

Working together for equity and healthier populations

Sustainable multisectoral collaboration
based on Health in All Policies approaches

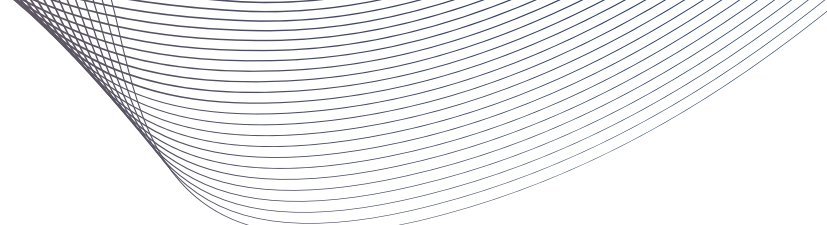


World Health
Organization

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ISBN 978-92-4-006753-0 (electronic version)

ISBN 978-92-4-006754-7 (print version)

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Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

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Acknowledgements

The development of this document was led by Nicole Valentine at the World Health Organization (WHO) and Carmel Williams of the WHO Collaborating Centre for Advancing Health in All Policies Implementation, under the overall direction of Kumanan Rasanathan, Unit Head, Equity and Health, WHO, and Etienne Krug, Director, Social Determinants of Health (SDH), WHO.

The document was produced as part of the workplan agreement between WHO and the WHO Collaborating Centre for Advancing Health in All Policies Implementation. The WHO Collaborating Centre for Advancing Health in All Policies Implementation, based at the Government of South Australia, is co-directed by Katina D'Onise and Carmel Williams, and designated to the South Australian Department for Health and Wellbeing through Wellbeing SA. Carmel Williams is also Director of the Centre for Health in All Policies Research Translation, based in Health Translation SA and the University of Adelaide.

The following individuals are acknowledged for contributions to the initial draft: Carmel Williams, Claudia Galicki, Deb Wildgoose, Beth Keough, Brenda Muturi and Nicole Valentine. Useful inputs that shaped the document were received from Guy Fones and Cristina Gonzalez, Global Coordination Mechanism on Noncommunicable Diseases, WHO; and Liz Tayler, Tripartite Joint Secretariat, WHO. Inputs on joint budgeting were provided by Alexandra Earle and Susan Sparkes, WHO Health Financing Unit. Inputs on the overall document and examples were provided by Nanoot Mathurapote, Health Commission, Thailand; and Julia Caplan and Colin Gutierrez, Public Health Institute, United States of America.

The document benefited from internal reviews by WHO regional SDH and health and equity focal points: Peter Phori, WHO Regional Office for Africa; Leticia Rweyemamu, WHO Country Office, United Republic of Tanzania; Chris Brown and Tatjana Buzeti, WHO Regional Office for Europe; Zahra Ahmed, WHO Regional Office for the Eastern Mediterranean; Orielle Solar, Pan American Health Organization; Suvajee Good, WHO Regional Office for South-East Asia; and Kira Fortune and Jaitra Sathyandran, WHO Regional Office for the Western Pacific. Useful advice was provided by Faten Ben AbdelAziz and Mervat Gawrgyous, Health Promotion Unit, WHO; and Monika Kosinka, Commercial and Economic Determinants Unit, WHO. The document benefited from reviews by other area specialists: Annette Pruss-Ustun (environmental health); Gerard Schmets and Dheepa Rajan (governance and civil society engagement); Thiago Hérick de Sá (healthy ageing); Nathalie Roebbel (urban health and housing); and Kaylee Errecaborde and Elizabeth Mumford (zoonoses and One Health).

Feedback from the internal WHO Technical Working Group on Universal Health Coverage (UHC) and Primary Health Care (also called the UHC partnership), facilitated by Sophie Genay-Diliautas and Denis Porignon, is acknowledged with thanks.

The document underwent several external reviews, with the assistance of Michaela Told, HumanImpact5-HI5. Thanks go to participants of the Expert Meeting to Advance Action on SDH in the WHO South-East Asia Region; the WHO Collaborating Centre for Cross Sectoral Approaches to Health and Development at the Centre for Health and Development Murska Sobota, Slovenia, where a review was facilitated by Peter Bezez; and Sara Peacock, Daniella Stewards and Catherine Weatherup, WHO Collaborating Centre on Investment for Health and Well-being, Wales, United Kingdom of Great Britain and Northern Ireland, and the Welsh Health Equity Status Report initiative Joint Scientific and Advisory Group.

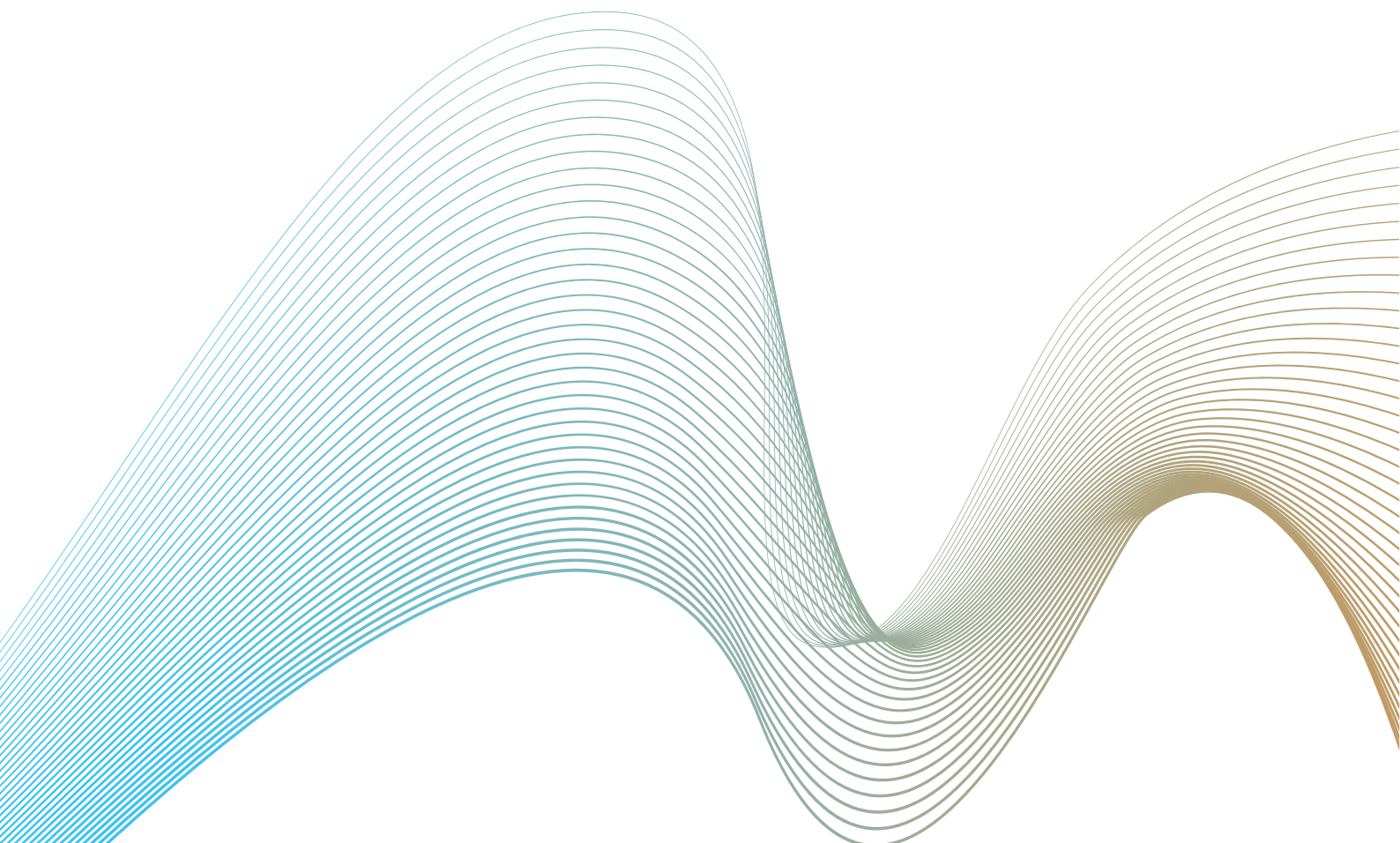
WHO acknowledges the inputs received from Health in All Policies experts: Horacio Arruda, Québec Ministry of Health and Social Services, Canada; Debashis Basu, WHO Collaborating Centre for Health in All Policies and Social Determinants of Health; Meri Koivusalo and Lauri Kokkinen, Tampere University, Finland; Marianne Jacques, National Collaborating Centre for Healthy Public Policy, Québec, Canada; Catherine Joachim, Ministry of Health, United Republic of Tanzania; Jaap Koot, University of Groningen, Netherlands (Kingdom of the); Nanoot Mathurapote, National Health Commission Office, Thailand; Sangeeta Mishra, Ministry of Health and Population, Nepal; Sally Mtenga, Ifakara Health Institute, United Republic of Tanzania; Sylvie Poirier, Québec Ministry of Health and Social Services, Canada; Weerasak Putthasri, National Health Commission, Thailand; Khanitta Seaiw, National Health Commission, Thailand; and Timo Ståhl, Finnish Institute for Health and Welfare, Finland.

Participants of the WHO Expert Meeting to Advance Action on SDH in the WHO South-East Asia Region, convened by Suvajee Good, WHO South-East Asia Regional Office, were Siddharth Agrawal, Vinya Ariyaratne, Shalini Bharat, Niluka Gunawardena, Lam Khee Poh, Shweta Khandelwal, Nanoot Mathurapote, Hadi Pratomo, Sharad Raj Onta, Mohammad Rauf, Srinath K. Reddy, Kailash Satyathi and Viroj Tangcharoensathien.

Financial support was provided by the European Commission, the Norwegian Government and the Swiss Agency for Development and Cooperation.

Abbreviations

HiAP	Health in All Policies
NHCO	National Health Commission Office (Thailand)
SDGs	Sustainable Development Goals
SDH	social determinants of health
WHO	World Health Organization





1. Understanding Health in All Policies approaches

1.1 Introduction

1.1.1 The need for multisectoral collaboration for health and health equity

Governments across the globe are increasingly facing intersecting social, political, economic and environmental challenges. Among these are social inequalities that impact health dramatically. Health is created and destroyed by many different factors in society and in the environment, beyond an individual's behaviour and direct control. The growing evidence base supporting the call for social and environmental justice underscores this point. The 2022 Geneva Charter for Well-being stresses that fairer societies are healthier societies (1). In response, there is growing recognition of the importance of inter- and multisectoral collaboration among ministries and departments to achieve sustainable development. Following the Paris Agreement, the call for a “just transition” to a low carbon-based economy has gained traction in the acknowledgement that policy goals do not naturally align. Not all climate transition policies will yield positive health and social impacts. For example, insulation and energy pricing may have negative health and health equity impacts, arising through poorer air quality; and forest protection initiatives may focus too little on material wealth and cultural issues impacting health for Indigenous Peoples (2).


Siloed public institutions are effective in producing focused policies and services. But these institutions are less nimble at addressing intersecting social challenges when acting alone – one sector may be less ambitious on its own in striving for policies that yield benefits to other sectors. Evidence shows that enhancing nutrition requires integrated packages of interventions involving agriculture, nutrition, water/hygiene/sanitation, linkages to health care, women's empowerment, income generation and advocacy. This requires collaboration both at the policy level and in practical programming (3).

Addressing intersecting challenges requires formulating policies that yield co-benefits multiple sectors. Yet formulating policies with co-benefits is difficult without meaningful input from other sectors, and most siloed governmental structures do not have mechanisms in place that encourage meaningful input and collaboration. Failure to collaborate has both human and financial costs. The European Parliament has estimated that losses linked to health inequities cost around 1.4% of gross domestic product (GDP) within the European Union (EU) – a figure almost as high as EU defence spending (1.6% of GDP). This arises from losses in productivity and tax payments, and from higher health-care costs (4).

A complex challenge facing many governments is the issue of social inequalities. Social inequalities intersect many policy spheres and arise as a result of a set of interrelationships across policies and institutions. For governments committed to fairer societies, improving collaboration across sectors is needed to ensure policies and institutions positively reinforce each other to reduce social inequalities. Also, although all sectors are essential for creating fair healthy societies, most public agencies have a weak understanding of their health and health equity impacts, or the links of these to social inequalities. Frequently, other sectors do not reach out to the health sector to understand the implications of their actions or fear that doing so will undermine their sectoral goals.

Efforts to encourage health actors to play more proactive roles in engaging with other sectors and in influencing the policies of other sectors for the good of health and health equity are known as promoting Health in All Policies (HiAP) approaches. HiAP approaches use public policy and public administration practices that support multisectoral work to improve population health and health equity. HiAP approaches recognize that public value and public interest are best served by assessing which parts of the population benefit from policies and how they benefit, thus aiming to ensure fairer societies. They use scientific evidence that emphasize the social origins of health beyond biological vectors and medical and pharmaceutical remedies, and hence emphasize the importance of other policy spheres (5, 6). This means assessing how policies in different spheres affect the conditions of daily life, which in turn impact patterns of illness for different social groups.

HiAP approaches aim for all sectors to contribute to better public policies by considering the health



implications of decisions, seeking synergies and avoiding harmful health impacts (7). Through deliberate reflection on health and health equity impacts, HiAP approaches seek to promote transparency in policy trade-offs by advocating thorough assessments of impacts across multiple policy domains. For example, this allows health equity impacts to be compared with carbon emission reduction impacts, or with profit results for specific industries. Advancing towards this goal requires fostering and sustaining collaboration across policy sectors at national and subnational levels. Collaborative work among sectors on complex social problems will create new formal and informal relationships in bureaucracies, resulting in better solutions for communities, cities and countries.

1.1.2 Focus on the social determinants of health and health equity

Given that the larger proportion of health is impacted by the living and working conditions experienced long before visiting a health professional, all sectors are essential for creating healthy societies. Advancing health is fundamentally connected to other social, political, economic and environmental policy imperatives – capacities to work, to socialize, to participate in education, and to go about daily life safely and without damaging the environment.

Catalysed by the COVID-19 pandemic, as a growing awareness of factors important for nurturing health emerges, people will increasingly require their governments and broader society to act on these.

Growing inequalities in all aspects of society – including income, employment, education, ethnicity and territories – present a major challenge to the agenda of advancing health equity. Social inequalities cut across government sectors and have powerful impacts on population health and health equity through the social determinants of health (SDH). Social determinants are the conditions in which people are born, grow, work, live and age and their access to power, money and resources.

SDH can be characterized by five essential conditions needed to secure long, healthy lives: access to health services; income security and social protection; safe and environmentally sound living conditions; nondiscrimination, social inclusion and human capital; and employment and working conditions.

Health inequity arises when these conditions are not met for particular groups of people. Yet life expectancy gaps between the most and least affluent people within countries can be reduced in relatively short timeframes by paying greater attention to how social inequalities are causing health inequities through affecting SDH. Although the health sector normally focuses its attention on access to health services, it needs to broaden its focus to the other essential conditions for healthy lives.

There are two main goals of acting on SDH: to improve the level of health in the population, and to improve health equity. If other government agencies are unaware of the positive and negative impacts of their decisions, health and health equity can be undermined. A strengthened culture of collaboration across government is important to optimize the impacts of all policies for health and health equity. Collaboration relates to both between government portfolio sectors and between government levels (national and local jurisdictions).

Health actors need to be lead advocates to support different spheres of public policies to address social inequalities, while taking appropriate measures within health policies and systems. This advocacy work needs to go beyond information-sharing to ensuring practical support. The engagement may form part of a multisectoral governance mechanism or strategy, or it may form part of a multisectoral agenda focused on specific health (e.g. noncommunicable diseases, tuberculosis) or social issues (e.g. well-being, economy, sustainability, reducing inequalities). The support that the health sector can provide may be in political advocacy, joint budget development, or specific technical support.

The COVID-19 pandemic has highlighted the importance of SDH in improving health equity (8). All multisectoral health initiatives can benefit from incorporating an SDH lens. Other sectors also benefit. Multiple planetary and economic benefits arise from improvements to policies to address SDH equity, such as universal social protection, employment rights, social inclusion and improved urban governance.

1.1.3 Scope and target readership

This document summarizes current knowledge about HiAP approaches and presents practical advice on fostering and sustaining collaborations across policy sectors. HiAP is presented in the context of addressing SDH for advancing health equity for the first time.

Part 1 provides an overview of HiAP approaches and SDH.

Part 2 is organized around a new HiAP model that draws out and provides examples on important government functions and capacities for sustaining collaboration.

The document recognizes the role of other multisectoral approaches and does not suggest HiAP approaches are better. It is suggested, however, that some form of HiAP approach is essential for dealing with SDH and health equity. In addition, the operational advice presented in the new model is relevant for many different forms of multisectoral action. Cases where it may not be useful include multisectoral approaches with a singular aim to ensure legislative frameworks that structure manufacturing and licensing processes (e.g. safety in energy production) or to prescribe wholesale or marketing policies (e.g. tobacco, breastmilk substitutes). All of these initiatives will require some form of collaboration, but not the type of collaboration described in this document.

This document discusses HiAP with explicit references to health equity, but the practices and principles outlined are relevant to and synergistic with other public health issues. The new HiAP model on which the document is based reconfigures existing WHO-referenced literature covering HiAP. The practical lessons learnt through case studies (9) and other WHO publications (10, 11) are summarized in the new model as key functions and capacities. The added value of this new model is the focus on functions and capacities needed for sustaining multisectoral collaboration and the illustration of these functions and capacities alongside practical examples.

The document complements other WHO resources on strategies and mechanisms to advance multisectoral approaches.

Box 1. Key concurrent WHO resources on multisectoral collaboration

- ➔ Framework for National Multisectoral and Multi-stakeholder Coordination Mechanisms for the Prevention and Control of Noncommunicable Diseases (in preparation);
- ➔ WHO Implementation Handbook for National Action Plans on Antimicrobial Resistance: Guidance for the Human Health Sector (12);
- ➔ Taking a Multisectoral, One Health Approach: A Tripartite Guide to Addressing Zoonotic Diseases in Countries (13).

The noncommunicable diseases document acknowledges the role and describes the need to build the responsiveness of different social groups to prevention. The antimicrobial resistance and zoonoses documents draw on One Health approaches built on a rich literature of multisectoral collaboration (14), while not necessarily focusing on action on SDH as a theme.

The primary readership is health advisers to policy-makers and programme leaders at all levels of government that wish to establish and sustain multisectoral collaborative approaches with agencies, authorities, ministries and departments that do not fall within their institutions' hierarchy. The content is relevant to support planning for HiAP approaches, even if the work is not envisaged to be led by the health sector.

This document does not target policy-makers outside the health sector as it aims to support the development of relevant practices and behaviours from within the health sector – to make health actors better advocates for HiAP. A companion guidance note is to be developed with other sectors as a primary readership.

Other stakeholders, including international organizations and non-state actors in academic and non-governmental organizations, can be considered a secondary readership as they can support the work of the public sector.

Government and other actors can use the information in this document to inform existing processes. While drawing on common principles and practices for HiAP, the specific inclusion here of a focus on SDH and health equity will be of interest.

1.1.4 Intersectoral and multisectoral action terminology and concepts

The concepts described under HiAP approaches have their roots in several disciplines and fields. These include public administrative literature on whole-of-government, whole-of-society and collaborative governance. Highly relevant are specific public health literature on intersectoral and multisectoral action for health, healthy public policy, multisectoral governance for health, and governance and stewardship for health and health equity.

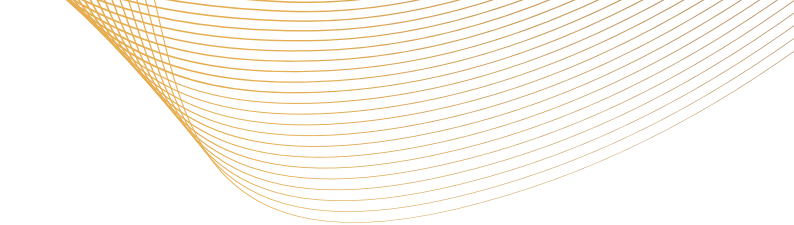
For the purposes of this document, the terms “multisectoral” and “intersectoral” are used interchangeably. Intersectoral action for health has been defined as the involvement of several sectors in developing and implementing public policies intended to improve health, equity, well-being and other policy outcomes. Some definitions of intersectoral action stipulate that this engagement generates outcomes more effectively, efficiently and sustainably than could be achieved if sectors were working alone (15, 16).

Intersectoral or multisectoral approaches for health fit within a continuum of action to promote healthy public policy and are central to the 1986 Ottawa Charter for Health Promotion (17) and the 2022 Geneva Charter for Well-being. Multisectoral action for health can be implemented with varying degrees of formality, varying degrees of collaboration expected of the sectors involved, and varying emphasis on the determinants of health and equity. HiAP approaches seek to systematize and formalize the application of multisectoral action for health in these different spheres.

1.2 Sustainable Development Agenda and HiAP approaches

1.2.1 Sustainable development and SDH

Actions addressing SDH, health equity and well-being at the national, subnational or local level of government are embedded in the context of the Sustainable Development Agenda. The United Nations 2030 Agenda for Sustainable Development provides renewed impetus for viewing how different sectors of government and society contribute jointly to development. The agenda recognizes the indivisibility of the Sustainable Development Goals (SDGs) and the importance of sectors working across the SDGs towards achievement of successful development. This recognition has raised awareness that development cannot be addressed in silos.



Achievement of the 17 SDGs requires collaboration among sectors and stakeholder coordination at the national level. In particular, Goal 16 (promote just, peaceful and inclusive societies) and Goal 17 (partnerships for the goals) call on governments to take stronger, coordinated, collaborative action to achieve all 17 SDGs.

The direct links between the SDGs and SDH have been elaborated in several different publications (e.g. see the annex to the second Adelaide Statement on Health in All Policies (7)). Adverse SDH cause inequities in infection, disease, morbidity, mortality and life expectancy, through material deprivation, long-term chronic stress, increased physical and psychosocial exposures to health risks, and negative health behaviours. Inequities in these pathways to health are shaped by a group's social position. Promoting health and health equity means ensuring political and economic decisions and policies unlink social position from health to ensure more equitable health distribution, regardless of social position.

Good health is an outcome and positive indicator of sustainable development. It is also a precondition and an input to achieving many of the SDG targets. Improving the role of the health sector in promoting health and well-being across sectors, in addition to running health-care services to alleviate and treat disease and ill health, is a key action needed to help the whole of government and the whole of society deliver better on the 2030 Sustainable Development Agenda.

1.2.2 HiAP approaches

HiAP is a recognized multisectoral approach for action on the determinants of health. The concept dates back several decades, but the term itself has been used since 2006, following the Finnish Presidency of the European Union. The same precepts are echoed in differently named efforts to promote health, health security, sustainability and well-being through improved people-centred public policies addressing health determinants.

The Helsinki Statement on Health in All Policies, agreed at the 8th Global Conference on Health Promotion, proposed the definition of HiAP as a public policy approach: “Health in All Policies is 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” (6).

WHO has adopted this definition and worked on various information and training resources on HiAP. Alongside this, One Health information has grown as an important systematic approach for addressing zoonoses. HiAP approaches and One Health are similar, sharing common foundations in public administration literature. They both aim to move action beyond the health sector into the policy domains of sectors outside health.

The general principles underpinning HiAP approaches can be used to address specific health issues and diseases, but a general aim is to sustain engagement across sectors on societal problems that influence many health problems.

The following features distinguish HiAP from other forms of intersectoral and multisectoral action:

- emphasis on formalized governance structures and mechanisms that are able to deal with emerging new problems and incomplete health evidence;
- partnerships centred on collaboration between health and other sectors to facilitate action to explore problems and solutions;
- emphasis on co-benefits for health and development, while also noting conflicts of interest;
- investment in trusting relationships for collaboration over time and issues;
- focus on upstream SDH, with a comprehensive equity emphasis centred on inequities in power, money and resources.

HiAP approaches aim to improve the accountability of policy-makers for impacts on health and well-being over time and therefore need to ensure sustained collaboration. HiAP is a cornerstone of sustainable development, as its aim is mutual reinforcement of sectoral policies and strategies of the SDGs.

Box 2. Core literature at the foundation of HiAP approaches

Health promotion and primary health care

Declaration of Alma-Ata in 1978 (20)

Ottawa Charter for Health Promotion (17)

International conferences on health promotion (21–23) and primary health care (24, 25)

Geneva Charter for Well-being (1)

Links to social determinants of health

WHO Commission on Social Determinants of Health (2005–2008) (26)

Adelaide Statement on Health in All Policies

Rio Political Declaration on Social Determinants of Health

HiAP in resolutions beyond health and with non-health actors

United Nations General Assembly 2012 and 2018 resolutions on prevention and control of non-communicable diseases

Second Global Conference on Health and Climate: conference conclusions and action agenda. Paris: World Health Organization and Government of France; 2021 (31)

#HealthyClimate prescription: an urgent call for climate action from the health community – open letter to COP26

Health systems for universal health coverage: a joint vision for healthy lives. Geneva: World Health Organization and World Bank; 2017

Box 3 discusses the country HiAP framework proposed by the Helsinki Conference, which aimed to guide the identification of steps and entry points for initiating and advancing HiAP approaches. The new HiAP model in this document complements this 2015 country framework by drawing attention to the practical implications of this framework for functions and capacities of a bureaucracy. These generalized functions and capacities are necessary to sustain collaborative approaches among government agencies, with the aim of creating synergies and policy coherence among their different mandates, objectives and activities.

Box 3. WHO Country Framework for Action across Sectors for Health and Health Equity (2015)

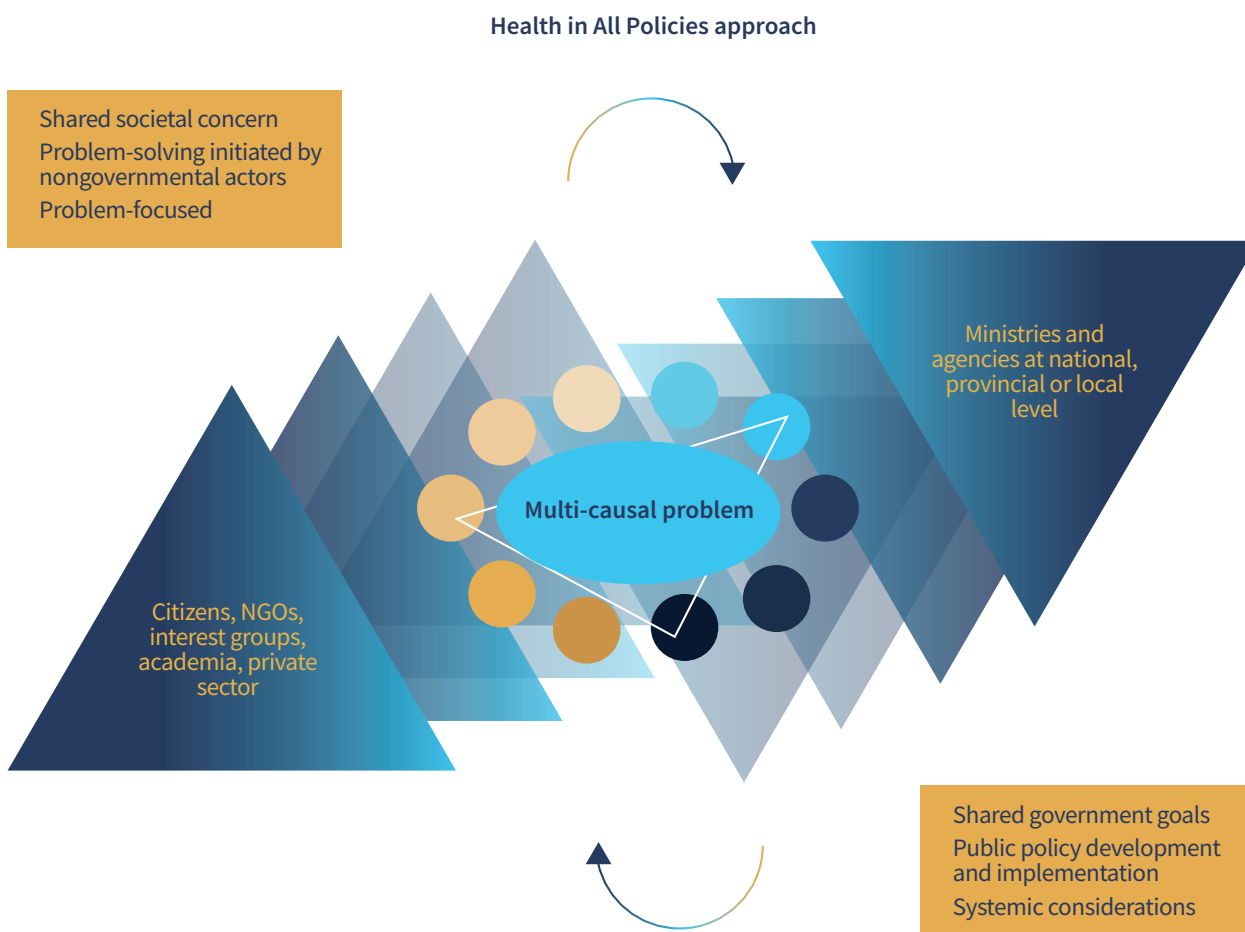
The WHO Country Framework for Action across Sectors for Health and Health Equity (10), adapted from the 2013 Helsinki Statement (6), was the first generalized framework describing country-level multisectoral action. Adopted in 2015 by Member States, it describes opportunities for implementing HiAP through six main steps: establish priorities; identify a supportive structure; frame plans; facilitate assessments and engagement; build capacity; and establish accountability (see Annex 1).

The literature on a whole-of-government approach discusses the general means for addressing complex public policy problems. A whole-of-society approach includes stakeholders from both inside and outside government, such as nongovernmental organizations, academic institutions, philanthropic foundations and private-sector entities. This approach acknowledges the important role of citizens and communities in influencing public policy, ensuring accountability and initiating multisectoral action. It can also be a catalyst for HiAP (Fig. 1). The HiAP approaches in countries aim to create a whole-of-government, whole-of-society response to improving health.

HiAP approaches have taken the lessons learnt from whole-of-government and whole-of-society political, public policy and public administration thought and evidence, contextualized them for a health audience, and added the related practice evidence base, also contributing their own evaluations (9).

Notably, HiAP explicitly emphasizes the protection of public interests and the state's redistributive role before the engagement of private profit-making interests that may influence the state's redistributive role. HiAP approaches bridge sectors and ministries and their different policies and actions to drive social progress and human development with equity. The health sector has an explicit role to advocate for HiAP approaches, providing evidence on the health impacts of decisions, and identifying problems and solutions, even if the health sector does not lead the work.

Fig. 1. Whole-of-society, whole-of-government and HiAP approaches to health and health equity



Source: Achieving co-benefits for sustainable development through multisectoral approaches: opportunities and implications for health. Bern: Swiss Agency for Development Cooperation; 2017.

1.2.3 Need for sustained collaboration

Health workforces and health systems have evolved in hierarchical structures and as command control organizations. These origins can result in a reluctance from health actors to collaborate and generate a perception of sectoral superiority. Added to this, the image of health seen from other policy actor perspectives is often as a sector that focuses on expenditure to treat disease, rather than a sector that takes proactive steps to promote the determinants of health and well-being. In view of this, the health sector has to make a special effort to take collaboration seriously and be better equipped to collaborate.

The health-focused logic for championing multisectoral collaboration to address SDH for advancing health equity is based on the following:

- Given increasing inequalities, health equity is increasingly becoming a technical characteristic of good governance in its own right. Addressing social inequalities through improving social determinants is also closely linked to improved health outcomes and thus essential for well-functioning societies.
- Social inequalities have a very strong link with health equity given that many problems driving health inequities arise before people see a health professional. This was observed during the COVID-19 pandemic, when low income and low social protection coverage prevented people from staying at home, exacerbating the spread of the virus (8). These determinants are generally beyond the direct influence of the health sector but are under the influence of other policy sectors.
- Improved attention on SDH will improve management of comorbidities and emergency preparedness, responses and recovery planning.
- Health systems strengthening through the primary health-care approach is a means towards universal health coverage. Working towards universal health coverage requires broader coalitions across social (universal social protection, education, gender), business and work policies. It requires policy dialogue to connect various parts of government.
- Co-benefits and win-wins are important incentives for building stronger multisectoral governance for the SDGs. They are increasingly discussed in environment, climate, energy, transport and agriculture fields. Identifying SDH co-benefits can strengthen the role of the health sector as a facilitator or contributor to action.

Although the health sector leadership may be persuaded to take SDH and health equity seriously, perceptions of the importance of health may differ among sectors and ministries beyond health. Actors in the health sector may consider health, equity and well-being as the most important outcomes of development, but actors beyond the health sector may think differently. Changes in mindset, awareness and views cannot be brought about simply by repeating the evidence or a position. Changing mindsets requires longer-term engagement to understanding the origins of the perceptions of the problems and the solutions.

Health is a political choice, and policy-making is an inherently political process. Multisectoral approaches to public policy are influenced by political debates and interests. Practitioners and policy-makers must understand the politics and priorities of other sectors and be able to explain what the collaborative approach offers. This means presenting arguments for collaboration to central government.

Several broad arguments in favour of collaborative approaches as part of the Sustainable Development Agenda are outlined in Section 1.1. Further key messages that can be used to advocate to central government to support multisectoral collaboration are presented in Box 4.

Box 4. Key messages for health actors to use in promoting multisectoral collaboration

- ➔ Collaboration mechanisms are necessary to complement siloed, hierarchical government sectors, as many of the challenges that governments and broader society face are too complex to be solved by one directive, one sector or one discipline.
- ➔ Collaboration mechanisms and structures should be in place to explore co-benefits in public policy-making and policy implementation as collaboration is hard work and will not develop naturally.
- ➔ Successful collaboration is built on trust and supportive relationships, which take time to develop.

1.3 New HiAP model and stakeholders

1.3.1 Key aspects of new HiAP model health and health equity

A new model of HiAP has been developed to supplement the original WHO 2015 Country Framework for Action across Sectors for Health and Health Equity (see Annex 1). The new model emphasizes collaboration and the HiAP functions and capacities necessary to sustain collaboration. These functions and capacities are described by four HiAP pillars supported by key elements (Table 1). The four pillars of the HiAP approach are:

- **Pillar 1:** governance and accountability.
- **Pillar 2:** leadership at all levels.
- **Pillar 3:** ways of working and work methods.
- **Pillar 4:** resources, financing and capabilities.

The elements under the four pillars provide a useful checklist for applying the HiAP approach. More features of the new HiAP model and details of the elements, with examples, are given in Part 2.

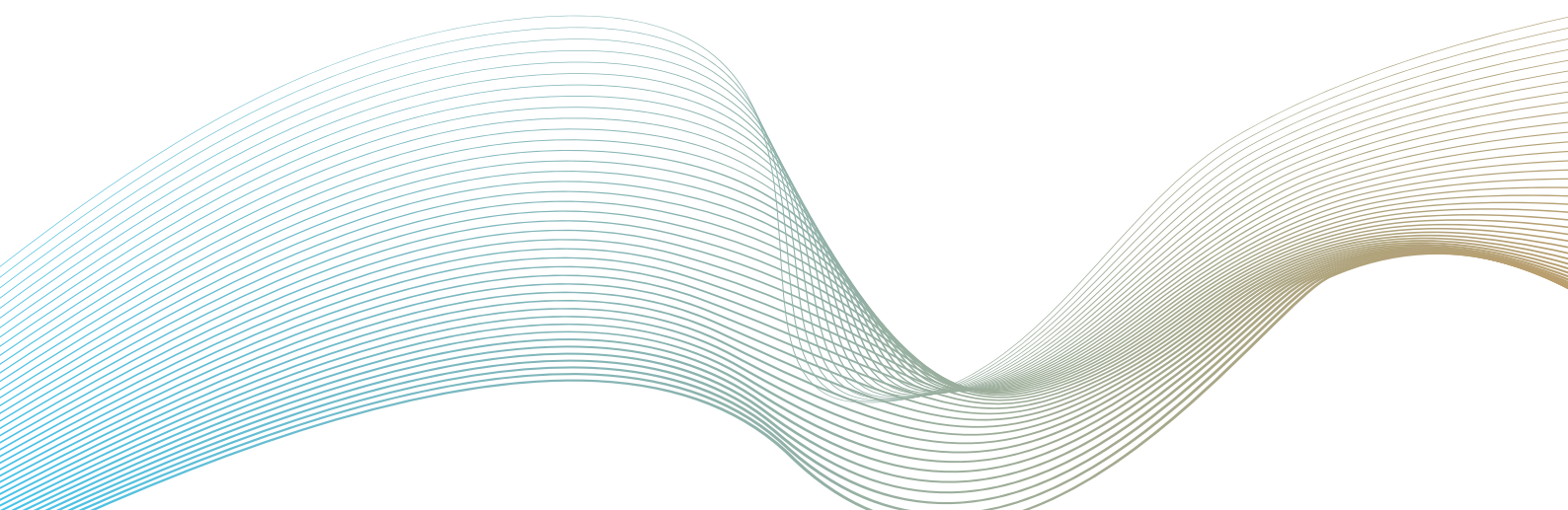


Table 1. Elements of HiAP approaches important for effective multisectoral collaboration

Pillar 1: governance and accountability

- Element 1.1: authorizing environment and mandate
- Element 1.2: layered cross-government committees and using existing structures and mechanisms
- Element 1.3: whole-of-government plan for policy action
- Element 1.4: support for collaboration and joint projects and project proposals

Pillar 2: leadership at all levels

- Element 2.1: advocating for HiAP and other collaborative approaches
- Element 2.2: fostering culture of collaboration
- Element 2.3: network of HiAP champions
- Element 2.4: generating and activating a whole-of-government plan.
- Element 2.5: joint identification of issues and shared policies and projects for shared goals

Pillar 3: ways of working and work methods

- Element 3.1: developing collaborative partnerships built on trust and maintaining open communication
- Element 3.2: understanding policy priorities of partners and co-designing policy and project plans

Pillar 4: resources, financing and capabilities

- Element 4.1: dedicated HiAP roles
- Element 4.2: dedicated HiAP budget
- Element 4.3: capabilities to act on determinants and translate knowledge

1.3.2 Engagement continuum


The development and implementation of HiAP approaches in public policy require stakeholders to be familiar with different engagement strategies.

Table 2 shows the engagement continuum, illustrating the scope of relationships that can be formed between government agencies and ways in which individuals can work together. Each type of engagement is legitimate in certain circumstances. At one end of the scale are informal networks through which information is exchanged for mutual benefit, but no action is taken and there is no long-term commitment. One of the aims of HiAP and other multisectoral approaches is to bring about the collaborating form of engagement, as it is through collaborative action that public policy can be shaped to support health, equity and well-being.

The continuum can serve as a map to further action to reach the next level and thereby progress collaboration. Each subsequent level in Table 2, from networking, to cooperating, to coordinating to collaborating, corresponds to those in the spectrum of public participation of the International Association for Public Participation (37).

Table 2. Engagement continuum

Networking (inform)	Cooperating (consult)	Coordinating (involve)	Collaborating (work together)
Exchange of information for mutual benefit	Exchange of information for mutual benefit	Exchange of information	Exchange of information
Informal relationship	Formal relationship	Formal relationship	Formal relationship and structure
Requires minimal time and trust	Requires moderate time and trust	Requires substantial time and trust	Requires extensive time and trust
No sharing of resources	Minimal sharing of resources	Sharing of resources for common purpose	Shared resources
		Some sharing of risks and rewards	Sharing of risks, responsibilities and rewards
			Enhance capacity of another to achieve common purpose
			Joint planning, implementation and evaluation

Better, more enduring policy and programmes 

Source: adapted from Collaboration: a Tasmanian Government approach. Hobart: Tasmanian State Government; 2010 (www.dpac.tas.gov.au/divisions/policy/collaboration).

1.3.3 HiAP stakeholders

HiAP approaches to addressing SDH can be introduced at all levels of government – municipal, subnational and national – and sometimes globally through international networks. Understanding different roles of stakeholders at each level is an important enabler of successful multisectoral collaboration.

Many governments already have mechanisms and structures in place to support cross-sector engagement. They may have whole-of-government priorities and policies that require whole-of-government responses such as HiAP. It is important to identify and map these existing structures before establishing any new multisectoral approach. These existing structures can support the progress of the multisectoral approach for addressing SDH by building on them and including them in the newly extended governance structure. This can minimize the likelihood of duplication and reduce the potential of creating competing structures and processes.

Actors and responsibilities

Action for health among sectors requires various structures and mechanisms, but a facilitating agency or actor is always necessary to drive, coordinate and manage the process.

The facilitating agency must have the authority to work with other sectors, the required expertise, and the necessary knowledge and information on public policy issues and their implications for health and other government priorities. The facilitating agency should be aware of the priorities and decision-making processes of other sectors. Initially, the facilitating agency is likely to be within the health sector or a partnership between the health sector and another agency. As the HiAP approach matures and a network of HiAP champions emerges, the agency may shift to other government agencies.

The facilitating agency needs to recognize that the multisectoral process is likely to lead to the identification of conflicting issues and interests. It is important to establish at the outset strategies and processes for negotiating and addressing potential conflicts of interests.

Whatever agency or actor is the facilitator, roles, responsibilities and accountability within the government should be established at the outset to ensure all actors understand their roles and responsibilities and the benefits they may gain.

Role of central government

The term “central government” refers to the office of the prime minister or the highest political office in a jurisdiction, which may be national, subnational or local (e.g. president’s office at the national level, premier’s office at the subnational level, mayor’s office at the local level). The central government is an essential stakeholder in multisectoral collaboration, as it issues mandates and commitment to initiate or advance collaborative action, therefore ensuring policy coherence.

The role of central government includes:

- creating a shared whole-of-government vision and strategic goals;
- fostering a culture of collaboration in all government agencies;
- establishing structures and mechanisms for collaboration throughout the government;
- providing funding and other resources to encourage and support collaborative approaches;
- establishing reporting and accountability processes to monitor cross-government collaboration.

Health authority

For a health authority or health agency to advance HiAP, whether at the local, city, regional or national level, it must broker and facilitate collaboration with other sectors and jointly explore policy ideas and structures, mechanisms and instruments for effective collaboration. The health sector must be outward-oriented and open to the ideas, perspectives and priorities of others. Internal coordination must be strengthened in health authorities and health HiAP champions fostered to minimize “health imperialism”.

The roles of a health agency or health authorities include:

- understanding the priorities and decision-making processes of other sectors;
- facilitating cooperative design and production for joint policy development to deliver co-benefits;
- initiating regular, continuous dialogue with other sectors and creating structures and mechanisms for such dialogue if necessary;
- building knowledge and generating an evidence base for policy development and strategic planning;
- identifying and prioritizing health issues;
- assessing effectiveness of action among sectors and costs of inaction;
- advocating for health protection and for addressing SDH in public discourse and public policies;
- promoting synergy and negotiating trade-offs, including addressing potential conflict of interests among sectors and potential institutional partners.



Public policy actors outside the health sector and central government

The involvement of ministries, agencies or public authorities outside the health sector is the essence of a HiAP approach. Early engagement may be complicated. Co-design and co-production of policies, challenges and solutions are valuable in building opportunities for early engagement.

The roles of public policy actors outside the health sector include:

- participating and engaging in co-design and co-production;
- communicating and sharing policy imperatives and exploring connections with health and well-being;
- supporting development of trusting, transparent relationships;
- navigating internal vertical decision-making processes to support collaborative work;
- engaging in discussions to identify potential tensions and working together to resolve differences;
- advocating for collaboration within their agency or portfolio and contributing to the network of HiAP champions.

Actors outside government

An effective multisectoral response to improve health and health equity requires the participation of actors outside the government.

Academia and universities are valuable partners for HiAP approaches to provide evidence for policy-making. Evidence and knowledge translation is required from many disciplines and types of research, including research based on qualitative and quantitative methods. In addition, academia can support evaluation of collaborative processes and policy outcomes. Academia can support training initiatives to enhance HiAP capabilities. The academic community thus plays a key role in helping to build knowledge and evidence to advance HiAP, while it is a constant challenge to ensure sustained engagement and responsiveness of researchers in the changing policy environment given other education incentives.

Communities are in key positions to identify health issues and inequities and to suggest suitable local solutions based on collective local wisdom. It is important to build community capacity by supporting community members in full participation in action for health. This may include promoting health literacy and training leaders in supporting and enabling communities to make informed choices and promoting the voice of the community in decision-making.

Nongovernmental organizations play a critical role in promoting health action among sectors because of their significant influence on public policy and political decision-making. They often provide data and evidence on lived experiences of health and health equity, which can be powerful tools in shaping public policy. Nongovernmental organizations are usually led by passionate, committed individuals with the advocacy skills and capacity to influence public opinion. Nongovernmental organizations can also provide expertise in evaluating with communities whether HiAP actions are improving the impacts on health. International nongovernmental organizations are responsible for advocating for coherent policy action at the global level to support achievement of the SDGs and to improve the living and working conditions of people from disadvantaged populations.

The private sector comprises a diverse range of enterprises engaged in economic and commercial activity, trade and investment. The private sector is increasingly associated with the economic and commercial determinants of health. Some of their activities contribute to better health, but others may be harmful. Understanding the interests of the private sector in collaboration and identifying their best roles is critical to navigating their complexities and potential conflicts of interest. Involvement of the private sector requires consideration of issues such as prevention and management of conflicts of interest and undue influence, especially if the private-sector entities involved produce goods or services that are detrimental to health.

1.4 Assessing success of HiAP approaches

1.4.1 Levels of success

The ultimate successful outcome of any HiAP approach is to influence and sustain policy decisions, goals and actions of other sectors that also promote positive SDH and health equity.

Along the path to success, there are many ways to evaluate progress. There will be public policy changes, laws and budget shifts. There will be greater understanding of social inequalities in other sectors, including as demonstrated in their data systems. Previously unknown interlinkages between health and policies in other sectors will emerge. Capacity-building and training will enhance capabilities. New networks within health and beyond and partnerships with civil society and academia will be formed. Multisectoral collaborations for health will be supported by central government. Partnerships among sectors will be more cooperative. Other sectors will appreciate the usefulness of health knowledge for their own policy goals. Bottom-up experiences will demonstrate greater reach and effectiveness of public policies.

A conceptualization of monitoring and evaluation drawing on different elements of success should be included from the outset. Monitoring and evaluation are important for tracking progress, demonstrating the outcomes achieved and for seeking long-term support for the HiAP approach. There should be tangible short-term outcomes and long-term outcomes for health and wider public policy goals that are evaluated.

It is important to assess three main levels of success of multisectoral collaboration:

- Effectiveness of the collaboration mechanism, often measured by inputs – whether the process sufficiently meets the expectations of all agencies and actors involved, and whether it helps to establish and maintain the appropriate collaborative working climate (e.g. whether there is support for continuing engagement and whether resources have been allocated).
- Policy processes – whether there is documentary or other evidence of an impact on policy, and whether governance decision-making processes and institutions themselves have been impacted to consider equity and health.
- Policy impacts – whether measures or proxy measures indicate the likelihood that the policy goals of other agencies and actors have been met and social determinants and health impacts have been positive in the medium to long term. Monitoring the SDH is most closely associated with the area of assessing policies and policy impacts.

A monitoring and evaluation plan will identify indicators of success and ensure evaluations are conducted. Monitoring is conducted regularly, but evaluations are done periodically, at critical points of implementation. As multisectoral processes evolve, engagement with different actors will lead to setting specific goals that may not be known at the outset of a HiAP initiative. Thus, a small set of indicators at the outset may focus more on effectiveness activities and processes. Other specific indicators will be developed, depending on the sectors involved.

1.4.2 Monitoring and indicators

Monitoring the HiAP process can be conducted quite simply initially, using indicators on inputs and multisectoral processes. Information on these will generally be known by the agencies playing the facilitating roles. Monitoring the HiAP approach is important as it can provide useful information for making the case for investment of time and funds. Indicators derived from the work processes of multisectoral collaboration itself do not generally require assistance from academia or nongovernmental organizations, but this depends on how the facilitating agency for HiAP is formed. Although indicators on inputs and processes can be monitored by facilitating agencies, which often include the health sector, indicators on outcomes are generally best monitored as a joint activity with the sectors beyond health.

Box 5 provides a checklist of indicator areas to be monitored by a health or other authority engaged in facilitating HiAP. These items may also be included in evaluations. Some of the process inputs referred to in this list may be useful to monitor only at the start of work. Other items are useful for tracking over time and for reporting on or sharing experiences of implementation. Information on tasks, networks and specific determinants themes addressed by HiAP also provide useful information for furthering HiAP strategies.

1.4.3 Evaluations

Evaluations of HiAP approaches and their impact on health and health equity are generally more feasible through partnering with local academia or civil society. Sometimes specific public-sector evaluation units may provide useful skills and resources. Academia and civil society are important partners that can help multisectoral actors set up logic models and measure impact. Academics with public health skills are often trained in this sphere, but academics from other fields, such as economics or political science, may also be helpful.

Usually, evaluations involve focusing on specific policy areas where changes in SDH are envisaged. Evaluations can be an important incentive for involvement of other sectors and may be an important activity of the multisectoral collaboration. Evaluations can show how taking health into consideration has improved the outcomes of interest for the other sector – the co-benefits.

In general, evaluations of impacts on SDH should focus on changes in SDH among disadvantaged groups and the resultant equity gaps. Common domains for SDH include good-quality and accessible health services; income security and social protection; decent living conditions; social and human capital; and decent work and employment conditions.

Box 5. Checklist of operational characteristics and outcomes of HiAP approaches

Inputs

Governance

- ➔ Existence of endorsement at the political level of explicit HiAP approach or multisectoral action that could advance addressing SDH.
- ➔ Existence of formal or informal multisectoral coordination mechanism specific to SDH, health equity and broad HiAP; or integrated with other issues (e.g. noncommunicable diseases, antimicrobial resistance, One Health, COVID-19).
- ➔ Existence of national policy or strategy specific to HiAP or SDH.
- ➔ Existence of national health plans that embed and mention HiAP or multisectoral action.
- ➔ Existence of priorities in addressing SDH for advancing equity.

Finance

- ➔ Resources allocated or mapped to HiAP through separate or integrated budget lines.
- ➔ Government spending on HiAP as percentage of government health spending.
- ➔ Source of spending.

Health workforce

- ➔ Number of dedicated full time equivalent personnel working on HiAP or multisectoral action, or working on other issues but with HiAP elements integrated in the job description.

Monitoring and evaluation

- Existence of system to capture best practices, lessons learnt and innovation related to HiAP.

Processes

- Occasional or ongoing regular collaboration to address one issue or social determinant or multiple issues or determinants with a single partner or multiple partners.
- Existence of multisectoral and multistakeholder mechanisms with clearly defined roles and functions.
- Interventions at community level in support of HiAP.

Outputs

- Frequency of meetings of multisectoral and multistakeholder coordination mechanism.
- Representation (types, seniority, numbers) of ministries or departments involved in multisectoral and multistakeholder coordination mechanism.
- Other stakeholders and sectors involved in multisectoral coordination mechanism.
- Inclusion of health considerations in the work, policies and programmes of non-health ministries, independent of health sector input.
- Improved community perception, knowledge and access to information on HiAP approaches.

Outcomes

- Existence of reporting structures or accountability measures that address policies impacting on determinants of health.
- Level of engagement with different types of sectors as a result of collaborative work, indicating level of engagement of economic, home affairs/interior/local government, labour, finance, and infrastructure ministries, compared with social sector ministries.
- Characterization of the problem of inequity explicitly framed in terms of SDH (essential conditions for health – good-quality and accessible health services; income security and social protection; decent living conditions; social and human capital; decent work and employment conditions).

Impact at policy level

- Improved public policies aligned to evidence on SDH.
- Systematized mechanisms for HiAP implementation.
- Improved outcomes for other policy sectors (co-benefits).
- Improved equity in health or in SDH.

When evaluation of multisectoral collaboration is linked to implementation of an existing set of public health measures (e.g. the framework of key interventions for addressing noncommunicable diseases), evaluations will use logic models that describe changes related to those specific measures but may also include some specific SDH.

Evaluation designs will be linked to the programme design and the theory of change being used in the specific multisectoral collaboration context. Specific considerations for understanding the programme logic of interventions from a realist perspective are individual capacities, interpersonal relationships and institutional settings, and how they these relate to wider social and physical infrastructure, resources, welfare and development systems.

Evaluations can require talking to actors across different policy spheres and with stakeholders in communities. Box 6 describes some of the specific tools used to structure evaluations. Academic and technical experts will be able to identify further appropriate approaches and adapt generic tools to the

Box 6. Evaluation approaches relevant to SDH and health equity

The following formal approaches and specialist methods can be used for in-depth evaluation of impacts and contributions of policies to improving SDH and health equity:

- ➔ Prospective methodological approach – advancing equity through health impact assessments (38, 39).
- ➔ Retrospective methodological approach – natural policy experiments and quasi-experimental quantitative approaches, such as regression adjustment, propensity score matching, difference-in-differences analysis, fixed-effects analysis, instrumental variable analysis, regression discontinuity and interrupted time-series (40, 41).
- ➔ Systems evaluation method – contribution analysis (42).
- ➔ Use of narratives and community evaluation (43).
- ➔ Use of realist methods for explanatory case studies (44).
- ➔ Specific principles for equity policy evaluation: where to evaluate – shifting from familiar to unfamiliar terrain; who to evaluate – shifting from structures of vulnerability to structures of privilege; what to evaluate – shifting from simple figures to complex constructs; and how to evaluate – shifting from gold standard to more appropriate fit-for-purpose designs (45).



2. Ensuring multisectoral collaboration across public policy sectors

2.1 New HiAP model

2.1.1 Overview

A HiAP approach provides a framing to help public agencies promote health and address SDH, equity and well-being in government decision-making.

The new HiAP model formalizes a set of operational functions and capacities discussed in existing WHO guidance (10) and common to HiAP case studies as shared by these countries. Fig. 2 describes three main components of the new model – arches, pillars and foundations. A fourth component – outcomes – is not shown in the figure but is referred to below. These components summarize the core determinants, challenges, organizational values and functions (or capacities) needed to operationalize a HiAP approach and are elaborated below.

At the centre of the model are the four pillars that focus on important functions and capacities needed to use a collaborative HiAP approach. Many of these functions are relevant to sustaining multisectoral collaboration, regardless of the issue of focus. Governance, leadership, working methods (ways of working) and resources are at the heart of the new model. The exact form of the HiAP model in any country depends on the context and levels at which collaborative action is operationalized – local, subnational, national or all.

The new model does not provide a set structure but proposes a common framework for understanding the practical activities needed, recognizing that this approach may require several years to achieve wide-ranging influence and impacts.

In summary, the new HiAP model on which sustainable multisectoral collaboration is based:

- outlines the organizational structures and mechanisms required to build collaboration;
- acknowledges SDH and the structural drivers of health inequity;
- applies to any public policy or health issue that requires multisectoral collaboration;
- is adaptable and relevant to different countries and political contexts;
- supports achievement of the SDGs, and social development with equity.

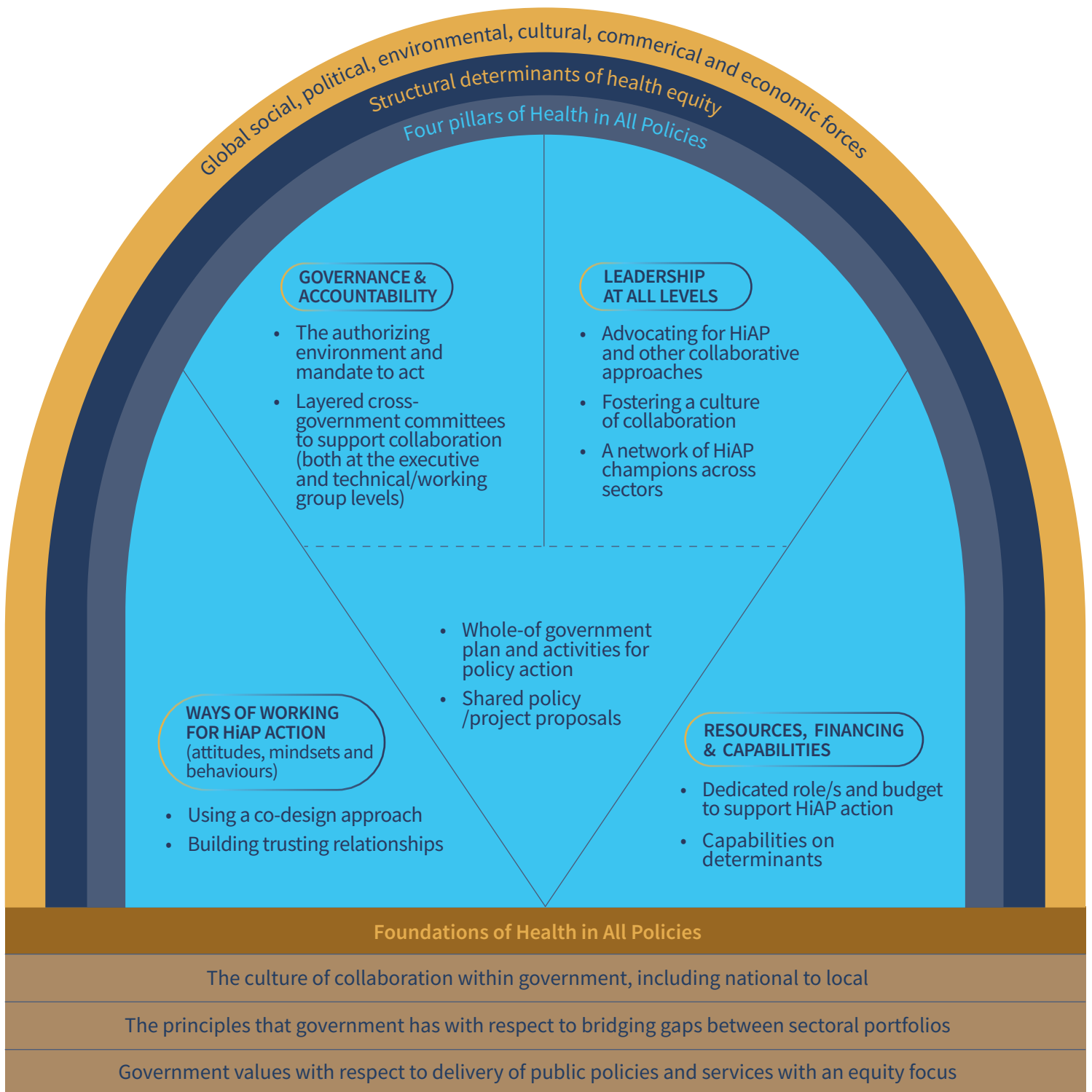
2.1.2 The arches


The arches show the broad contextual factors that shape and influence health, equity and well-being and signal the importance of the mechanisms at play.

The first arch is a reminder of the global forces that affect societies everywhere. These include global capital movements, migration, information technology, war and climate change. The arch also refers to social, political, environmental, cultural, commercial and economic sectors explicitly to identify the powerful influence of multiple sectors on health, well-being and health equity, both within and between countries.

The second arch – action on the structural determinants of health equity – highlights that structural drivers of health inequity emerge from within the decision-making processes and institutions of governance. These impact social position and its interplay with health. Social position associated with social, political, environmental, cultural, commercial or economic spheres of life delineates structural drivers towards health inequities.

Fig. 2. New HiAP model





Structural determinants of health equity work through influencing the distribution of essential conditions for health and well-being. Concretely, their influence operates through well-known SDH mechanisms – differential exposures, vulnerabilities, behaviours and consequences of ill health – as associated with social stratification. For example, if manual workers, relative to professional workers, have less access to paid sick leave, then manual workers are less able to protect themselves in times of illness as they need to be present at work to earn income even if they are ill. This phenomenon was highlighted during the COVID-19 pandemic. Changing the structural determinants of health equity to ensure a fairer, more equitable health distribution across different groups in society is good for society as a whole and a core motivation of using a HiAP approach.

2.1.3 The foundations

A HiAP approach builds on the foundations of existing governance, bureaucracy and administrative systems. Optimal foundations are not always present, but it is important to understand this context. More realistic expectations of a HiAP approach can be set, and how the approach is applied will be adjusted.

The first foundation important for an effective HiAP approach is the set of values, expressed formally or informally, guiding the system of government to deliver fair outcomes for people, regardless of social position. In some countries, this value is expressed in their founding documents or constitutions.

The second foundation recognizes that all governments function with principles that can either widen the gap between government portfolios or bridge the negative impact of working in silos. Governments may use common evaluations to bridge silos, or they may use cross-portfolio accountability mechanisms in parliaments.

The third foundation recognizes the critical importance of organizational incentives that reward or deter civil servants from collaborating with others. The extent to which government systems recognize the need for these incentives is visible through civil service conduct rules. The administrative systems underpinning these will often reach across different sectors.

2.1.4 The outcomes

The outcomes of improving multisectoral collaboration through the HiAP approach can be summarized as to:

- improve the value obtained from public policy-making;
- strengthen government systems and structures to increase action on the SDGs;
- advance universal health coverage, universal social protection coverage and human development.

These outcomes ultimately lead to better health and well-being, health equity, fairer societies and improved environmental sustainability.

2.1.5 The four HiAP pillars

The four pillars at the heart of the HiAP model are the main motors supporting collaboration that HiAP champions exercise. Although depicted as standalone, the pillars are central functions of a HiAP approach that intersect to weave the cultural fabric of collaboration across government. They are governance and accountability; leadership at all levels; methods of work and ways of working; and resources, financing and capabilities.

Developing a culture of collaboration and integration is the main cross-cutting theme of the new HiAP model. In the context of HiAP, a collaborative culture should be embedded at leadership and operational levels and encouraged from within but also beyond the HiAP approach. Collaboration requires trust, and establishing trust with partners is essential for achieving long-term, sustained co-benefits and outcomes. A culture of collaboration and teamwork enables a HiAP approach (Box 7), and the HiAP approach fosters and sustains that culture.

Box 7. Principles of collaboration

The principles of collaboration are outlined in the second Adelaide Statement on Health in All Policies (7), and include the behaviour and attitudes (both individual and organizational) that ensure successful collaborative approaches.

Table 3. How principles of collaboration are demonstrated in practice

Principle	What should be done
Invest in building trust and relationships	Ensure dedicated staff, with time and space to build strong, trusting relationships with other sectors
Respect for responsiveness to partners' needs	Understand, acknowledge and respect expertise and policy agendas of all sectors in partnership, and respond to them in co-design; this fosters collaborative relationships based on trust
Flexibility and adaptability	Be aware of and actively respond to changes in partners' priorities, political realities and policy imperatives; adaptation to new policy environment is critical for HiAP practice
Transparent, open communication	Recognize importance of open conversations and addressing issues professionally and honestly to ensure strong, trusting relationships and best outcomes for all
Coordinated or integrated implementation approaches	Establish and implement mechanisms to co-define, co-design and co-deliver policies
Skilled HiAP workforce	Recognize and foster skills for diplomacy, negotiation and political science in the HiAP workforce
Focus on public value	Put citizens at centre of policy and service design and delivery by focusing on positive societal and environmental impacts
Systematization and institutionalization	Seize strategic opportunities to formalize HiAP processes and practices in legislating administrative and political structures of government to embed HiAP into ethos and architecture of government decision-making



2.2 Applying the four pillars of the HiAP model

The concepts, key elements and examples are outlined below for each pillar of the HiAP model. The context envisaged for applying a HiAP approach is a proactive initiative on the ground that may start small in scale (maybe only two people). Many governments are operating with multisectoral mechanisms but without being explicit or deliberate about how they relate to an overall HiAP strategy.

The reasons for initiating a HiAP approach will differ by country. The pillars of the new HiAP model have no fixed priority or order but refer to functions that can be applied according to the country's context. Many opportunities can be used to initiate or expand HiAP approaches and will depend on the engaged policy actors and local, national and international agendas and priorities that can be leveraged. Although not all the elements in each of the four pillars are required, at least some features should be present to develop and sustain multisectoral collaboration as part of an overall HiAP strategy. The elements described under the four pillars should be under the influence of the HiAP approach, whereas the elements described under the arches and foundations set the context of the work. Most implementation examples for each pillar below are extracted from existing publications, namely Progressing the Sustainable Development Goals through Health in All Policies: Case Studies from Around the World and Global Status Report on Health in All Policies.

2.2.1 Pillar 1: governance and accountability

The purpose of governance and accountability for HiAP is to provide a mandate and high-level oversight of HiAP activities. Governance legitimizes multisectoral work and a mechanism for action and structures for accountability to ensure the success of the approach.

Ideally, all the elements of governance and accountability should be in place for effective HiAP. This may not always be possible, and the elements available will depend on the country context and opportunities.

The reconfiguration of administrative, legislative and executive systems of governance to place a greater priority on health equity through action on SDH will result in a series of specific characteristics that have been summarized by various tools. Annex 2 summarizes a checklist on these characteristics extracted from a tool on governance for health equity developed in the European region (11).

Element 1.1: authorizing environment and mandate

A mandate for HiAP from the highest level of government establishes a culture of collaboration, provides the necessary support, and contributes to embedding HiAP in government structures and mechanisms. Establishment of formal governance structures or embedding HiAP in existing structures signals a long-term commitment to a sustained HiAP approach. Formal governance structures can facilitate the development, implementation and monitoring of a clear, shared strategic vision and a whole-of-government plan to address the determinants of health. Governance strategies can build shared ownership of the HiAP approach and shared accountability for its outcomes.

Element 1.2: layered cross-government committees and using existing structures and mechanisms

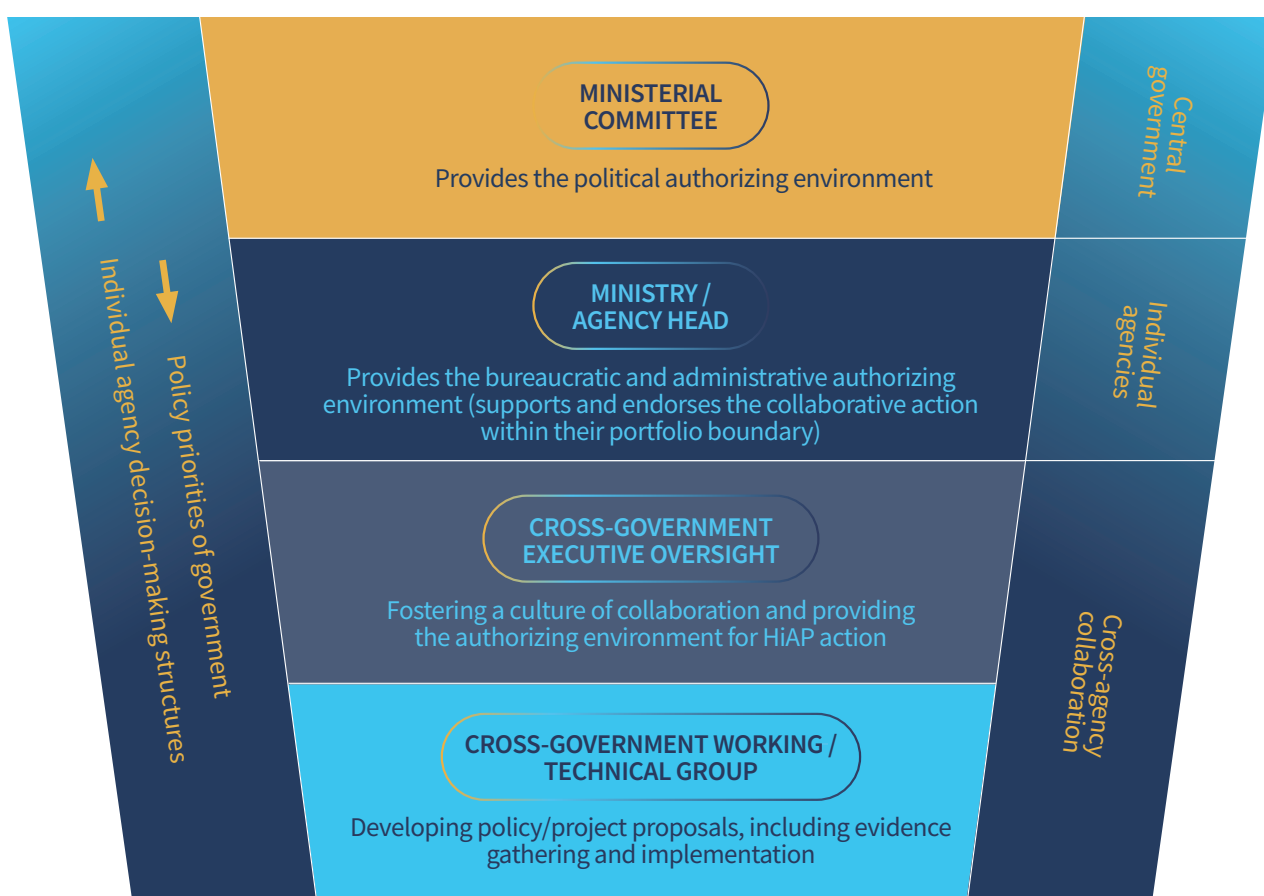
Horizontal and vertical governance structures are important for anchoring commitment and implementation of a HiAP approach. Vertical governance structures maintain authority and high-level executive oversight. Horizontal governance facilitates horizontal operational levels of policy-making and project development. Fig. 3 illustrates the hierarchy of vertical and horizontal structures used in HiAP processes.

Layering cross-government committees should be balanced to include both a high-level executive group and technical or other working groups. Further examples of governance structures and mechanisms are given in Table 4.

Various structures in various degrees of formalization may be used for working across sectors. When a HiAP model or another form of collaborative action is being considered, existing structures or mechanisms should be examined to determine whether they can be used to build a HiAP approach.

Each structure and mechanism should be adapted to the relevant governance setting and context. Existing structures and mechanisms may have been established to address a particular health issue, such as noncommunicable diseases, air pollution or antimicrobial resistance, and the new HiAP model should not disrupt their operation.

Fig. 3. Horizontal and vertical governance in HiAP approaches



Source: Government of South Australia, World Health Organization. Progressing the Sustainable Development Goals through Health in All Policies: case studies from around the world. Adelaide: Government of South Australia; 2017 (<https://www.who.int/publications/m/item/progressing-the-sustainable-development-goals-through-health-in-all-policies>).

Table 4. Examples of multisectoral governance structures and mechanisms

Government level	Cabinet committees and secretariats
Parliament	Parliamentary committees
Public sector or civil service	Interdepartmental committees and units Mega-ministries and mergers Cross-sector working and technical groups
Management of funding arrangements	Joint budgeting Delegated financing
Engagement with nongovernmental entities	Civil society Nongovernmental organizations Private sector

Source: Health in All Policies training manual. Geneva: World Health Organization; 2015

Element 1.3: whole-of-government plan for policy action

A whole-of-government plan or strategy with a clear shared vision and objectives is one of the key vehicles to support collaboration and can drive investment in a HiAP or other multisectoral approach. Such plans are rallying points to unify policy-makers across sectors. Although development of a shared vision may be time-consuming, it is essential for shared ownership. Using the plan to document the rationale for partnerships, approaches, activities, roles and outcomes will clarify the intent of the collaborative approach and contribute to understanding by partners of shared priorities and opportunities for mutual benefit. These enhance incentives for collaboration.

Strategies and indicators to monitor the delivery of the whole-of-government plan, individual policies and projects, and the collaborative HiAP approach are important. Indicators can help build an evidence base and refine the collaborative approach. Monitoring includes collecting evidence, reporting and promoting, and sustaining acceptance and accountability in sectors. A clear set of indicators can help track the progress of a whole-of-government plan and indicate where adjustments are necessary.

Element 1.4: support for collaboration and joint projects and project proposals

To acknowledge the importance of collaboration, shared policy or project proposals should be drawn up, outlining collaborative opportunities and responsibilities in the whole-of-government plan. The proposals should be endorsed at the highest level of government and by each agency or ministry. Updates on progress should be provided regularly.

Actions to support governance and accountability

Actions of governance and accountability include establishing or strengthening:

- a mandate, endorsement or supportive legislation for HiAP issued in a government statement or a national or subnational policy or plan or a memorandum of understanding or other formal agreement among government sectors;
- a multisectoral coordination mechanism or other formal structure, such as a high-level cross-sectoral committee, working group, technical group or alliance;
- cross-sectoral policies or plans to support HiAP, such as an agreement between the education and health ministries to work together;

- formal structures for reporting and accountability of multisectoral policies or programmes, such as key performance indicators on HiAP, benchmarking of HiAP practice and annual reports;
- public accountability through public reporting on agreed goals, activities and outcomes related to HiAP, and transparency in the provision of information to the public on HiAP activities undertaken by the government.

Examples of implementation of governance and accountability include the following:

- In Canada, the Québec Government Policy of Prevention in Health was developed with a central Government mandate to integrate action across Government departments. There was a common vision for population health and to search for synergies between sectors.
- Ecuador's 2008 Constitution and the National Plan for Good Living 2013–2017 and Metropolitan Ordinance regarding the organization of health actions of the municipality created an enabling legal framework for a HiAP approach and for a more holistic rights-based approach to and for social participation in health.
- In the Pomurje region in Slovenia, the Programme Mura has established multisectoral collaboration at two levels. At the national level, an interministerial project group coordinates the work of ministries with a political and strategic mandate. At the local level, the Center for Health and Development coordinates horizontal activities within the region and vertical activities with national actors.
- In the United Republic of Tanzania, the Prime Minister's Office is responsible for coordinating multisectoral action and implementation of their Health in All Policies framework.

2.2.2 Pillar 2: leadership at all levels

Government officials who advocate for and support HiAP can shift administrations and bureaucracies towards more collaborative practices. This influence may change the foundational values of governance. Leaders in collaborative practice can connect across disciplines, issues and agencies, cultivating collaboration and accountability at all levels of agency hierarchies. Networks can strengthen multisectoral action across government.

Collaborative leadership in its formal sense is a strategic system that requires, enables and rewards the sharing of power, control and resources. Not all HiAP leaders are in the most senior positions. Leaders with vision can emerge at any level, including senior executives, managers or technical officers. The pillar emphasizes leadership at many levels of the hierarchy, which is critical for sustaining collaboration across government.

Element 2.1: advocating for HiAP and other collaborative approaches

Leadership and advocacy are interdependent in the HiAP context. Leaders who promote HiAP approaches advocate for embedding it in the system. Leaders may be supported by formal (and some informal) governance frameworks, structures and mechanisms.

The pillar of leadership at all levels covers the mindsets and values of decision-makers and policy officers and practitioners who influence change, advocate for new activities and enable collaboration.

Effective leadership and advocacy for HiAP require people with skills in diplomacy and negotiation and the ability to navigate the political and policy imperatives of other agencies. Effective leaders build and implement a vision, influence change, are driven by values and are grounded. The characteristics of these leaders make them effective advocates for HiAP, who can communicate and articulate the HiAP vision and win others over to embrace and implement it. HiAP leaders can thus drive a strong co-design and co-benefits approach.

Element 2.2: fostering a culture of collaboration

The culture of collaborating is a cross-cutting theme of the new HiAP model, but leaders of HiAP approaches can set examples. Collaboration is effective when information is readily shared and collective responsibility underpins the work and team culture. Leaders of HiAP help shape the culture and practice of HiAP and other collaborative approaches. They ensure the conditions necessary to help others to collaborate. Effective leadership can shift government towards more collaborative practice and make connections among agencies.

Element 2.3: network of HiAP champions

People who lead and advocate for the HiAP approach become agents of change and champions of policies with co-benefits, as they mediate among different interests and foster and support collaboration. 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 champions advocate for policies that can improve health and address the determinants of health. They recognize both the potential for better policy and the value of the HiAP approach for better outcomes in their own policy sector and for public policy as a whole. As advocates, they will try to push the idea through internal resistance to change and promote it throughout their organization. Their roles include harnessing collaborative opportunities, identifying and exploring windows of opportunity, and helping to initiate new policies.

Element 2.4: generating and activating a whole-of-government plan

Leadership for developing and implementing a whole-of-government plan supports creation of a shared vision, provides a sense of purpose, sets the direction, and unites people and organizations in moving towards a valued future. Leaders are therefore essential for achieving the HiAP vision and bringing to fruition government priorities through a whole-of-government plan.

Element 2.5: joint identification of issues and shared policies and projects for shared goals

A common understanding and working across sectors towards a common purpose are at the heart of HiAP. The rationale for scanning the policy environment for shared goals is to explore opportunities for collaboration. This allows sectoral stakeholders to better understand overlapping policies, positions and values and explore their positions, values and experiences. Leadership at all levels is important for these discussions to take place. Leaders can facilitate coherent, cohesive, shared goals.

Once shared goals have been established, leadership at all levels is necessary to promote joint identification of policy issues and opportunities for policies or projects aligned with the shared goals. Leadership at all levels drives the necessary collaborative actions and brings together the people necessary to deliver joint policy and projects.

Actions to support leadership at all levels

General guidance and ideas on how leadership for collaborative action may be developed in country contexts include:

- developing a clear HiAP vision that leads to a common direction and emphasizing values for collaborative practice;
- understanding shared goals and jointly identifying issues and relevant activities by:
 - becoming familiar with the policy priorities of each government agency;
 - developing a whole-of-government plan for policy action, which includes the priorities of the government and their relation to policy, and the relation between this agenda and health and well-being;
 - describing and mapping the links among the policy priorities of different agencies and ministries and their application to health and well-being;
- establishing supportive organizational structures and mechanisms to enable HiAP leadership (moving away from sectoral and organizational silos);

- networking with professionals at informal or formal meetings of policy or project officers in various government and nongovernment sectors;
- taking opportunities for cross-sectoral learning, peer support and joint problem-solving;
- identifying champions to promote HiAP in different government sectors;
- advocating for multisectoral approaches to leadership and seizing strategic opportunities by highlighting early success in collaboration, such as by briefing decision-makers, reporting, or organizing seminars and conferences at which decision-makers and policy and technical officers can demonstrate their involvement and commitment and engage new partners;
- establishing incentives or recognizing the importance of HiAP in:
 - documents, speeches, and sponsorship of multisectoral activities;
 - reward mechanisms for supportive multisectoral collaboration, including recognizing specialist HiAP skills and abilities;
 - introducing HiAP performance indicators for leaders at all levels.

Examples of implementation of leadership at all levels include the following:

- In Australia, South Australia established a network of HiAP champions working across government to share knowledge and build capacity for collaborative action.
- Bhutan applies a HiAP approach through leadership and governance of the Gross National Happiness strategy. The strategy has four pillars: good governance, sustainable socioeconomic development, preservation and promotion of culture, and environmental conservation.
- In the United Kingdom of Great Britain and Northern Ireland, Wales established a Future Generations Commissioner to facilitate delivery of the well-being goals outlined in its Wellbeing of Future Generations Act.

2.2.3 Pillar 3: ways of working and work methods

Ways of working consist of the attitudes, mindsets, behaviours and practices used to collaborate with partners. They include the tools and processes used to implement, embed and sustain multisectoral action. Effective communication, working collaboratively in partnerships, and understanding the drivers and agendas of partners are all important ways of working. They are fundamental to the establishment and maintenance of trusting, respectful relationships. It is important throughout to use the experiences of working together and respectfully negotiating different agendas and priorities to demonstrate the value of collaboration.

Element 3.1: developing collaborative partnerships built on trust and maintaining open communication

As HiAP is based on the concepts of mutuality and reciprocity, the nature of relationships and partnerships, from long-term partnerships to networks and informal exchanges, is crucial. Formal and informal structures and mechanisms and flexible methods and tools are essential for partnerships to flourish. Open, trusting relationships and communication hold partnerships together. Without trust and open communication, collaboration is not viable. Longer-term plans for collaboration between partners recognize that collaboration is an emergent process, with shared responsibility and accountability for achieving agreed outcomes.

Element 3.2: understanding the policy priorities of partners and co-designing policy and project plans

To work across sectors, policy officers must know and navigate their agencies' interests and priorities and understand the motivations and interests of other agencies. It is not unusual for this to create tensions within government, with the emergence of conflicts about values and diverging interests. Co-design of policies, projects and activities can promote understanding and trust to discuss and resolve issues as they arise and ensure a clear direction for policy. A positive attitude to engagement and communication is more likely to result in the acceptance of common goals as envisaged by the leadership.

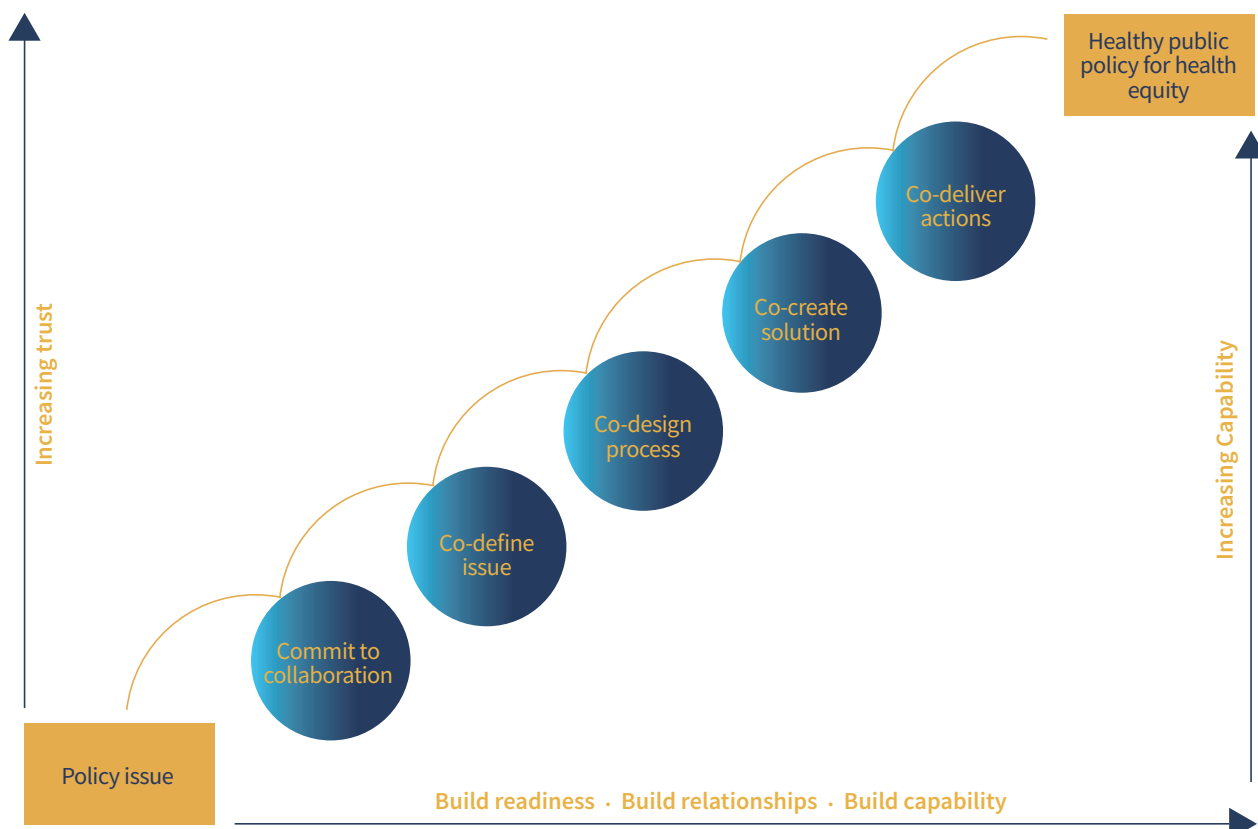
Fig. 4 visualizes the pathway to collaborative governance, built on steps that include co-design.

Actions to support

Actions for improving new ways of working include:

- promoting behaviour necessary for HiAP activities, such as listening to and understanding the perspectives of partners;
- co-designing all aspects of collaboration for co-benefits;
- identifying issues where potential conflicts of interest may emerge and being prepared to negotiate;
- being flexible, agile and adaptable to context by responding to the political and organizational environment and the situation;
- using communication tools and joint plans to clarify, ensure transparency and build trust in the collaboration;
- creating platforms for policy dialogue and problem-solving with other sectors to foster a culture of trust within and among agencies;
- engaging in formal and informal activities to nurture relationships with people in other sectors and ministries;
- creating or participating in knowledge exchange or networks with policy officers and practitioners in other government sectors;
- taking on multidisciplinary and participative evidence-informed approaches such as using literature reviews, focus groups, citizens’ juries and workshops to build shared knowledge and evidence for policy options and strategies.

Fig. 4. Collaborative governance pathway



Source: adapted from Government of South Australia, Global Network for Health in All Policies. Global status report on 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>).

Examples of implementation for ways of working include the following:

- In Australia, the South Australian HiAP approach comprises a collaborative co-design, co-benefit approach to partnerships that ensures a shared vision and ownership by actors founded on a memorandum of understanding.
- In Ecuador, the city of Quito fosters community development teams to bring the voice of local community to decision-making processes for the creation of healthy environments, which aim to close the gap in health inequalities.
- In New Zealand, the development of a joint plan across agencies in Canterbury was critical for supporting HiAP implementation to update the Greater Christchurch urban development strategy.
- In Thailand, the National Health Assembly promotes the involvement of civil society, clearly demonstrating how community involvement in decision-making can result in meaningful responses to community-identified needs.
- In the United Kingdom, Wales includes in its Wellbeing Act five ways of working: balancing short-term needs with long-term needs; integrating health and well-being objectives with well-being goals and objectives, and the objectives of other public bodies; involving people with interest in achieving well-being goals; acting in collaboration with any other person who could help to meet its well-being objectives; and preventing problems to help public bodies meet their objectives.

2.2.4 Pillar 4: resources, financing and capability

There is a common misperception that cross-sectoral work can be carried out without particular resources, finances or training and development on dealing with the determinants of health and health equity. For a short burst of activity on intersectoral work, it may be possible to load extra duties on to existing staff. Sustaining momentum and building up the required trust across actors, who may change over time, requires a resources strategy and consistent investment, however, including training of staff. The resources for HiAP include appropriate, dedicated personnel and financial resources, comprising a dedicated HiAP budget and mechanisms for matching the budget with those of partners to support co-production.

Element 4.1: dedicated HiAP roles

Dedicated roles are important for HiAP activities and approaches. Allocation of sufficient appropriate resources is important for collaboration. One or more staff members should be responsible for overseeing day-to-day management and implementation of HiAP activities as their primary role, so they have sufficient time to prioritize these activities. Dedicated resources, particularly staff time, are essential for collaborative relationships.

Element 4.2: dedicated HiAP budget

The budget should be clearly aligned with common goals. Dedicated budgets should be available to develop or strengthen capabilities, including skills and knowledge of HiAP practitioners, such as in health diplomacy and negotiation. Resources and capabilities are essential for HiAP activities.

HiAP does not require large amounts of funding, but it takes time and some financial resources for collaborative work. The funds could include an allocation from the ministry of health to convene workshops, collect evidence, develop communication materials and reports, and establish HiAP training programmes.

As the HiAP partnership matures, shared HiAP budgets should be available to ensure sustainability. Funds should be available to establish and maintain a network of HiAP champions (e.g. policy officers in different sectors) to build capability across government and to sustain the collaborative approach. Box 8 summarizes the key issues related to joint budgeting and financing.

Box 8. Addressing and foreseeing challenges of joint budgeting and financing

The structure of a country's budget, both horizontally, across sectors, and vertically, across central to local subnational administrations, can place constraints on or help to facilitate multisectoral collaboration.

Two types of situation commonly present. First, when financing is spread across different sectors, it may lead to fragmented approaches to identifying beneficiaries and services, with inefficient means to achieve intended results. Second, difficulties may arise when linking spending and health priorities with budgets structured around inputs and administrative units. This latter difficulty requires budgeting and financial systems that allow identification of common functions and impacts across different administrative units, based on a sound understanding of the links between different activities and the governance and accountability structures within them.

Budgeting mechanisms that allow for improvements in coordinated investments or improved cooperation in addressing SDH are essential. Joint budgeting and financing mechanisms facilitate and sustain collaboration across policy sectors and are important for achieving key impacts.

Addressing fragmentation and supporting better coordination of services is likely to involve changes to (or within) public financial management and budgeting systems to allow funds to flow to shared functions. Additional institutional arrangements that shift responsibility and accountability may also need to be shared across government – any adjustments here need to be supported by the attention to governance arrangements that can underpin this, such as the use of a memorandum of understanding, or the linkages and ownership of common indicators of impact or service across more than one ministry.

Addressing budgets and accountability can be difficult from a political perspective and should be dealt with sensitively. In general, the relationship between health and other sectors has as an endpoint not extending the health budget, but rather allowing health targets to be associated with actions in other sectors where these actions are reinforced by evidence of their health and health equity impacts.

The case of fragmented budgets is more sensitive. Again, the solutions do not necessarily require removing budget from a particular agency but rather improving coordination based on a common impact theory grounded in the SDH evidence. Nonetheless, potential complications may arise where, as in many low- and middle-income countries, the coordinated activities have direct implications for how donor funds are pooled and used to enable cross-cutting investments. Here, the case for improving impact should be shown clearly through narratives describing why addressing social determinants can lead to better co-benefits for health and other sectors. Issues related to on-budget financing (funding that runs through government public financial management systems), flexibility to invest across diseases and sectors, and time horizon considerations are all critical areas that should be addressed when re-examining how donors provide financial support to countries.

In some cases, consolidation of financing and authority for particular areas of work that emerge from multisectoral collaboration may be warranted and involve establishing new institutions. For examples, see *Leveraging PFM for Better Health in Africa* (48) and *Budget Matters for Health* (49).

Source: adapted from Sparkes SP, Kutzin J, Earle AJ. Financing common goods for health: a country agenda. *Health Syst Reform*. 2019;5(4):322–333.

Element 4.3: capabilities to act on determinants and translate knowledge

The development of capabilities in the health workforce is a recurring theme within WHO guidance documenting the need for inter- and multisectoral action. The Framework for Action across Sectors (see Annex 1) made this area of “capacity building” one of the six core areas. The following areas of capability strengthening are fundamental to sustaining HiAP:

- Systems for knowledge generation and translation for HiAP activities: development and implementation of a HiAP approach often require practitioners to change their work habits, develop new or refine existing processes, and view government business and activities differently. Practitioners need to keep informed about the evidence base on the SDH and impacts on health equity, as well as how to operationalise SDH and HiAP strategies. Knowledge also refers to knowledge on working intersectorally. Leaders identify and create opportunities to support others within their circle of influence to gain their confidence and skills to work collaboratively through mentoring and other means for developing capability.
- Links with networks outside government: policy decisions for successful, sustained HiAP action not only are influenced by government but also require engagement with professionals and practitioners in nongovernmental and academic sectors. Investment in collaborative relationships with academics and professionals outside government can ensure timely access to evidence and the perspectives of people working in different fields.

Actions to ensure resources, financing and capabilities

Implementing new ways of working for collaborative action requires:

- dedicated personnel with knowledge and experience in multisectoral activities, programmes or initiatives (Box 9);
- establishing cross-sectoral action teams or working or technical groups to pool intellectual resources, integrate multidisciplinary research and share practices;
- training or mentoring programmes or other opportunities to enhance knowledge and experience in HiAP activities;
- dedicated funding for multisectoral action from the budgets of both the health sector and other government agencies;
- strategically built capacity for HiAP practice.

Box 9. Capabilities necessary for practitioners of HiAP

- ➔ A good negotiator can prioritize the core requirements (the practitioner’s or their agency’s) and determine which elements can be negotiated; assess the requirements of other agencies; and enter into discussions with a clear understanding of how to manage conversations and reach agreement on mutually agreed priorities.
- ➔ An excellent listener spends more time listening to partners or potential partners than speaking, and knows that understanding the partner’s position is critical to success.
- ➔ A good facilitator helps partners articulate their views and positions, identify consensus or disagreement, and find solutions.
- ➔ An innovative practitioner values innovation and is prepared to try new approaches and take risks by questioning the status quo, observing, experimenting and networking.
- ➔ An intrapreneur (“inside entrepreneur”) exercises initiative and pursues opportunities, strategically assesses the political environment, and finds how best to take advantage of opportunities as they present with an entrepreneurial spirit.

- ➔ An excellent communicator has strong verbal and written communication skills.
- ➔ A relationships-builder demonstrates the importance of building and maintaining relationships with the team and across sectors.
- ➔ A systems thinker takes a holistic approach to analysis to identify a system's constituent parts and their interrelations, and how systems work over time and in larger systems.
- ➔ A respectful practitioner values diversity and recognizes the importance of drawing on a wide range of skills.
- ➔ A practitioner who is able to compromise recognizes there is no point in being rigid in a collaboration.
- ➔ A practitioner with strong political acumen is conscious of politics within and between agencies and also the political environment in which the government operates.

Examples of implementation of resources, financing and capabilities include the following:

- In Australia and the United States of America, small HiAP teams were established in South Australia and California to initiate and establish the approach. The teams are modified and adapted over time according to political drivers and administrative requirements.
- In South Australia, links with academia from the outset of the HiAP approach provided evidence when necessary and reinforced the value of the approach to the government.
- Finland draws on an extensive research network to inform HiAP action at various levels of government.
- In Slovenia, before starting any multisectoral action, a capacities assessment is conducted to understand the current and needed resources and capabilities.
- International organizations such as WHO, with support from governments, bring together networks of key actors to deliberate and distil the research – for example, national commissions on SDH have been held in various countries across WHO regions.

2.3 Case studies constructed around the four HiAP pillars

The examples selected in this section aim to show how the different pillars of the new HiAP model are brought to life in practice. Both countries have HiAP models that are mature and established, having been run for more than a decade.

The examples were selected for several reasons. Both jurisdictions have sustained multisectoral collaboration for health for more than a decade in diverse contexts. The experience in California is set in the context of high social inequalities and a socioeconomic and health system context dominated by a strong private sector. The dominance of the private sector is a feature of the mixed economy context that many countries can relate to as well as its large inequalities. Nonetheless, in this model, the outlay on the HiAP approach is relatively small and could be considered feasible in many other contexts.

The example from Thailand used a bottom-up approach to HiAP. In this context, the investment in HiAP has likely been proportionately larger than in the Californian example – but it has been sustained over a long period, and it occurs in the context of a less industrialized country that has continued to emphasize expansion of universal health coverage with the primary health-care approach.

Ultimately, it is not possible to maintain brevity in the guidance while providing examples that can be applied more directly to every different context. The aim is for several elements of each example to resonate for policy-makers from different contexts.

2.3.1 Example of California, United State of America

California is the largest and most diverse state in the United States. It has a population of nearly 40 million people, and it has no single racial or ethnic majority. It has significant health equity and racial equity challenges, including climate disasters such as extreme droughts and wildfires, high rates of chronic disease, and large inequities along racial, gender and socioeconomic lines.

The four pillars of HiAP are clearly illustrated through the California HiAP Task Force. This state-level Task Force, established through executive action (an order of the Governor) in 2010, engages leadership at a wide range of levels, relies on a culture of trust and collaboration, and has systematically pursued strategies to institutionalize its work in the California State Government. The HiAP Task Force is staffed through a collaborative relationship between the cabinet-level Strategic Growth Council, the California Department of Public Health, and the nongovernmental organization Public Health Institute.

The HiAP pillars discussed in this guidance have been consistently present over the Task Force's nearly 12 years, as its work has evolved from a focus on SDH and equity to an explicit focus on addressing structural and institutional racism as the key drivers of health inequities. In 2020–2021, in response to lessons learnt through the COVID-19 pandemic and nationwide protests for racial justice, the Task Force conducted a stakeholder planning process that has led to a 2022 relaunch with a new commitment to using the Task Force's cross-sectoral convening capacity to address the structural barriers that many Californians face in accessing healthy, racially just and resilient community services.

The following examples show how the four pillars of the new HiAP model appear in the operations of the California HiAP Task Force:

- **Governance and accountability:** the Task Force was established in 2010 through a Governor's Executive Order (S-04-10), affirmed by the legislature in 2012, and subsequently affirmed through a budget act in 2019 that formally committed Government-funded staff positions for continued work. Funding requirements and public accountability mechanisms have ensured priorities are driven by public input, and ensured a whole-of-government approach, which is unusual in the United States. Reporting up through a cabinet-level council has been critical for ensuring leadership support and public transparency.
- **Leadership at all levels:** a blend of government and nongovernment leadership has been critical for success. Within the Government, executive leaders lend political support to health and racial equity issues, while subject matter experts bring experience and solutions-oriented approaches as members of the Task Force. Outside the Government, advocacy groups, community members and nongovernmental organizations shape priorities, guide solutions, demand transparency and hold the Government accountable.
- **Ways of working:** the Task Force is built on trust, collaboration, co-benefits and co-design. This has been particularly important due to the lack of legislated mandates for participating organizations and limited funding for this work. Every participating entity must benefit to remain involved. This way of working includes involvement of civil society. As the Task Force affirms its focus on racial equity, it is taking steps to further centre the voices of affected communities.
- **Resources, financing and capabilities:** backbone or facilitation staff of the HiAP Task Force come from three separate organizations – the cabinet-level Strategic Growth Council, the non-profit-making Public Health Institute, and the California Department of Public Health. Each of these organizations has a different role in the partnership based on strengths and positionality. The Strategic Growth Council leverages the connection with the Governor's Office for executive-level support. The Public Health Institute connects with outside advocate groups and community-based organizations for grassroot support. The Public Health Institute and the California Department of Public Health both bring public health expertise. The California Department of Public Health connects the Task Force with local health jurisdictions. Building the case for Government-funded HiAP positions has been essential for the staffing of this initiative and a key programmatic outcome of normalizing the concept of an all-of-government approach to health and racial equity.

For more on the California HiAP Task Force, see Chapter 4 of Progressing the Sustainable Development Goals through Health in All Policies.

2.3.2 Example of Thailand

Thailand is a middle-income country in Asia with a population of about 70 million people. Thailand is renowned for its universal health care programme and success in child nutrition, but it faces several challenges in addressing SDH. Thailand's National Strategy has identified equity as one of its key challenges for sustainable development. Types of inequity include urban/rural, informal/formal employment, and wealth, education and exclusion of marginalized groups such as migrants.

The concept of HiAP has been applied in Thailand since the primary health care era, as witnessed in development and application of the Basic Minimum Needs Survey to evaluate quality of life of people for economic and human development planning purposes. This nationwide survey is a collaboration of four ministries – health, education, agriculture and interior. Institutionalization of the HiAP concept in Thailand is concrete, however, because of the promulgation of the National Health Act in 2007. The Act demonstrates the four pillars of HiAP:

- **Governance and accountability:** according to the Act, the National Health Commission is established and mandated to provide recommendations on health policies and strategies to the Cabinet. This multisectoral mechanism is chaired by the Prime Minister and consists of six ministries, local government, civil societies, academia and health professional institutes. The National Health Commission Office (NHCO) is formed as a secretariat of the Commission, to facilitate collaboration among Government agencies, the private sector, academia and civil societies for participatory public policy development. NHCO is therefore under the Office of the Prime Minister. In addition, regional health commissions for people are subsequently established to strengthen multisectoral collaboration of the clusters of provinces and set strategies in response to the need of the people of each region.
- **Leadership at all levels:** NHCO creates multisectoral mechanisms and platforms at all levels. As well as the mechanisms mentioned above, the National Health Assembly and provincial health assemblies bring together various sectors and stakeholders to interact, discuss complex problems and collectively find solutions. The resolutions of the health assemblies are submitted to relevant Government agencies. Implementation of the resolutions by all sectors involved is encouraged, however. Although the National Health Assembly is organized by NHCO through the organizing committee, the provincial health assemblies are owned and designed by people in each province. With this way of working, leadership is built at all levels.
- **Ways of working:** a silo working culture can be changed if a participatory mechanism and platform are in place. An interactive and flexible atmosphere with systematic management stimulates exchange of information, increases capability of involved agencies and builds up trust. Various networks are formed after working together, such as a Health Assembly network of each province and a health impact assessment consortium, to pursue their common goal. Engaging civil societies in public policy process assists Government agencies to respond accurately to people's needs and complements Government work by civil societies. Fifteen years of this undertaking have transformed the way of working from a silo mindset mode to a more collaborative mode.
- **Resources, financing and capabilities:** if the law makes HiAP institutionalized in Thailand, resources and financing provide ongoing impetus to make HiAP work. The fiscal budget for HiAP comes from the Government through NHCO. This resource is mostly for conducting a platform for dialogue, goal-setting, joint planning and collaboration. The cost for HiAP programme and project action is commonly shared by relevant agencies. Capability-building is provided to all sectors and stakeholders to understand SDH, participatory public policy process and soft skills. Most training courses therefore involve a mix of participants from different sectors in academia, government and civil society, who subsequently are involved in developing an action plan or forming a network. Informal platforms such as training courses allow participants to meet and network. When they come to work together in a formal platform such as a health assembly or a provincial planning meeting, they do so collaboratively. With continuing advocacy, HiAP is more widely accepted as it is specified in Thailand's 12th National Economic and Social Development Plan (2017–2021) as an approach to reduce health risks and health impacts under the human capability development strategy.

NHCO affirms that these four pillars make HiAP implementation more strategic and sustainable.

For more information on the Thailand experience, see Chapter 3 of Progressing the Sustainable Development Goals through Health in All Policies.

2.4 Conclusion

This document presents key features of the development and implementation of multisectoral collaboration based on HiAP approaches. It uses a new HiAP model to synthesize the lessons learnt on sustaining multisectoral collaboration. It should be interpreted according to the local context and adapted to the prevalent systems and structures.

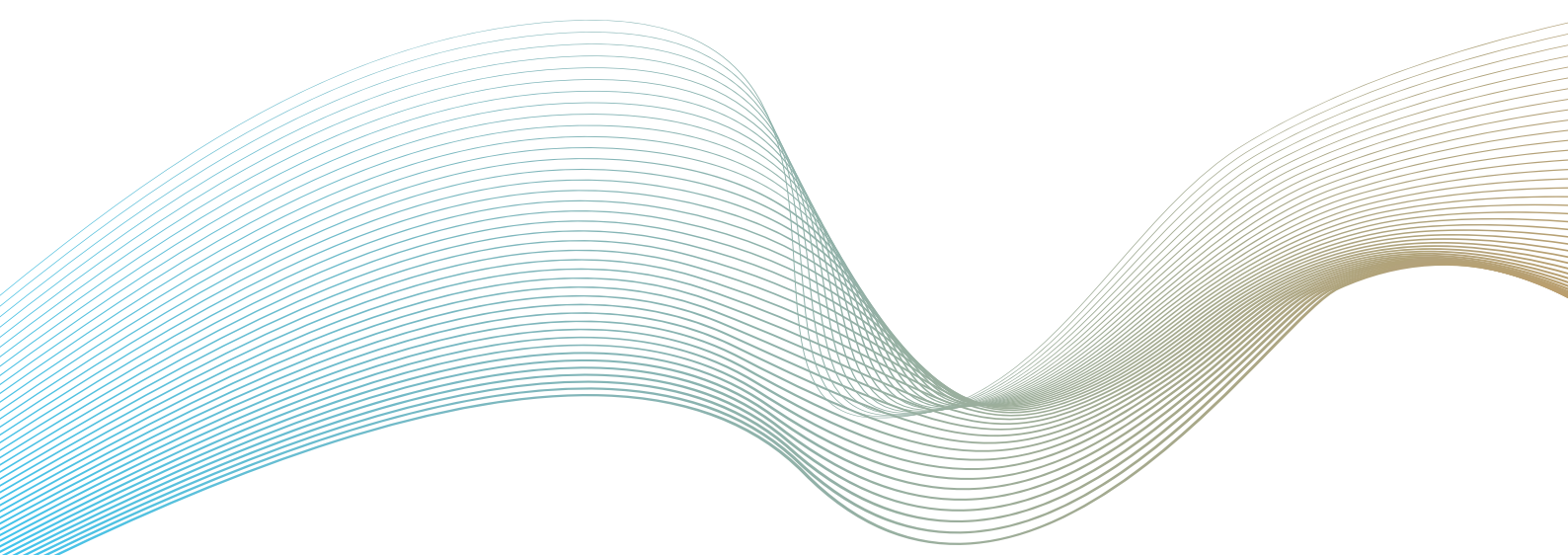
There is no one successful HiAP application of the model: the approach must be modified to each context of government. Although the model focuses on the national, state or province level of the country, city or local government levels can also benefit from understanding the operational elements discussed under the new HiAP model.

The new model introduced in this document, with its four pillars, describes key elements for the delivery of a HiAP approach. It emphasizes the part of the WHO HiAP approach definition that refers to “seeking of synergies” with other government portfolios and sectors beyond the health sector, while not ignoring the many complications that can arise when true conflicts of interest between sectors emerge. Much more needs to be done, however, to explore co-benefits.

Although aiming to support the implementation of comprehensive HiAP approaches to address SDH and health equity – also termed the wider determinants of health – the model with its four pillars can also be used for specific foci, such as noncommunicable diseases, children’s health or tuberculosis.

Depending on the context and time, it may be important for very specific health challenges to be addressed through the collaborative practices described here, but at the same time there remains a longer-term agenda to support processes that deal comprehensively with the interface between health, equity and development.

Developing a HiAP approach can be considered both an art and a science. Successful implementation requires a balance between scientific and technical skills and political intuition, emotional intelligence and creative insight. This document focuses mostly on the operational features, but other political features are also important considerations. HiAP is not a linear, straightforward process. Rather, it is iterative, adapted and strengthened over time, creating a web of HiAP actors across government and beyond to improve health, well-being and equity for all.



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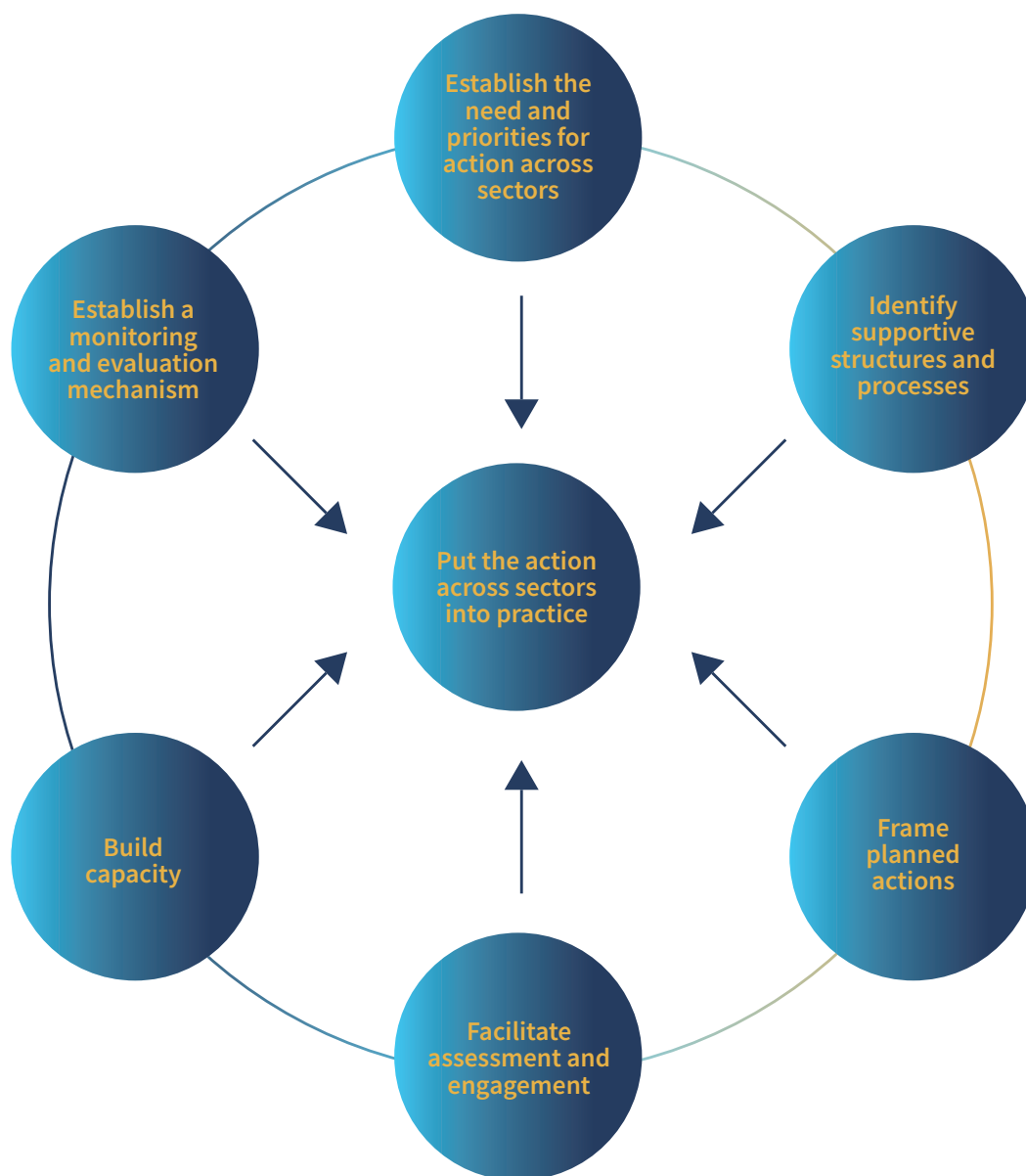
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Annex 1 Summary of 2015 WHO Country Framework for Action across Sectors for Health and Health Equity

This framework was developed following the Helsinki Conference on Health in All Policies and published as an appendix to the World Health Assembly Resolution 68.17 in 2015. The main components of the framework consist of a series of steps and activities to be undertaken to improve intersectoral action for health implementation (Fig. A1.1). These steps and activities can be applied to different intersectoral

Fig. A1.1. Overview of Country Framework for Action across Sectors for Health and Health Equity



Establish the need and priorities for action across sectors

- Ensure there is high-level political will and commitment.
- Build a case for action across sectors, increasing the awareness of decision-makers, civil society and the public.
- Use political mapping.
- Prioritize actions.
- Analyse information about the factors affecting health.

Identify supportive structures and processes

- Strengthen the ministry of health in terms of its capacity to identify and engage with different government sectors, WHO and other United Nations organizations and intergovernmental organizations, and non-state actors.
- Identify the most appropriate facilitating agency to manage, take forward and account for the action across sectors for a given topic or priority.
- Create realistic and functional structures for communication and for working across sectors or use existing structures, where available, with clear roles and responsibilities.
- In countries with a decentralized government structure, consider using the existing inter-territorial coordination mechanisms, ensuring regional and local entities are involved in the process.
- Use legal frameworks, including international treaties, presidential orders and memoranda of understanding to foster intersectoral collaboration.
- Improve accountability and explore available mechanisms for scrutiny within the legislative process, such as oversight committees, public hearings, issue-based groups and coalitions, and public health reports to legislatures.

Frame planned actions

- Identify and review the data available for a given issue – this will include a legal and policy analysis and a summary of available evidence-based interventions.
- Identify existing action plans, policy documents and mandates of the different sectors involved to determine synergies and develop a common plan that ascertains community and systems changes to be sought and who will do what.
- Define and agree on objectives, targets, indicators, population coverage, roles and responsible agencies and individuals, timelines, resources and a contingency plan.
- Ensure adequate human and financial resources – although an increase in staff might not be necessary, changes in job practices may be required.
- Develop a strategy to identify, prevent or counteract conflicts of interest.
- Develop a strategy to report the results and give adequate feedback to all sectors involved, and to the general public.
- Develop a monitoring and evaluation strategy with input from all sectors involved, including a health impact assessment.

Facilitate assessment and engagement

- Use appropriate tools such as health and health equity impact assessment, health and health equity lens analysis, policy audits and budgetary reviews to assess the health impact of policies.
- Create an inclusive policy-making process that includes key people, civil society groups, associations of health-care professionals, community leaders and individuals, and clients who are likely to be affected by existing or proposed policies.
- Identify people involved in decision-making or policy implementation, and invite them to engage in the dialogue to understand their priorities and recommendations.
- Specifically identify opportunities to engage with non-state actors, including academia and professional associations, to seek assistance with assessment and engagement processes, and with the private sector, to facilitate shared understanding of the health agenda.

Establish a monitoring and evaluation mechanism

- Start planning for monitoring and evaluation early in the process and, where appropriate, develop an evaluation framework.
- Identify and agree on shared meaningful indicators.
- Incorporate monitoring and evaluation throughout the action process.
- Establish the baseline, targets and indicators, as appropriate. For intersectoral action, these can be formal indicators and performance targets (on health status, on health inequities and their determinants, and on health action).
- Obtain data that can provide estimates for the different subpopulations, especially for vulnerable groups. Consider whether disaggregated data (including data on determinants of health) can be included.
- Carry out agreed monitoring and evaluation activities according to negotiated schedules.
- Ensure reporting mechanisms are not too demanding for participants, to avoid compromising implementation.
- Measure co-benefits and provide evidence to support future cooperation among sectors.
- Disseminate results and lessons learnt to all participating sectors, to provide feedback for future policy and strategy rounds.

Build capacity

- Encourage sectors to share and exchange skills and resources for capacity-building.
- Promote the formation of communities of practice.
- Build capacity on research and innovation – for example, on the use of new technologies for disease prevention and treatment.
- Build capacity on innovative financing or existing financing mechanisms to ensure long-term sustainability.
- Develop diplomacy and negotiation skills, which are invaluable to successful action across sectors. These skills are often acquired through specific training focused on action across sectors.
- Encourage sectors to put in place and implement strong accountability mechanisms.

Annex 2 Functions and characteristics of governance for equity in health

Table A2.1. Systems for health equity governance: domains and actions

System characteristic	Exemplified by
Domain 1: political commitment	
Clear political commitment to address SDH equity	<p>Ministerial accountability for governance and delivery of SDH and health equity</p> <p>Specific political roles for SDH and health equity at national, regional and local levels</p> <p>Cross-government committee for social determinants and equity</p> <p>Explicit budget for SDH and health equity Institutional and legislative framework for equity in health and development</p>
Domain 2: intelligence	
Evidence and information to:	
→ inform policy and investment decisions	SDH and health equity as core work and funding stream in research budgets
→ monitor progress	SDH and health equity systematically reviewed and publicly reported
→ hold stakeholders to account for: <ul style="list-style-type: none"> - research and intelligence on SDH and health equity trends and policies - effectiveness of governance and delivery systems - metrics (targets and indicators for improvement in health equity and distribution of social determinants at national and local levels) 	<p>Dedicated health intelligence and analysis services producing open access data</p> <p>Input, output and outcomes data published on SDH and health equity at local, national and regional levels</p> <p>Agreed minimum datasets and reporting requirements, on social determinants, equity and health inequities at national and local levels</p>

System characteristic

Exemplified by

Domain 3: accountability structures and systems

Legislative structures and systems enabling intersectoral action on social determinants and health inequities at regional, national and local levels

Legal framework involving duty placed on all health and non-health stakeholders to collaborate and report on SDH and health equity actions and outcomes

Statutory governance boards capable of holding all stakeholders to account

Community health status and outcome boards established with explicit power to review data and progress of policies, review options and solutions for improving health equity, and hold all stakeholders to account

Legislative structures and systems enabling formation and action of nongovernmental organizations and civil society groups as partners in action to reduce inequities and monitoring progress

Statutory roles with formal duty to reduce inequities through action on social determinants, empowered to publicly mandate action at regional, national and local levels (public health minister, chair of parliamentary development committee, prime minister, ombudsman)

Domain 4: policy coherence across government sectors and levels

Formal and explicit framework setting out stakeholders and policy action for improving equity in health and development

Coherence of sectoral actions (national and local) on agreed SDH and equity targets

Framework linked to ministerial portfolios and budgets, nationally and locally

Outcomes explicitly defined for all government and sectoral spending, nationally and locally

Government policy audited through health impact assessment and equity impact assessment

Specific agreements with private sector (industry and commerce) on their contribution to delivering equity targets

Outcomes assessed and published by all ministries and directorates at all levels of governance

System characteristic

Exemplified by

Instruments that institutionalize collaboration across sectors and levels of government

Impact assessments (which should be public domain documents) changeable through accountability mechanisms

Systems for joint accounting for results in place, including pooled budgets, shared targets, joint review and reporting on progress, integrated intelligence systems

Domain 5: involving local people

Commitment to participation of local people and subnational authorities in policy design and review

Mechanisms, organizational design and capacity-building to enable diversity of voices and perspectives from community and local level in local decision-making and solutions

Instruments and systems that secure community involvement in solutions

Representatives at all levels of SDH and health equity governance, who should be equal members alongside professional members of decision-making committees

Tools, instruments and support at local level to define local problems and solutions, informed by local data

Intelligence and data on health, equity and social determinants made accessible within public domain, locally, nationally and regionally

Public reporting of actions and progress to allow access to and debate on results and new challenges, by and with community and third parties

Domain 6: institutional and human resource capacity

Capacity development, including:

- ➔ development of competent and trained SDH and health equity staff
- ➔ institutional processes
- ➔ formal accountability, annual publishing of progress results

Programmes supporting political, civic and professional leadership of SDH and health equity within different institutional and social systems of society, locally, nationally and regionally

Curriculum modules on equity, health and social determinants in professional and vocational training, within and outside health sector

Formal protocols defining institutional arrangements and expectations related to SDH and health equity in all sectors

System characteristic	Exemplified by
Domain 7: modernized public health	
Review and modernization of public health training and practice	<p>Revised descriptors and competences for national public health practice</p> <p>Revised descriptors for domains of public health intervention (with increased focus on use of new social media technology, management of social change and citizen mobilization)</p> <p>New or updated training for public health professionals</p>
Domain 8: learning and innovation systems	
Commitment to continuous improvement in understanding of social determinants, equity and efficacy of policies and interventions to reduce inequities	<p>Stronger learning transfer systems within and between countries to accelerate uptake of promising policies and governance instruments</p> <p>Enriched national and regional capacity to tackle inequities in health through establishing multi-country innovation programmes, live demonstration sites and exchanges, and documented and disseminated learning</p>
Commitment to ongoing performance review and improvements in governing for equity in health, through action on social determinants	Established regional registry of policies and governance systems addressing inequities through action on SDH

Source: Brown C, Harrison D, Burns H, Ziglio E. Governance for health equity: taking forward the equity values and goals of Health 2020 in the WHO European Region. Copenhagen: World Health Organization Regional Office for Europe; 2014 (https://www.euro.who.int/__data/assets/pdf_file/0020/235712/e96954.pdf).

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[https://www.who.int/health-topics/
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[https://www.who.int/health-topics/
health-equity](https://www.who.int/health-topics/health-equity)

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promoting-health-in-all-policies-and-
intersectoral-action-capacities](https://www.who.int/activities/promoting-health-in-all-policies-and-intersectoral-action-capacities)

