

If the public, political and professional debates are not conducive to HiAP it might be difficult to get individual collaborators on board. However, it is not impossible and sometimes wider change starts from the micro-level. Therefore, work simultaneously at the general and the specific levels.

STEP 5

What one says is not necessarily what another one hears. It takes at least two to communicate. Therefore, **rehearse** one-on-one or with an audience, including before meetings with opinion leaders, policy-makers, sectoral collaborators and others.

Hints!

HiAP team-members can be useful sparring partners for each other. Small role plays with one team member playing the devil's advocate or a 'difficult-to-convince' person from a targeted sector. A bit more sophisticated (and expensive) is to use focus groups though it may be worthwhile for improving effectiveness and saving money in the longer run. The rehearsals may suggest going back to STEP 4 before going out.

STEP 6

"Talk-the-talk"! And do it tirelessly, constantly and consistently learning as you "walk and talk".

Hints!

This sounds easy but it is not at all a small thing. How HiAP and more generally health, health inequity and the causes are talked about is a fundamental pillar of HiAP. It will make the difference between success and failure.

Annex

Annex 5 - Work stream C Organizing the work (Tool C.2)

Annex 5.1: Examples of mission statements and strategic activities

Table A-4 Examples of mission statements and strategic activities

Information and research	Facilitating intersectoral collaboration	Framing and politics	Governance and capacities
The Mission is to maximise use of national and subnational data sources to provide solid evidence and appropriately disaggregated data for analysis and policy-making; to ensure collection and monitoring of data at all levels across sectors; to perform data analysis to inform and guide implementation; and to produce reports for different audiences.	**The Mission** is to engage key partners and stakeholders and to ensure the implementation and continued realization of Health in All Policies in coordination with all relevant stakeholders and in accordance with the guiding principles.	**The Mission** is to enhance the understanding in public, political and technical arenas of the influence of the social, economic and environmental determinants on population health and promote the HiAP guiding principles; and to make politicians, opinion leaders and others realize their role and importance in improving health and well-being in the nation.	**The Mission** is to provide HiAP leadership and facilitate the establishment and effective functioning of intersectoral governance and accountability.
Strategic activities include: guiding 'owners' of service data monitoring systems and repeated surveys; identifying knowledge gaps and encouraging research; creating and promoting innovative monitoring systems; analysing and documenting knowledge on the causes of the health situation and progress towards the success criteria; enabling national electronic data base accessibility for research purposes; performing health impact assessments; and encouraging and empowering research teams in sectors to inform policy-making.	**Strategic activities include:** mapping and analysing partner and stakeholder interests and positions; building deep relationships with partners and stakeholders; facilitating understanding of shared values and co-benefits and managing engagement; identifying priority policies to be established or modified; support policy negotiation, formulation and co-design; support policy enforcement; encouraging and guiding 'policy implementation projects' (path-finder, 90-day projects, etc.); encouraging and supporting HiAP champions in all sectors to convey correct messages and foster change.	**Strategic activities include:** framing the health discourse; conducting briefings for and building relations with opinion leaders; establishing media relations and educating journalists on population health; conducting/guiding opinion polls and devising actions to counter misconceptions of population health; informing and educating professionals, managers and decision-makers in health and other key sectors on what shapes population health; actively lobbying for changes to how health challenges are perceived and acted upon.	**Strategic activities include:** envisioning; establishing guiding principles; HiAP strategy formulation; pushing and articulating the HiAP agenda; institutionalizing governance and accountability; identifying and prioritizing capacity building needs; management of the HiAP unit/team; secretariat support for the governance structure.

Annex

Annex 6 - Work stream C HiAP core team (Tool C.3)

Annex 6.1: Terms of reference for a minimum core HiAP two-person team

A minimum HiAP core team of one senior and one junior staff is described below. The senior officer is here called the '*HiAP Coordinator*' and the junior officer '*HiAP Officer*', others might use different terms. These generic terms of reference can be adapted to different settings, including national and decentralized levels.

HiAP Coordinator

- *Reporting lines:* by nature, HiAP work cuts across sectors and within sectors across different organizational units. Therefore, to function effectively, the HiAP Coordinator must report to a Senior Executive (Permanent Secretary, Chief Administrative Officer in a district or similar) and have a mandate on behalf of the executive to operate and speak freely about HiAP across sectors and units. HiAP Coordinators operating further down in the hierarchy have proven to rarely function effectively.
- *Tasks:* develop and steer the HiAP strategy and activities, collate, analyse, commission and present evidence; plan and guide processes, including systematizing and institutionalizing HiAP; mobilize commitment, resources (financial, human and in-kind) across and within sectors and organizations; monitor process and achievements and initiate corrective action; report; organize and/or commission process, outcome and impact reviews and evaluations.
- *'Soft' competencies:* passionate about HiAP and health equity values; results-oriented and persistent – never giving up, always finding new innovative ways around resistance and obstacles; good at understanding, communicating and negotiating with people having very diverse backgrounds, and with different interests and view-points; ability to convincingly interact with politicians and senior policy-makers and managers.
- *'Hard' competencies:* comfortable at the science-policy-society interface; good knowledge and hands-on experience with both quantitative and qualitative data analysis in public health; ability to transform complex information into easily understandable texts and visuals, knowledge of and experience with political processes; effective management, administrative and planning skills; and fluency in relevant national and international languages (desirable).

HiAP Officer

- *Tasks:* support the HiAP Coordinator in performing all the above tasks with particular emphasis on collating, analysing and presenting evidence; and physical and virtual logistics of meetings and consultations.
- *'Soft' competencies:* potential over time to develop the same soft competencies as the HiAP Coordinator; strong communication and interpersonal skills are essential.
- *'Hard' competencies:* similar to the HiAP Coordinator.

Annex

Annex 7 - Work stream D Review and revise national plans (Tool D.2)

Annex 7.1: Summary matrix for review of national plans and linkages to health and health equity

Table A-5 **Matrix for the review of national plans**

(Document the below information as part of the review of national plans. Each key element and goal in the plan should be analyzed separately using the matrix)

Step 1: inequity dimensions	Step 2: health determinants and potential health impacts on population groups				Step 3: mitigation	Step 4: co-benefits	Step 5: monitoring	Step 6: evaluation
Population groups (see note)	*Economic, social or environmental determinants of health*	*Positive health impacts*	*Negative health impacts*	*More knowledge needed*	*Ways to reduce negative and enhance positive health outcomes and impact*	*Positive mitigation-effect on the plan's primary objectives*	*Ways to integrate indicators, early warning and reporting*	*How to integrate into evaluation component*
Income – the entire gradient from the most to the least well off								
Gender – male, female, other, sexual orientation								
Age – infants, children adolescents, adults, older people								
Race – used in some countries to socially classify people								
Ethnicity – cultural and linguistic communities								
Migratory status – internal and external migrants and refugees								
Disability – e.g. physical, hearing, visual, intellectual/ developmental, learning, mental, addictions, etc.								
Geographical location – urban/rural, remote, inner-city, shanty-towns, etc.								
Other characteristics relevant to national context								

Note: The listed population groups refer to the SDG agenda and will need to be adjusted to the specific country context. However, the same list should be used for all reviews of plans.

Contact

Social Determinants of Health
World Health Organization

20, Avenue Appia
CH-1211 Geneva 27
Switzerland

Email: valentinen@who.int
https://www.who.int/activities/promoting-health-in-all-policies-and-intersectoral-action-capacities

9789240057128