Framework for country action across sectors for health and health equity
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Background

In May 2014, the Sixty-seventh session of the World Health Assembly accepted Secretariat Report EB 134.54 on “Contributing to social and economic development: sustainable action across sectors to improve health and health equity (follow-up of the 8th Global Conference on Health Promotion)”, and approved the associated Resolution EB 134.R8.

Resolution WHA67.12, Operative Paragraph 3 (1) charges the Secretariat “… to prepare, for the consideration of the Sixty-eighth World Health Assembly, in consultation with Member States, UN organizations and other relevant stakeholders as appropriate, and within existing resources, a framework for country action, for adaptation to different contexts, taking into account the Helsinki statement on health in all policies, aimed at supporting national efforts to improve health, ensure health protection, health equity and health systems functioning, including through action across sectors on determinants of health and risk factors of noncommunicable diseases, based on best available knowledge and evidence.”

The resolution is based on a history of commitment from institutions and WHO Member States to the promotion of health and health equity, and effort towards universal health coverage, the social determinants of health, and combating both communicable and noncommunicable diseases (NCDs). It draws on various resolutions, statements and commitments adopted by WHO Member States, including:

- the 2011 Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases (A/RES/66/2) and the 2014 Outcome Document of the High-level Meeting of the United Nations General Assembly on the Comprehensive Review and Assessment of Progress Achieved in the Prevention and Control of Noncommunicable Diseases (A/RES/68/300);
- the Outcome Document of the 2012 UN Conference on Sustainable Development: “The future we want” (A/RES/66/288);
- the 2011 “Rio political declaration on social determinants of health” (WHA65.8);
- the outcome documents of the WHO Global Conference Health Promotion Series from Ottawa (in 1986) to Helsinki (in 2013); and
- the 1978 “Alma-Ata declaration on primary health care”.

Following on from resolution WHA67.12, the 2014 Outcome document of the High-level Meeting of the United Nations General Assembly on the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of NCDs (resolution A/RES/68/300) welcomed the request that the Director-General of WHO prepare the framework for country action as set out in resolution WHA67.12.

The call for a framework for country action highlights the urgent need to engage all sectors of government of countries of all levels of development, because many factors lie beyond the reach and control of ministries of health. Such factors include the causes of many diseases (both communicable and noncommunicable); the unfair disparity in their distribution at population levels; their risk factors; and their social, economic and environmental determinants.

The framework will assist Member States in taking action across sectors on health and health equity; that is, action across different sectors and levels of government. The meaning of the term “action across sectors” is discussed in detail below.

Action across sectors has proven to be an effective way to address many health issues, most notably in tobacco control and in combating HIV/AIDS. Such action is a key part of sustainable health intervention in the context of the post-2015 development agenda. The approach works best when opportunities for achieving win–wins and co-benefits are available, communicated and committed to.

The need for action across sectors is vital and urgent in countries of all levels of development. However, it is particularly important in low-income countries, in view of the weak physical infrastructures in such countries, such as lack of or inadequate supply of clean water and waste management, lack of social protection, overemphasis on economic development, weak regulation and legislation for the prevention and control of noncommunicable diseases and for environment and human protection, and limited capacity of and access to health systems.

A lack of preparedness and action across sectors for health contributes substantively to failure to respond to health-emergency situations. Such situations usually require the rapid participation and cooperation of various sectors: health, trade and industry, education and travel. Experience in and commitment to working across sectors would enable more effective responses to emergent health and social issues.

Objectives and key content areas

The aim of this paper is to invite input from WHO Member States on the formulation of the “Framework for country action promoting health and health equity through action across sectors”, based on their experiences of effective approaches to the development and implementation of health action – including policies, programmes and projects – across sectors.

The meaning of the term “action across sectors” has continued to develop since the Alma-Ata declaration, but at a different pace and with different disciplinary parameters in different parts of the world. For clarity, the meanings of terms used here are as follows:

- **Multisectoral action** refers to action between two or more sectors within the public sector.\(^2\) **Multistakeholder action** refers to action by actors outside the public sector (e.g. nongovernmental organizations [NGOs] and the private sector).\(^3\) The terms *multisectoral action* and *intersectoral action* are often used interchangeably, and they have the same meaning unless otherwise specified.

- **Health in all policies** (HiAP) is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergy and avoids harmful health impacts, in order to improve population health and health equity.\(^4\)

- The **whole of government approach** is one that “denotes public services agencies working across portfolio boundaries to achieve a shared goal and an integrated

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\(^2\) Paragraph 36 of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases A/RES/66/2.

\(^3\) Paragraph 37 of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases A/RES/66/2.

government response to particular issues. Approaches can be formal or informal. They can focus on policy development, program management, and service delivery. This approach, which is a response to departmentalism, aims to achieve policy coherence in order to improve effectiveness and efficiency.

The paper contains technical material for discussion, and has six sections that set out the draft framework’s possible key content:

1. Values and principles
2. Forms of health action across sectors
3. Action across sectors at work
4. Public sector roles and responsibilities
5. International and non-state actor engagement
6. Monitoring and reporting progress

Each section includes discussion questions intended to gain feedback from WHO Member States and other key stakeholders, including UN agencies and non-state actors. The content of each section is drawn from existing work on action across sectors by all three levels of WHO.

Section 1: Values and principles

The implementation of the proposed framework will be guided by core values, key principles, and the potential for strategic application. The core values are the right to health and the achievement of health equity, which are embedded in WHO’s constitution. The key principles include fulfilsments of international obligations and good governance, such as accountability, transparency and participation. Strategic application refers to the need to address priority real-life public health concerns according to a country’s situation when applying the framework, in order to evince the impact of the various forms of action across sectors. A few country examples of impact are provided.

When selecting priority health issues, the four main NCDs (cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) and their risk factors and social determinants must be a priority, given that, in relation to these NCDs, we know:

- what is to be achieved (i.e. the nine voluntary global targets that have been set and agreed upon); and

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6 Christensen, Tom & Lægreid, Per. Autonomy and regulation: Coping with agencies in the modern state. Edward Elgar Publishing; 2006.
7 Including documents such as the:
8 For details see: http://www.who.int/nmh/global_monitoring_framework/en/
• what works (i.e. “best buys” or highly cost-effective interventions are available).

Recent examples of priority real-life public health concerns include communicable diseases such as Ebola, HIV/AIDS, malaria and tuberculosis; major killers of mothers and children aged under 5 such as childbirth related complications as well as diarrhoea, malaria and pneumonia; and, the health impacts of environmental changes such as urbanization. Targets and baselines as well as best practices in combating these diseases and their risk factors and social determinants are also available.

Section 2: Forms of health action across sectors

Action across sectors for health and health equity works best when health and health equity is the priority of the whole of government (e.g. as is the case during disease outbreaks and health emergencies). However, governments are faced with a range of priorities; hence, health and equity may not automatically gain precedence over other policy objectives. Action across sectors for health can therefore take many forms.

This section sets out five common forms of health action across sectors. The first and most common form is when actions are initiated by the health authority, with participation from one or more ministries, and is primarily focused on improving health and health equity.

A second form of action, often arising to combat disease outbreaks or manage health emergencies, is when the head of government initiates action on an outbreak or emergency, with all ministries participating most of the time.

A third form of action involves the establishment of a new government entity to oversee and promote collaboration among different ministries, to address a priority public health concern. This form of action has been common in national responses to HIV/AIDS.

A fourth form of action can be reflected by country examples that show that success can also be achieved when health authorities do not assume the lead role. For example, in the prevention of road deaths and injuries, the road and transport authorities have become increasingly willing and capable of assuming the lead agency role.

Finally, at the local government level, it is increasingly common to find various sectors working together to address one or more public health issues through community-based or setting-based health promotion activities; for example, healthy cities and health-promoting schools initiatives.

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<thead>
<tr>
<th>Forms of health action across sectors – general questions</th>
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</thead>
<tbody>
<tr>
<td>• What different forms of action across sectors have been used in your country?</td>
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<tr>
<td>• What experiences have been gained and what evidence has been collected, using the different forms of action across sectors in your country?</td>
</tr>
<tr>
<td>• Based on your country’s experience in recent years, which form of action across sectors is the most favoured or used?</td>
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</table>
Section 3: Action across sectors at work

Various WHO technical documents have identified strategic components of action and implementation tools that are most effective for promoting health through action across sectors. These components are as follows:

- **Establish the need and priorities for action across sectors.** Key activities include, for example, ensuring that there is high-level political will and commitment to action, identifying common interests and mapping power dynamics.

- **Frame planned action.** Key activities include, for example, identifying data for planning and monitoring, identifying evidence-based interventions for implementation, and considering implications for staff, funding and accountability.

- **Identify supportive structures and processes.** Key activities include, for example, identifying a lead agency to direct the actions, and building on the existing structure and agenda.

- **Facilitate assessment and engagement.** Key activities include, for example, assessing the impact of public policies on health and health equity, and engaging key groups and communities.

- **Implement planned action across sectors.** Key activities include, for example, promoting ownership among key actors, undertaking follow-up, and inviting feedback from the actors.

- **Ensure that monitoring, evaluation and reporting occurs.** Key activities include, for example, developing and agreeing on milestones; establishing baseline, targets and indicators; and disseminating lessons learnt.

These components are not fixed in order or priority, and they should not be taken as a rigid checklist or linear protocol. The actual process and activities will depend on factors such as a country’s socioeconomic situation and governance system; thus, each country will adopt and adjust the components in ways that are most relevant for its specific context.

<table>
<thead>
<tr>
<th>Action across sectors at work – general questions</th>
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<tbody>
<tr>
<td>• How do these components apply in your country context at national and local levels?</td>
</tr>
<tr>
<td>• What effective strategic actions have you used to implement health policies across sectors?</td>
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<tr>
<td>• Do these components complement your existing strategic action across sectors for health and health equity?</td>
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</table>

**Tools**

Tools are required to enable countries to effectively implement the components. They include national strategies for action, health sector self-assessments, impact assessments, disaggregated data (including data on determinants of health), and mapping of government activities and opportunities. Governments may also use legislation, presidential orders, establishment of new government units, and memoranda of understanding to improve intersectoral action.

Tools can also be used to incorporate health action across sectors within legislative processes; for example, through oversight by committees with statutory responsibilities for health, public hearings and consultations, issue-based groups and coalitions within the legislature, and public health reports to legislatures.
Other tools can be used to facilitate actions within a sector or between sectors. Such tools include joint budgeting, health impact assessments, health and health equity lens analysis, environmental impact assessment, policy audits and budgetary reviews.

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<tr>
<th>Action across sectors at work – questions related to tools</th>
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<tbody>
<tr>
<td>• What implementation tools have you used to promote health action across sectors, and which of these tools have proven useful and effective?</td>
</tr>
<tr>
<td>• What are the main challenges in learning and using these tools for scaling up health action across sectors?</td>
</tr>
<tr>
<td>• Which tools are needed to accommodate actions across sectors at a national, regional or local level?</td>
</tr>
</tbody>
</table>

**Institutional and community 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 non-health), and people in the wider community. Institutional capacity refers not only to the expertise of individual practitioners but also to existing policy commitments; availability of funds, information and databases for planning, monitoring and evaluation; and organizational structure. There are many readily available approaches that can be used to build institutional capacity:

- **Train or support health professionals in acquiring the requisite knowledge and skills, in particular, to communicate findings to policy makers and community members; engage with other sectors to increase interest in health outcomes; and learn about the goals and interests of other sectors.**
- **Build capacity in other ministries, ensuring that they have proper guidance on health impacts for their impact assessments and, where possible, providing them with a focal point for consultation.**
- **Build research capacity by reinforcing public health institutions and existing multidisciplinary research on the health of populations.** This approach should include systematic collection and analysis of health data and policy analysis, and development of solutions to any issues identified. Efforts should be made to share expertise, and to allow access to quality data and technical assistance across sectors.
- **Develop case studies that demonstrate the co-benefits of engaging with health issues for other sectors. Multidisciplinary knowledge and teams can assist in formulating such studies.**

It is also important to build community capacity by supporting the ability of community members to fully participate in community action for health. This may include promoting health and policy literacy, training leaders in techniques to support and enable informed community participation and engagement with decision-making, and implementing and evaluating community action for health.

WHO provides toolkits that facilitate capacity-building processes; for example, a training manual with 12 modules comprising interactive lectures and group activities (an overview of these modules is given in Annex 1).
Action across sectors at work – questions related to institutional and community capacity

- Are the training modules useful?
- What experiences can you draw on when building capacity at the national and local levels?
- What training sources do you currently adopt?
- Which priority sectors and group of individuals require training in your country?

Section 4: Public sector roles and responsibilities

Health is an outcome of all policies. Moreover, policies made in other sectors can have a profound and often a potentially adverse effect on health.

To facilitate effective action across sectors, actors in all sectors need to be involved, and one agency may be required to lead. This section outlines the role of the health sector as the traditional initiator of action across sectors for health, as well as the general role of other government sectors.

Role of the health sector

The health sector has the mandate, legitimacy and expertise to initiate partnership with other government sectors in order to increase cooperation in addressing issues related to the promotion of health and health equity. The health sector has a core advocacy function in promoting action across sectors and in articulating the mutual benefits of such an approach.

The “Regional framework on health in all policies for South-East Asia” and the WHO “Health in all policies (HiAP) framework for country action” recommend that the health sector take the lead in:

- building knowledge and generating an evidence base for policy development and strategic planning;
- advocating for health-centred political agendas and administrative imperatives of other sectors;
- assessing comparative health consequences of options within the policy development process;
- creating regular and continuous dialogue with other sectors;
- reviewing and assessing the effectiveness of intersectoral or multisectoral work and integrated policy-making;
- building capacity through better mechanisms, resources and agency support for skilled and dedicated staff;
- working with other governmental agencies to achieve their goals and, in doing so, advancing the health and well-being of the population;
- advocating for health protection and for social determinants of health to be addressed in public discourse; and

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• promoting synergy and negotiating trade-offs between sectors and among potential institutional partners.

**Role of other government sectors**

Action by sectors other than health can contribute to improved health and health equity; for example, through policies involving social protection, food security, education, poverty reduction, transportation, environment, finance, and trade and commerce. The intensity of action for health by other sectors, however, varies. Some sectors work more closely with the health sector than others, depending on two key factors: common interests and co-benefits. For example:

• the education and health sectors have been working closely in a number of areas including vaccinations, and promotion of healthy eating and physical activity; and

• coordination, collaboration and cooperation between the transport and health sectors are increasing, because of common interests and the comparative advantages to both sectors in terms of expertise and shared information.

Conversely, competing interests have caused tension between the health sector and other sectors. For example, there is tension between the health sector and the trade sector with regard to direct foreign investment by the tobacco industry.

Synergy of action can make it easier for all sectors to take into account the health implications of policy decisions, and thus avoid harmful impacts, and improve health and health equity.

Local governments have many advantages in creating platforms for and implementing action across sectors for health. The close proximity between elected officials and government departments and the people receiving services can increase community engagement, articulation of demand and accountability. In many countries, local government authorities have autonomous budgets for health planning and spending, and thus play a central role in the implementation of action across sectors.

**Lead agency**

For action across sectors to be effective, a lead agency is needed that will actively seek opportunities to provide directions to other sectors, and to collaborate with and influence these sectors. In most cases, the health authorities are in a natural position to assume the lead role.

To effectively influence other sectors to undertake action for health, the lead agency must possess the authority to lead, the necessary expertise, and the requisite information about the health issues and their implications for the role of other sectors. Whatever agency takes the lead, the terms of reference for all sectors of government must be established at the outset of the planning process, so that all are clear about their roles and responsibilities, and the potential benefits they may gain. This will avoid duplication of activity and increase effective collaboration among various actors.
Action across sectors at work – questions related to the lead agency

- Who takes the lead in health action across sectors in your country?
- What are the key roles of your country’s health sector in the promotion of health action across sectors?
- How can government sectors strengthen cooperation with other government sectors in the promotion of health?

Section 5: International and non-state actor engagement

This section sets out the important role of WHO and other UN organizations in supporting Member States in the implementation of health action across sectors. It also highlights the importance of coherence in policy across international organizations.

Role of WHO

WHO has a unique and key role in taking the lead in multisectoral initiatives on health promotion around the world. In line with its expertise and experience in responding to health issues, the WHO should aim to:

- promote evidence based practices
- bring health considerations into global and regional policy-making and UN interagency work;
- promote action on the social determinants of health;
- support policies for global health protection and health promotion;
- promote inclusion of health indicators as benchmarks for development; and
- address emerging global issues that could have harmful health impacts.

At the country level, WHO can provide technical assistance and advocacy to national efforts to implement the framework on health action across sectors. The following are examples of good practice:

- compile and analyse good practices being used by Member States;
- provide guidance and technical assistance for implementation of policies across sectors at the various levels of governance;
- ensure coherence and collaboration across programmes and initiatives within WHO; and
- work with and provide leadership for other UN organizations, to encourage them to take health considerations into account in the implementation and monitoring of major strategic initiatives.

Role of other UN agencies

International institutions can provide support to Member States in implementing health action across sectors by providing technical assistance, financial support, or knowledge sharing activities. Many UN organizations and global forums support action on social determinants for health in fields such as education, environment, refugees, gender and human rights. Strengthening health considerations within these efforts would improve their potential impact on health and health equity. The Joint United Nations Programme on HIV and AIDS is one example of success in demonstrating how UN agencies and partners helped
countries mount and support an expanded response to HIV/AIDS for improved health and health equity. More recently several UN organizations support various government sectors by providing information and strengthening their capacity, to address the spread of NCDs.

To contribute to the implementation of the WHO Global NCD Action Plan 2013, the UN Interagency Taskforce on the Prevention and Control of Noncommunicable Diseases (UNIATF) has a core function in promoting and assisting with national efforts towards action across sectors. The taskforce coordinates the activities of the relevant UN organizations and other intergovernmental bodies, to help the Heads of State to meet their commitments in the 2011 UN Political Declaration on NCDs, and the 2014 UN Outcome Document on NCDs.

The terms of reference for the taskforce outline its purpose, objectives, participants (and their responsibilities), periodicity of general meetings, working groups, secretariat, administrative arrangements, accountability and collaborative division of tasks and responsibilities for its members. Tasks and responsibilities are allotted in line with the six objectives of the WHO Global NCD Action Plan 2013–2020, including reducing modifiable risk factors for NCDs and underlying social determinants, through creation of health-promoting environments.

A workplan for the UNIATF for 2014–2015 has been developed, in line with the WHO Global NCD Action Plan 2013–2020. Actions include UNIATF missions to countries to support governments and UN Country Teams; follow-up on the second joint letter from the Administrator of the UN Development Programme (UNDP) and the Director-General of WHO to UN country teams that reiterated the importance of mainstreaming NCDs into the UN Development Assistance Framework (UNDAF) roll-out processes; and ensuring a coherent UN system response. The integration of NCDs into UNDAF roll-out processes will support governments in their national efforts to integrate measures to address NCDs into health planning, as well as national development and policies beyond the health sector.

As set out in Resolution 67 12 OP 3 (4), it is essential that the taskforce develop and implement mechanisms that will allow them, in their work with Member States, to achieve coherence and synergy with commitments and obligations related to health and health determinants, including social determinants of health.

Role of non-State actors

Non-State actors, individuals and organizations not associated with a particular state include both members of the private sector (e.g. multinational companies) and those outside the private sector (e.g. NGOs). Due to their significant influence on affairs of the state, non-State actors play a critical role in promoting action on health across sectors.

The outcome document of the high-level meeting of the UN General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of NCDs (A/RES/68/300) asked WHO to develop an approach to registering and

10 For details see: http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf
11 For details see: http://www.who.int/nmh/events/2014/outcome-document.pdf?ua=1
12 http://www.who.int/nmh/events/2014/ecosoc-20140401.pdf?ua=1
13 http://www.who.int/nmh/events/ncd_action_plan/en/
publishing contributions of the non-state actors (including the private sector and civil society) towards achieving the global voluntary NCD targets.

The “Helsinki statement on health in all policies” urges governments to adopt conflict of interest measures to protect policies from distortion by commercial and vested interests and influence.

Thus, to avoid conflicts of interest, Member States’ engagement with non-state actors must be regulated in line with international law and principles.

Governments should conduct transparent due diligence and risk assessments before entering into engagement with non-state actors and, as far as possible, should ensure that financial resources are independent. States can obtain the support of the international community in the oversight and management of engagement.

Using WHO as an example, a framework of engagement is being developed to clarify:

- the distinctions between real and perceived conflicts of interest, and between individual and institutional conflicts of interest
- how WHO should deal with actors not sharing the interest of WHO, or with situations where secondary interests undermine public health; and
- how WHO should distinguish between direct and indirect interests.

The WHO Global Coordination Mechanism (GCM) on the prevention and control of NCDs (the GCM/NCD) is another example of non-state actor engagement. The scope and purpose of the GCM/NCD are to facilitate and enhance coordination of activities, multistakeholder engagement and action across sectors at the local, national, regional and global levels, in order to contribute to the implementation of the WHO Global NCD Action Plan 2013–2020, while avoiding duplication of efforts, using resources in an efficient and results-oriented way, and safeguarding WHO and public health from any undue influence by any form of real, perceived or potential conflicts of interest.16 The functions of the GCM/NCD will be as follows:17

- advocating for and raising awareness of the urgency of implementing the WHO Global NCD Action Plan 2013–2020; mainstreaming the prevention and control of NCDs in the international development agenda; and giving due consideration to the prevention and control of NCDs in discussions on the post-2015 development agenda;
- disseminating knowledge and sharing information based on scientific evidence or best practices regarding the implementation of the WHO Global NCD Action Plan 2013–2020, including health promotion, prevention, control, monitoring and surveillance of NCDs;
- providing a forum to identify barriers and share innovative solutions and actions for the implementation of the WHO Global NCD Action Plan 2013–2020; advocating for the mobilization of resources: and identifying and sharing information on existing and potential sources of finance and cooperation mechanisms at the local, national, regional and global levels for the implementation of the WHO Global NCD Action Plan 2013–2020; and

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16 A67/14 Add1 para 12
17 A67/14 Add1 para 13
• advancing multisectoral action by identifying and promoting sustained actions across sectors that can contribute to and support the implementation of the WHO Global NCD Action Plan 2013–2020.

**International and non-state actor engagement – general questions**

- What type of international engagement is required to deliver health action across sectors?
- How can international organizations ensure coherent policy on actions related to health and health determinants?
- In what ways can WHO and other international organizations support Member States in implementing health action across sectors?
- Do you have examples of how government manages various (including conflicting) interests across stakeholders?

**Section 6: Monitoring and reporting progress**

Effective means of monitoring and reporting progress are needed in order to gain evidence for what works and thus to share best practice. A country may adopt formal indicators and performance targets associated with health status, health inequities, their determinants and health action; alternatively, a country may adopt a more flexible case-studies approach based on its specific situation and needs. It is best to use existing governance-related monitoring and evaluation (M&E) structures and frameworks whenever possible. Reporting mechanisms must not be too onerous for the participants, to avoid taking effort away from the actual work of implementation.

Some of the key activities in collecting evidence in relation to health action across sectors are listed below:

- Start M&E planning early; where appropriate, develop an evaluation framework and incorporate M&E throughout the process of taking action across sectors (see Annex 2 for examples of possible key result areas).
- Identify key stages of the policy process, and thus identify opportunities to introduce action across sectors for health equity. The WHO Urban Health Equity Assessment and Response (Urban HEART) is a practical tool that is being used in many countries to engage communities in documenting health inequities and their determinants, and in formulating responses to redress the inequities.
- Identify potential opportunities for collaboration with key partners in and out of government.
- Identify specific focus areas; develop and agree on milestones; and establish the baseline, targets and indicators, as appropriate.
- Carry out agreed M&E activities according to agreed schedules.
- Disseminate lessons learnt in order to provide feedback for future policy and strategy rounds.
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) at the 53rd Directing Council in September 2014. This plan of action 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. The plan sets out a total of 12 indicators, and includes baselines and targets (see Annex 3).

A set of indicators are also being developed by WHO for monitoring intersectoral influences on equity in health and universal health coverage (see Annex 4).

### Monitoring and reporting progress – general questions

- What are the existing means of monitoring and reporting progress on health promotion and health equity in your country?
- What are the challenges and opportunities of such reporting mechanisms?
- In which areas do you require further guidance and assistance on monitoring and reporting progress?

### Time line and next steps

A three-step approach is being taken to prepare the framework for country action:

- First, a discussion paper will be developed and uploaded on the web for consultation with Member States, UN agencies and non-state actors, from the 29 October 2014 until the 31 December 2014. During this initial phase, WHO will also consult a technical reference group.
- Second, the first draft of the framework will be released by mid-January 2015, for another round of web-based consultation.
- Finally, the draft framework for country action will be revised, based on the feedback from the second web-based consultation and from consultations with experts. It will then be submitted for consideration by the Sixty-Eighth World Health Assembly in May 2015.

The key findings from the web-based consultations will be collated and made available online, to increase transparency and shared learning.

A key objective of this process is to elicit input from Member States, UN organizations and other intergovernmental organizations, relevant NGOs and selected private sector entities to the design and development of the framework for country action. This discussion paper will also be widely disseminated to Member States, UN organizations and non-State actors through existing networks such as the United Nations Interagency Task Force on the Prevention and Control of NCDs and the WHO Global Coordination Mechanism on the Prevention and Control of NCDs, as well as regional and international forums and web platforms.

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18 For details, see: [http://iris.paho.org/xmlui/handle/123456789/4770](http://iris.paho.org/xmlui/handle/123456789/4770)
<table>
<thead>
<tr>
<th>Time line and next steps – general questions</th>
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<tbody>
<tr>
<td>• Which additional elements should be added to the Framework?</td>
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<tr>
<td>• What other considerations should be taken into account?</td>
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<tr>
<td>• In terms of process moving forward, would you have any further recommendations?</td>
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Annex 1: WHO training manual modules

The information given in this annex was extracted from the WHO “Health in all policies (HiAP) training manual".

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<thead>
<tr>
<th>Module</th>
<th>Overview</th>
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<tbody>
<tr>
<td>Module 1</td>
<td>Greetings, outline of the course and initial introduction to HiAP and the social determinants of health.</td>
</tr>
<tr>
<td>Module 2</td>
<td>Introduces participants, especially those from a non-health background, to some stylized facts about burden of disease and contemporary socioeconomic trends such as globalization and urbanization that impact on population health and health inequities.</td>
</tr>
<tr>
<td>Module 3</td>
<td>Outlines the history, rationale and principles of the HiAP approach.</td>
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<tr>
<td>Module 4</td>
<td>Details the policy-making process in relation to HiAP including topics such as the framing of issues and managing complexity.</td>
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<tr>
<td>Module 5</td>
<td>Explains the role of government in promoting, implementing and evaluating HiAP including mechanisms by which different government departments or sectors can collaborate to improve population health.</td>
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<tr>
<td>Module 6</td>
<td>Reviews the qualities of effective written communication and provides participants an opportunity to refine these skills by preparing and presenting a HiAP policy brief.</td>
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<tr>
<td>Module 7</td>
<td>Introduces participants to the concept of whole-of-society HiAP approaches and the importance of engaging multiple stakeholders including civil society and industry.</td>
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<tr>
<td>Module 8</td>
<td>Details important considerations for conducting successful HiAP negotiations and prepares participants to use this knowledge through a role play.</td>
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<tr>
<td>Module 9</td>
<td>Elaborates using case studies some of the ways HiAP is being successfully implemented at the local, regional and global levels.</td>
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<tr>
<td>Module 10</td>
<td>Discusses issues related to monitoring and evaluating changes in population health due to effective public policy including introducing participants to tools such as health impact assessments.</td>
</tr>
<tr>
<td>Module 11</td>
<td>Highlights the critical role of the health sector in promoting HiAP.</td>
</tr>
<tr>
<td>Module 12</td>
<td>Recaps the key messages of the workshop and proposes ways in which participants can apply their learning in practice.</td>
</tr>
</tbody>
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For details, see: [http://www.who.int/social_determinants/tools/en/](http://www.who.int/social_determinants/tools/en/)
Annex 2: Examples of HiAP key result areas

The information given in this annex was extracted from the WHO “Health in all policies (HiAP) framework for country action (Annex 1, pg 21).”

Examples of HiAP indicators include participation of actors (by type, sectors or level), changes in organizational structures and culture (e.g. interministerial or interdepartmental committees), opportunities for joint actions, and willingness to share information and expertise.

A variety of dimensions of HiAP key result areas should be taken into account, including those that relate to process.

1. Assessing readiness to act and continually improve HiAP – how are professionals and institutions equipped to:
   a. Establish needs and priorities for HiAP?
   b. Map and understand issues and interests of parties?
   c. Use structures to support dialogue?
   d. Analyse and communicate health impacts?
   e. Negotiate policy changes?
   f. Engage community?
   g. Reflect on processes, relationships and lessons learnt?

2. Assessing effects of HiAP applications:
   a. Are there examples to demonstrate how the HiAP approach has influenced the considerations of health in public policies (such as health protection, address complex health issues, support health equity, sustainable health development and health system strengthening)?
   b. Are there examples of policies which could/should have had HiAP applied and did not? Why not?
   c. When and why were health interests compromised? Is there a change in willingness to engage over time? Increased institutional support for HiAP? Is there a system process in place to learn from success and failure?

3. Assessing effectiveness of the HiAP approach:
   a. Measuring longer term outcomes – what are trends in determinants of health, health equity, social determinants over time?
   b. Are there measureable changes in attitudes towards understanding of health determinants over time among health sector, other sectors, and individuals and communities?
   c. Assessing continued need and cost effectiveness.
Annex 3: Objectives, indicators, baselines and targets of the AMRO/PAHO “Plan of action on health in all policies”

The information given in this annex was extracted from the AMRO/PAHO “Plan of action on health in all policies” (CD53/10,Rev.1).  

**Line of action 1: Establish the need and priorities for HiAP**

**Objective 1.1:** Assess the potential impacts of public policies on people’s health, health equity and health systems, ensuring that those responsible for policy-making are aware of and understand these potential policy impacts on health.

**Indicator 1.1.1**
Number of countries with established national/regional networks of multisectoral working groups and stakeholders to evaluate the impact of government policies on health and health equity.

**Indicator 1.1.2**
Number of countries and territories implementing the HiAP framework for country action.

**Line of action 2: Frame planned action**

**Objective 2.1:** Promote policy dialogue and implement national policies based on data, analysis and evidence required to implement, monitor and evaluate HiAP.

**Indicator 2.1.1**
Number of countries and territories that have implemented policies to address at least two priority determinants of health among target populations.

**Indicator 2.1.2**
Number of countries that formally exchange information and best practices at least once every two years on policies addressing health inequities and HiAP.

**Objective 2.2:** Produce a national health equity profile with an emphasis on the evaluation of the determinants of health.

**Indicator 2.2.1**
Number of countries and territories producing equity profiles that address at least two priority determinants of health at the national or subnational level.

**Line of Action 3: Identify supportive structure and processes**

**Objective 3.1:** Identify a specific mechanism by which the health sector can engage within and beyond the public sector in policy dialogue and in the implementation of HiAP.

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22 For details, see: [http://iris.paho.org/xmlui/handle/123456789/4770](http://iris.paho.org/xmlui/handle/123456789/4770)

23 The equity profiles are two-page policy briefs using the methodology established in the WHO Handbook on health inequality monitoring ([http://apps.who.int/iris/bitstream/10665/85345/1/9789241548632_eng.pdf](http://apps.who.int/iris/bitstream/10665/85345/1/9789241548632_eng.pdf) accessed 9 October 2014).
**Indicator 3.1.1**
Number of countries and territories with a specific mechanism, such as intersectoral committees or HIA, by which the health sector can engage within and beyond the public sector.

**Objective 3.2:** Identify supportive structures and processes in the implementation of HiAP, as appropriate, at the national and subnational governments through the inclusion of HiAP in development plans.

**Indicator 3.2.1**
Number of countries that have identified supportive structures and processes in the implementation of HiAP, as appropriate, at the national and subnational governments through the inclusion of HiAP in development plans, as appropriate.

**Objective 3.3:** Strengthen accountability mechanisms so that they can be applied to different sectors.

**Indicator 3.3.1**
Number of countries with accountability mechanisms, which support civil society engagement and open access to information.

**Line of Action 4: Facilitate assessment and engagement**

**Objective 4.1:** Increase participation of civil society and communities in the policy-making and evaluation process involving HiAP to reduce health inequities.

**Indicator 4.1.1**
Number of countries and territories with mechanisms to engage communities and civil society in the policy development process across all sectors.

**Indicator 4.1.2**
Number of countries and territories with specific strategies to engage those experiencing inequities in policy discussions at the local, subnational, and national levels.

**Line of Action 5: Ensure monitoring, evaluation and reporting**

**Objective 5.1:** Develop a system for measuring the impact and outcomes of HiAP with respect to health and health equity in order to assess policies and identify and share best practices.

**Indicator: 5.1.1**
Number of countries and territories that monitor, evaluate, and report on progress towards introducing health and health equity in the development and implementation of government policies.

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24 Potential accountability mechanisms include auditing, promotion of open access to information, meaningful public and civil society participation at all levels, and efforts to promote disclosure and transparency.
Line of Action 6: Build capacity

Objective 6.1: Build capacity in the workforce in the health sector and other sectors on the HiAP approach, and encourage the implementation of HiAP among these groups.

Indicator: 6.1.1
Number of countries and territories with recognized institutes such as national public health institutes, universities and collaborating centres offering training courses on the implementation and monitoring of HiAP and related concepts.
Annex 4: Examples of indicators for a proposed framework for monitoring intersectoral influences on equity in health and universal health coverage (Work in progress)

Line of Action 1: Promote health and health coverage through inclusion and accountability

**Target 1.1 (Accountability):** Reduce the percentage (by X%) of people who are prevented from accessing adequate health care and social determinants of health because of corruption or a lack of accountability.


**Target 1.2 (Dignity and discrimination):** Reduce the percentage (by X%) of people who are prevented from accessing adequate health care and social determinants of health because of discrimination or disrespect.

*Potential indicators:* (1) Perceived discrimination by people using the health system in the past 12 months. (2) Respectful treatment and communication when interacting with health-care provider. (3) Discrimination in the law. (4) Recourse mechanisms for citizens that have experienced discrimination.

**Target 1.3 (Gender norms):** Reduce the percentage (by X%) of men and women who are prevented from accessing adequate health care and social determinants of health because of restrictive gender norms, roles and relations.

*Potential indicators:* (1) Adolescent childbirth. (2) Female employment to population ratio. (3) Autonomous decision-making. (4) Minimum age of marriage for girls and boys. (5) Laws on sexual violence and harassment.

**Target 1.4 (Participation):** Reduce the percentage (by X%) of people who lack the opportunity to express their needs, concerns and experiences in the decision-making processes that affect their access to adequate health care and social determinants of health.

*Potential indicators:* (1) Involvement in making decisions about treatment. (2) Involvement in decision-making about which services are provided. (3) System of institutionalized participation for the preparation and implementation of budget. (4) Voter turnout.

**Target 1.5 (Registration and administrative linkages):** Reduce the percentage (by X%) of men and women who are prevented from accessing health care and the social determinants of health because of lack of registration or proper administrative tracking systems.

*Potential indicators:* (1) Birth registration coverage. (2) Free birth registration. (3) Undocumented migrants’ access to emergency health care. (4) Data coverage of poor households.

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25 For a full definition of the social determinants of health, see [http://www.who.int/social_determinants/](http://www.who.int/social_determinants/)
Line of Action 2: Promote health and health coverage through knowledge and communications

Target 2.1 (Early child development): Reduce the percentage (by X%) of children who are prevented from benefiting from health care and social determinants of health because of poor early childhood outcomes.

Potential indicators: (1) Coverage of maternal or paternal leave. (2) Existence of free early childhood care and education. (3) Inequality in early child development. (4) Educational attainment of Caregivers

Target 2.2 (Knowledge and education): Reduce the percentage (by X%) of people who are prevented from benefiting from health care and social determinants of health because of limited education or knowledge.


Line of action 3: Promote health and health coverage through livelihoods and social support

Target 3.1 (Income and poverty): Reduce the percentage (by X%) of people who are prevented from accessing adequate health care and social determinants of health because of insufficient income or assets.

Potential indicators: (1) % Population below minimum level of dietary energy consumption. (2) Household structure with regards to dependents. (3) Income inequality. (4) Indirect costs of care. (5) % Population living on less than $1 (purchasing power parity [PPP] int. $) a day.

Target 3.2 (Social protection and employment): Reduce the percentage (by X%) of people who are prevented from accessing adequate health care and social determinants of health because of poor working conditions, including inability to get time off from work or lack of social protection.

Potential indicators: (1) Employment rate by type of employment (informal, formal, unemployed). (2) Income protection in light of unemployment, old age, sickness and disability. (3) Means-tested income assistance. (4) Level of daily minimum wage in PPP-adjusted dollars. (5) Regulations on working time and paid annual leave.

Line of Action 4: Promote health and health coverage through infrastructure and service

Target 4.1 (Travel): Reduce the percentage (by X%) of people who are prevented from accessing adequate health care and social determinants of health because of prohibitive travel costs or time, unsafe roads or lack of public transportation.

Potential indicators: (1) Travel time to outpatient and inpatient care in minutes. (2) Travel mode to outpatient and inpatient care. (3) Travel cost to outpatient and inpatient care in LCU. (4) Number of traffic injury deaths. (5) Subsides for travel. (6) Time spent travelling to work.

Target 4.2 (Housing and services): Reduce the percentage (by X%) of people who are live in substandard housing or lack access to basic social determinants of health (e.g. services within the household).

Target 4.3 (Community infrastructure and services): Reduce the percentage (by X%) of people who are prevented from accessing adequate health care and other social determinants of health because of unsafe or unhealthy neighbourhoods and inadequate investments in disease prevention and the infrastructure necessary for health.

Potential indicators: (1) Investment in disease prevention. (2) Outdoor air pollution. (3) Perceptions of safety. (4) Reported frequency of violence or violence-related events. (5) Infrastructure and services at health facilities.
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