WHO FRAMEWORK FOR COUNTRY ACTION ACROSS SECTORS FOR HEALTH AND HEALTH EQUITY

SELECTED CASE STUDIES
(Updated on 12 May 2015)

Example box 1. Reducing tobacco demand in Turkey

Turkey was the first country to attain the highest level of coverage in all of the WHO “best-buy” demand-reduction measures for reducing tobacco prevalence. In 2012, the country increased the size of health-warning labels to cover 65% of the total surface area of each tobacco or cigarette packet. Tobacco taxes cover 80% of the total retail price, and there is currently a total ban on tobacco advertising, promotion and sponsorship nationwide. The result of these concerted efforts has been a significant decrease in smoking prevalence among adults from 31.2% (16.0 million) in 2008 to 27.1% (14.8 million) in 2012. This represents a 13.4% relative decline in the smoking prevalence of a country that has a long tradition of tobacco use and high smoking prevalence. This progress is a sign of the Turkish government’s sustained political commitment to tobacco control, exemplifying collaboration between government, WHO and other international health organizations, and civil society.

Extracted from the Global status report on noncommunicable diseases 2014 p58
http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf

Example box 2. The WHO Urban Health Equity Assessment and Response Tool (Urban HEART)

The Urban Health Equity Assessment and Response Tool (Urban HEART) assists national and local level policy-makers to document health inequities and their determinants, and to generate and prioritize interventions to improve health equity in urban settings. The tool is centred on three key elements: the use of sound evidence, intersectoral action, and community participation.

In the Parañaque City, Philippines, a technical working group (TWG) of officials from city and regional government agencies, and a non-government organization, applied Urban HEART and identified equity gaps in infant mortality, access to safe water, facility-based deliveries and crime rates. Recommendations to address the gaps were developed in collaboration with city officials and community leaders. In response to the gap in facility-based delivery, a birthing facility was constructed and a program of activities to support its use was implemented (e.g. health education for expecting mothers; training for centre staff around safe birthing). Following the interventions, the TWG reported a decrease in the rate of home-based deliveries. National leadership, multisectoral action and a supportive, local leader were critical to the success of the Urban HEART application. The TWG facilitated collaboration and data sharing across a range of sectors including health, planning and development, social welfare, finance, education, housing and barangay (district) representatives. Urban HEART has since been integrated into the epidemiology and surveillance activities of Parañaque City. Two ordinances were also approved and passed in relation to the Urban HEART implementation, the Parañaque City Birthing Homes Regulation Act of 2008, and a resolution adopting Urban HEART as a guideline for the formulation of health policies for the city.


1 http://www.who.int/kobe_centre/publications/urban_heart/en/
Example box 3. Ecuador: The national good living plan

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

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

Example box 4. Health impact assessments in Thailand

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


Example box 5. PAHO Plan of action on health in all policies

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

Example Box 6. Operationalizing innovative funding for the treatment of HIV/AIDS

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

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


The WHO Health in All Policies Training Manual, launched in 2015 provides a resource for training to increase skills in working across sectors. It is designed to be used to organize workshops for health professionals and professionals from other sectors. The workshops can be used to build capacity and skills to promote, implement and evaluate cross-sectoral work; encourage engagement and collaboration across sectors; facilitate the exchange of experiences and lessons learnt; promote regional and global collaboration; or promote dissemination of skills to develop training of trainer (TOT) courses. The training manual is structured to be used by experienced trainers and to target professionals from middle to senior levels of policy-making in the public sector. Global roll-out of the training manual is underway, led by WHO in all regions.

The Master Plan for Roll-out has five components: (i) Dissemination, advocacy and demand generation; (ii) Supporting networks of institutions/trainers to deliver the training; (iii) Conducting regional and country trainings; (iv) creating a database of resources and generating new materials; and (v) Actively supporting course adaptation. Following the first global training if trainers meeting in March 2015, regional training of trainers meetings will build up capacities and cascade training to national settings.

Example Box 8. Salt-reduction campaigns in Bahrain, Kuwait and Qatar

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

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

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

Example Box 9. Multi-sectoral engagement for road safety in Viet Nam

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

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

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

Interventions implemented in two provinces, contributed to a 19% and 34% reduction in road traffic mortality between 2010 and 2013.
Example Box 10. The United Nations Interagency Task Force on the Prevention and Control of NCDs

The United Nations Interagency Task Force on the Prevention and Control of NCDs was established in 2013 by the United Nations Secretary-General at the request of the Economic and Social Council (ECOSOC). The Task Force is led by WHO and coordinates the activities of United Nations organizations and other intergovernmental organizations to support Member States in their national efforts to implement their national commitments included in the 2011 United Nations Political Declaration and 2014 United Nations Outcome Document on Noncommunicable Diseases, taking into account the WHO Global Noncommunicable Disease Action Plan 2013–2020. In 2014, ECOSOC endorsed the Task Force’s terms of reference and division of tasks and responsibilities.

At country level, the need for UN Country Teams (UNCTs) to support national NCD efforts has been highlighted in two joint letters to UNCTs from the UNDP Administrator and the WHO Director-General. Both letters emphasized the importance of integrating multisectoral NCD responses into UN Development Assistance Frameworks and other national development planning instruments. To bring this into practice, the Task Force undertakes joint programming missions to countries to support UN Country Teams in their work to scale up national action on NCDs. UNDP and WHO have also provided a Guidance Note on Integrating NCDs into UNDAFs. The World Bank, WHO and UNDP are developing a Global Joint Programme on National NCD Governance. Regional iterations of the Task Force have also been established in Europe and the Pacific.

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