HEALTH IN ALL POLICIES

TRAINING MANUAL

World Health Organization

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WHO Library Cataloguing-in-Publication Data:

Health in all policies: training manual.

1.Health Policy. 2.Health Status Disparities. 3.National Health Programs. 4.Teaching Materials. I.World Health Organization.

ISBN 978 92 4 150798 1 (NLM classification: WA 525)

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Editor: Vivien Stone.

Design and layout: L'IV Com Sàrl, Villars-sous-Yens, Switzerland.

Printed in Italy.

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ACKNOWLEDGEMENTS

The main developers of this training manual were Professor Ilona Kickbusch and Mr Callum Brindley, with key contributions from Ms Carmel Williams (Government of South Australia) and Ms Nicole Valentine (WHO, Geneva). Ms Nicole Valentine, of the Social Determinants of Health Unit, coordinated the development of the manual for WHO. Ms Anjana Bhushan, of the WHO Western Pacific Office, played a lead role in the concept's development and testing.

This work would not have been possible without drawing on the wealth of experience shared by colleagues in books, papers and articles culminating in the 8th Global Conference on Health Promotion in Helsinki on "Health in All Policies". This included the regional case studies work of WHO supported by Rockefeller grant 2012 THS 317, which was led, in the different regions, by Dr Davison Munodawafa, Dr Peter Phori, Dr Savajee Good, Dr Bhushan and Ms Britta Baer. From a historical perspective, this manual pays homage to the work of many WHO staff who have strived over the past three decades to promote intersectoral action in health and other development sectors, both within countries and internationally.

Dr Rüdiger Krech, Dr KC Tang, Dr Timo Stahl, Dr Douglas Bettcher, Dr Good, Dr Munodawafa, Dr Phori, Dr Haifa Husni Madi and colleagues, Ms Isobel Ludford, Mr Paul Stendahl Dy and Mr Julian Kickbusch provided valuable inputs and feedback during various stages of development of the manual. The contributions of the faculty and participants of two HiAP training courses in Adelaide and Manila that helped refine the participatory approach of this training manual are also gratefully acknowledged. Particular thanks are owed to the Government of South Australia for the early learning derived from the Health in All Policies Summer School in 2011, with particular mention in this regard of Dr Kevin Buckett, Ms Deborah Wildgoose and Amy Sawford. For the HiAP training course in Manila, special thanks are paid to Katrin Engelhardt of the WHO Western Pacific Regional Office, and the Philippines WHO country office team.

The publication was edited by Vivien Stone and designed by L'IV Communications Sàrl.

ABBREVIATIONS

AVN	value-added negotiating
CSDH	Commission on Social Determinants of Health
DALY	disability-adjusted life year
FCTC	Framework Convention on Tobacco Control
GBD	global burden of disease
GHO	WHO Global Health Observatory
HIA	health impact assessment
HLA	health lens analysis
IHME	Institute for Health Metrics and Evaluation (USA)
IHR	International Health Regulations
ILO	International Labour Organization
IMR	WHO Indicator and Measurement Registry
M&E	monitoring and evaluation
NCDs	noncommunicable diseases
NHA	National Health Accounts
ODI	Overseas Development Institute (UK)
OSH	occupational safety and health
PPP	public-private partnership
RWJF	Robert Wood Johnson Foundation (USA)
TOR	terms of reference
UHC	universal health coverage
UNSD	United Nations Statistical Division

ICONS/SYMBOLS USED IN THE MANUAL

Key reading for participants

Supporting material for instructors

Teaching resources/handouts

OVERVIEW

Purpose of training manual

The purpose of this manual is to provide a resource for training to increase understanding of Health in All Policies (HiAP) by health and other professionals. It is anticipated that the material in this manual will form the basis of two- or three-day workshops, which will:

- Build capacity to promote, implement and evaluate HiAP;
- Encourage engagement and collaboration across sectors;
- Facilitate the exchange of experiences and lessons learned;
- Promote regional and global collaboration on HiAP; and
- Promote dissemination of skills to develop training courses for trainers.

It is envisaged that these workshops will be held regionally and in-country, often with the support of the WHO. At the same time, using its global platform, the WHO will support the development of training standards globally, through levers of change such as training of trainers courses and curriculum changes in schools.

The training manual target audience is universities, public health institutes, non-governmental organizations, training institutions in government and intergovernmental organizations. The training is structured to target professionals from middle to senior levels of policy-making and government from all sectors influencing health. These include health, employment, housing, economic development, finance, trade, environment and sustainability, social security, education, agriculture and urban planning. Depending on the content, it would also be advisable to include participants from civil society.

Summary of contents

This HiAP training includes 12 modules consisting of interactive lectures and group activities.

MODULE		OVERVIEW
1	Introduction and the determinants of health	Greetings, outline of the course and initial introduction to HiAP and the social determinants of health.
2	21st-century health dynamics and inequality	Introduces participants, especially those from a non-health background, to facts about the burden of disease and contemporary socioeconomic trends such as globalization and urbanization that impact on population health and health inequities.
3	Heath in All Policies (HiAP)	Outlines the history, rationale and principles of the HiAP approach.

4	The policy-making process	Details the policy-making process in relation to HiAP including topics such as the framing of issues and managing complexity.
5	The role of government in HiAP/whole-of-government approaches	Explains the role of government in promoting, implementing and evaluating HiAP including mechanisms by which different government departments or sectors can collaborate to improve population health.
6	Preparing policy briefs	Reviews the qualities of effective written communication and provides participants an opportunity to refine these skills by preparing and presenting a HiAP policy brief.
7	The role of non-government stakeholders in HiAP/whole-of-society approaches	Introduces participants to the concept of whole-of-society HiAP approaches and the importance of engaging multiple stakeholders including civil society and industry.
8	Negotiating for health	Details important considerations for conducting successful HiAP negotiations and prepares participants to use this knowledge through a role play.
9	HiAP implementation at local, regional and global levels	Elaborates, using case studies, some of the ways HiAP is being successfully implemented at local, regional and global levels.
10	Measuring progress in health	Discusses issues related to monitoring and evaluating changes in population health due to effective public policy including introducing participants to tools such as health impact assessments and health lens analysis.
11	The leadership role of the health sector in HiAP	Highlights the critical leadership role of the health sector in promoting HiAP.
12	Next steps and round up	Recaps the key messages of the workshop and proposes ways in which participants can apply their learning in practice.

Additional modules

While we have tried to include as much material as possible, there are inevitably issues that can always be further elaborated upon. Should countries or regions want to expand this manual, the following supplementary modules or themes for further consideration would represent valuable additions.

- Economics of the social determinants of health;
- Intersectoral goals that contribute to health;
- Public health legislation and human rights;
- Private sector accountability incentives; and
- Public health ethics.

Module components

Modules in this training manual consist of the following components:

- Time schedule;
- Learning objectives;
- Key messages;
- Key reading for participants ;
- Supporting material for instructors ;
- Lectures;
- Group activities;
- Handouts ; and
- Group discussions.

The beginning of each module also provides suggestions to instructors on how to structure the workshop session and manage time. It is strongly hoped that instructors in different regions and countries will adapt and supplement the teaching material and course structure to suit their specific context and audience.

In addition to suggested teaching materials and key messages, this training manual contains a variety of case studies highlighting HiAP in practice from low-, middle- and high-income countries across the WHO regions. These are examples only and we suggest that instructors actively search for good case studies that reflect their own context and the experience of the participants. Participants will also be introduced to a number of policy tools for implementing HiAP including how to conduct a stakeholder analysis, carry out negotiations and prepare a health impact assessment (HIA).

The appendices to this training manual include a list of the learning objectives, a summary outline for each module, a full reading list for participants ( ), supporting material for instructors ( ), course evaluation forms and a glossary. The appendices also include a lengthy section of teaching resources/handouts ( ).

Educational approach

This training manual was prepared with the belief that workshop participants would gain the most from a "learning-by-doing", "participatory" pedagogy. That is to say, the modules emphasize group discussions and group activities to allow participants to build on and apply their knowledge and experience. Each module contains suggested teaching materials including handouts. However, instructors are encouraged to adapt and supplement the course to make it more relevant to the specific backgrounds and experience of the participants. Depending on the situation, instructors might want to expand the time allocated to lectures or to discussions. Our suggestions are indicative only.

WHO HEALTH IN ALL POLICIES TRAINING COURSE OPTIONS

1: Executive course for politicians and senior policy-makers

Many of the factors that influence a person's health and well-being, such as their education level, income, housing and work conditions are determined by social, environmental and economic policies beyond the direct control of the health sector. Thus, government policies and decisions made in all sectors and at all levels of government can have a significant impact on the health of the population, and in particular on equity in health. "Health in All Policies" (HiAP) is an approach that promotes collaboration between government sectors and non-government stakeholders to maximize the health benefits of government policies and reduce health inequalities such as differences in life expectancy. It is also an approach that aims to minimize any harmful consequences of public policies on determinants to health and health systems. The World Health Organization defines Health in All Policies as referring to "taking health implications of decisions systemically into account in public policies across sectors, seeking synergies, and avoiding harmful health impacts, in order to improve population health and health equity through assessing consequences of public policies on determinants of health and well-being and on health systems." (WHO WHA 67.12 2014).

With the growing problem of noncommunicable diseases and the increasing costs of health care, a healthy population is an important goal with benefits for all: healthy children are better able to learn; a fit and able workforce is more productive; and a country with good health is more stable politically and economically. HiAP promotes co-benefits, while also recognizing that when trade-offs are made, it is possible to avoid harmful impacts on health and health care systems. This executive course aims to provide participants with the knowledge and skills to promote health and its benefits at the highest levels of government. The course focuses on strategic communication, collaboration and networking, negotiation skills and leadership. A longer course for policy and programme managers that focuses on the implementation and evaluation of HiAP is also available.

Content overview

At the end of this executive course, politicians and senior policy-makers will have the necessary knowledge and skills to strategically promote and implement Health in All Policies. Participants will learn to:

- Identify the socioeconomic and environmental factors that influence health;
- Describe some of the major contemporary health challenges;
- Recognize the complex and political nature of the policy-making process;
- Identify the characteristics of a "window of opportunity" for policy change;
- Frame a complex health issue and identify its policy challenges and opportunities;

- List principles for effective and accountable stakeholder consultation;
- Identify mechanisms for non-government stakeholder involvement in HiAP;
- Prepare a stakeholder analysis and conduct intersectoral negotiations; and
- Explain the roles of the health and non-health sectors in HiAP.

The course is based on a "participatory" or "learning-by-doing" approach to teaching with each session including a formal lecture that introduces the key messages followed by group discussions and activities. During the course, participants will be exposed to a range of case studies and scenarios that will help them learn to apply their knowledge and skills from the workshop.

Who should attend the executive course?

This executive HiAP course is targeted at politicians and senior policy-makers from all sectors and different levels of government influencing health. This includes health, employment, housing, economic development, finance, trade, foreign affairs, environment and sustainability, social security, education, agriculture and urban planning. Senior representatives from different countries and from the non-government sector such as universities, public health institutes, civil society and the private sector could also be invited depending on how the course is implemented.

Executive course structure

DAY 1		
START TIME	**WORKSHOP MODULE**	**DURATION**
08:00	1 Introduction and the determinants of health	1:40
09:40	Break	0:15
09:55	2 21st-century health dynamics and inequality	1:30
11:25	3 Health in All Policies Part One	1:15
12:40	Lunch	1:00
13:40	3 Health in All Policies Part Two	1:15
14:55	Break	0:15
15:10	4 The policy-making process Part One	1:15
16:25	4 The policy-making process Part Two	1:15

After registration and a welcome in the morning on the first day, the concepts of the burden of disease and the social determinants of health will be introduced. The contemporary challenges impacting on health and the relevance of the concept of Health in All Policies will be discussed. In the afternoon, the course will explore the policy-making process using a case study of a complex health issue.

DAY 2		
START TIME	**WORKSHOP MODULE**	**DURATION**
08:00	5 The role of government in HiAP/whole-of-government approaches	1:30
09:30	Break	0:15
09:45	7 The role of non-government stakeholders in HiAP/ whole-of-society approaches Alternative One	1:30
11:15	8 Negotiating for health	1:45
13:00	Lunch	1:00
14:00	11 The leadership role of the health sector in HiAP	1:30
15:30	Course evaluation	0:30

On the second day, after discussing the critical role of whole-of-government in the HiAP approach, the benefits and challenges of non-government stakeholder engagement will be covered and participants will gain practical negotiation skills through a group activity involving multiple sectors and stakeholders with different interests. The course will conclude by looking at the role of the health sector in Health in All Policies as both leader and partner to create co-benefits and win-win situations.

2: Course for policy and programme managers

Many of the factors that influence a person's health and well-being, such as their education level, income, housing and work conditions are determined by social, environmental and economic policies beyond the direct influence of the health sector. Thus, government policies made in all sectors and at all levels of government can have a significant impact on the health of the population. "Health in All Policies" (HiAP) is an approach that promotes collaboration between government sectors and non-government stakeholders to maximize the health benefits of government policies and reduce health inequalities such as differences in life expectancy. With the growing problem of noncommunicable diseases and the increasing costs of health care, a healthy population is an important goal with benefits for all: healthy children are better able to learn; a fit workforce is more productive; and a country with good health is more stable politically and economically. HiAP promotes co-benefits and win-win situations. This course for policy and programme managers aims to provide participants with the knowledge and practical skills to implement a HiAP approach and evaluate its health impact. The course focuses on understanding contemporary health challenges, policy writing, working across government, performing stakeholder analyses, supporting negotiations and conducting monitoring and evaluation. A shorter executive course for politicians and senior policy-makers is also available.

Content overview

At the end of this course, policy and programme managers will have the necessary knowledge and practical skills to implement a Health in All Policies (HiAP) approach and evaluate its impact. Participants will learn to:

- Identify the socioeconomic and environmental factors that influence health;

- Describe some of the major contemporary health challenges;
- Recognize and appraise different structures and mechanisms for intersectoral action;
- Develop and present influential policy briefs;
- Conduct a stakeholder analysis and support negotiations for health;
- Discuss examples of HiAP implementation at local, regional and global levels;
- Recognize different types of monitoring and evaluation including health impact assessments; and
- Explain the roles of the health and non-health sectors in HiAP.

The course is based on a "participatory" or "learning-by-doing" approach to teaching with each session including a formal lecture that introduces the key messages followed by group discussions and activities. During the course, participants will be exposed to a range of case studies and scenarios that will help them learn to apply their knowledge and skills from the workshop.

Who should attend this longer course?

This longer HiAP course is targeted at policy and programme managers from all sectors and different levels of government influencing health. This includes health, employment, housing, finance, trade, foreign affairs, environment, social security, education, agriculture and urban planning. Representatives from different countries and non-government stakeholders could also be invited depending on how the course is implemented.

Course structure

DAY 1		
START TIME	**WORKSHOP MODULE**	**DURATION**
08:30	1 Introduction and the determinants of health	2:15
10:45	Break	0:15
11:00	2 21st-century health dynamics and inequality	1:30
12:30	Lunch	1:00
13:30	3 Health in All Policies Part One	1:15
14:45	3 Health in All Policies Part Two	1:15
16:00	Break	0:15
16:15	4 The policy-making process Part One	1:15

After the welcome, the concepts of the burden of disease and the social determinants of health will be introduced. Contemporary health challenges and the relevance of the concept of Health in All Policies will be discussed in detail. In the afternoon, the course will focus on the policy-making process including the concepts of a policy champion and policy entrepreneur.

DAY 2		
START TIME	**WORKSHOP MODULE**	**DURATION**
08:30	4 The policy-making process Part Two	1:15
09:45	Break	0:15
10:00	5 The role of government in HiAP/whole-of-government approaches	1:30
11:30	6 Preparing policy briefs	1:30
13:00	Lunch	1:00
14:00	6 Preparing policy briefs cont.	0:30
14:30	7 The role of non-government stakeholders in HiAP/ whole-of-society approaches Alternative One	1:30
16:00	Break	0:15
16:15	9 HiAP implementation at local, regional and global levels Alternative Two	1:10

On the second day, policy writing skills in the context of complex health issues will be developed and refined and the principals of effective and accountable stakeholder consultation will be considered. The afternoon session will be dedicated to the presentation of various case study examples of the implementation of HiAP.

DAY 3		
START TIME	**WORKSHOP MODULE**	**DURATION**
08:30	9 HiAP implementation at local, regional and global levels Alternative Two cont.	0:20
08:50	8 Negotiating for health	1:45
10:35	Break	0:15
10:50	10 Measuring progress in health	1:45
12:35	Lunch	1:00
13:35	11 The leadership role of the health sector in HiAP	1:50
15:25	Break	0:15
15:40	12 Next steps and round up	1:00
16:40	Course evaluation	0:30

The final day of the course will teach participants how to support intersectoral negotiations for health and understand different types of monitoring and evaluation including how to conduct a health impact assessment through a group activity simulating a complex contemporary policy challenge.

Introduction and the determinants of health 1

21st-century health dynamics and inequality 2

Health in All Policies (HiAP) 3

The policy-making process 4

The role of government in HiAP/ whole-of-government approaches 5

Preparing policy briefs 6

The role of non-government stakeholders in HiAP/whole-of-society approaches 7

Negotiating for health 8

HiAP implementation at local, regional and global levels 9

Measuring progress in health 10

The leadership role of the health sector in HiAP 11

Next steps and round up 12

module

1

INTRODUCTION AND THE DETERMINANTS OF HEALTH

module

1

INTRODUCTION AND THE DETERMINANTS OF HEALTH

Welcome and introductions 6

Lecture: Outline of course structure and learning objectives 6

Optional group activity: Expectations 8

Group discussion: What is health and well-being? 8

Optional group activity: Factors determining health 10

Video: Social determinants of health 13

Questions and feedback 14

MODULE OVERVIEW

This introductory module is for welcoming the participants, outlining the course and initiating a discussion about health and its determinants.

	DURATION
Welcome and introductions	30 mins
Lecture: Outline of course structure and learning objectives	30 mins
Optional group activity: Expectations	15 mins
Group discussion: What is health and well-being?	20 mins
Optional group activity: Factors determining health	20 mins
Video: Social determinants of health	15 mins
Questions and feedback	5 mins
TOTAL TIME	**1h 40 mins**
WITH OPTIONS	**2h 15 mins**

Learning objectives

- Note the objectives and arrangements for the workshop
- Explain the concepts of health and well-being
- Recognize the responsibility of states to uphold the health of their population
- Identify socioeconomic, biological and behavioural factors that influence health
- Explain the social determinants of health

Key messages

- The overall purpose of the workshop is to:
  - › Build capacity to promote, implement and evaluate HiAP;
  - › Encourage engagement and collaboration across sectors;
  - › Facilitate the exchange of experiences and lessons learned; and
  - › Promote regional and global collaboration on HiAP.
- Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.
- Health is an individual right and a social justice issue. It is also a public good.
- Governments have a responsibility for the health of their peoples.

- Many of the determinants of health and health inequities in populations have social, environmental and economic origins that extend beyond the direct influence of the health sector and health policies. Thus, public policies and decisions made in all sectors and at different levels of governance can have a significant impact on population health and health equity.
- The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.
- HiAP provides a means to identify and avoid the unintended impacts of public policy that can be detrimental to the health of populations or subgroups of the population; thus, reducing risk.
- Policy champions and policy entrepreneurs are crucial to the HiAP approach. A policy champion is a person or team willing and able to lead and manage the policy process. Entrepreneurial policy-makers are able to break with habits and initiate new policies. Their creative acts have transformative effects on politics, policies and institutions.

Key reading for participants

Recommended

- WHO (1946) WHO Constitution (AR) (CN) (ES) (FR) (RU) (Preamble, Chapters 1–2) (3 pages)
- Video: WHO (2013) Bringing Health to Life (AR) (CN) (ES) (FR) (PT) (RU) (3 mins)
- CSDH (2008) Closing the Gap: Health Equity Through Action on the Social Determinants of Health, *Final Report of the Commission on Social Determinants of Health*. Geneva, WHO (AR) (CN) (ES) (FR) (PT) (RU) (Executive Summary – 24 pages)
- Audio: WHO Podcast (2008) Commission on Social Determinants of Health (4 mins)
- Video: WHO (2011) 25 Years of the Ottawa Charter (11 mins)

Optional

- WHO (2013) *Communicating the Economics of Social Determinants of Health and Health Inequalities*. Geneva, WHO

Supporting material for instructors

- Video: WHO (2013) The Social Determinants of Health (15 mins)
- Kickbusch I (2012) Addressing the interface of the political and commercial determinants of health, *Health Promotion International*, Vol. 27, No. 4
- CSDH (2008) Closing the Gap: Health Equity Through Action on the Social Determinants of Health, *Final Report of the Commission on Social Determinants of Health*. Geneva, WHO (AR) (CN) (ES) (FR) (PT) (RU)
- Booske B *et al.* (2010) Different Perspectives For Assigning Weights to Determinants of Health, *County Health Rankings Working Paper*. University of Wisconsin

- WHO Social Determinants of Health Sectoral Briefings:
  - WHO (2011) *Housing: Shared Interests in Health and Development – Social Determinants of Health Sectoral Briefing Series One*. Geneva, WHO
  - WHO (2011) *Education: Shared Interests in Well-Being and Development – Social Determinants of Health Sectoral Briefing Series Two.* Geneva, WHO
  - WHO (2011) *Transport (Road Transport): Shared Interests in Sustainable Outcomes – Social Determinants of Health Sectoral Briefing Series Three.* Geneva, WHO
  - WHO (2012) *Social Protection: Shared Interests in Vulnerability Reduction and Development – Social Determinants of Health Sectoral Briefing Series Four*. Geneva, WHO
  - WHO (2013) *Energy: Shared Interests in Sustainable Development and Energy Services –Social Determinants of Health Sectoral Briefing Series Four.* Geneva, WHO

Teaching notes

The opening first morning of the course is critical to set the scene and the tone of the course. Participants need to get to know each other, what the instructors expect of them and the style of the course. They also need to know the practicalities of the venue and organizational matters.

Modules 1 and 2 do not assume any knowledge of public health, since it is likely and desirable that there will be participants from non-health sectors present. These introductory modules are designed to ensure everyone has some understanding of the contemporary challenges of improving population health and health equity.

In the event that a very large majority or all of the participants come from a public health background, you may wish to modify Modules 1 and 2 or cover them more quickly. All the same, it will be important to ensure that participants from the health sector fully understand the social determinants of health. As always, it is useful to point to the learning objectives and outline the structure of the module so that the participants know what to expect.

WELCOME AND INTRODUCTIONS

30 MINS

During registration on the first day of the workshop, you should arrange for the participants to receive a work book with the programme, learning objectives, list of participants and course material, including the handouts. Ideally, you should send some of this material electronically before the workshop to give the participants time to prepare. The participants should also receive name tags. It is important that the instructors arrive early to set up the room and ensure all of the facilities and course materials are ready.

You should begin the workshop by providing participants and instructors an opportunity to get to know one another and introduce themselves. You might want to do this in an interactive way using an "ice breaker". Ideally, it is useful to get participants to also share their motivation for attending the course and their experiences in implementing HiAP. This will help you adjust the content and structure of the workshop to the group's level of experience and knowledge. It can also allow you to encourage participants to share their experiences at relevant times during the workshop.

LECTURE: OUTLINE OF COURSE STRUCTURE AND LEARNING OBJECTIVES

30 MINS

At the beginning of the course, it is suggested that you outline the structure of the workshop, explain its purpose and clarify organizational and logistical issues. It is recommended that you inform the participants that they will be involved in some group work throughout the workshop and that you state any rules you would like to establish such as turn-taking when talking, rotating presenter or ensuring the groups have a diversity of backgrounds and experience. This is also a time to answer questions.

You may wish to start by outlining some of the questions that the course will attempt to answer, such as:

- What is the HiAP approach and when should it be used?
- How do health issues get placed on the political and policy agenda?
- What motivates politicians and policy-makers across sectors to take into account the health consequences of their policies?
- What are the conditions that favour HiAP?

- How can health policy-makers most effectively engage and negotiate with other stakeholders?
- What is the best way to monitor our efforts and progress?

Other points to cover in your general introduction might include:

- Overall purpose of the workshop. Specifically:
  - Build capacity to promote, implement and evaluate HiAP;
  - Encourage engagement and collaboration across sectors;
  - Facilitate the exchange of experiences and lessons learned; and
  - Promote regional and global collaboration on HiAP.
- Learning objectives (see Appendices).
- Structure and timetable of the course including start, finish and breaks.
- Pre-course reading that participants should try to cover if they have not already done so (see Appendices).
- Participatory approach to learning and group work.
- Workshop logistics such as bathroom facilities and emergency exits.
- Participant evaluation (if any) (see Appendices).

It is also suggested that you give an introductory explanation of the concept of HiAP and policy champions/entrepreneurs. You might note:

- Many of the determinants of health and health inequities in populations have social, environmental and economic origins that extend beyond the direct influence of the health sector and health policies. Thus, public policies and decisions made in all sectors and at different levels of governance can have a significant impact on population health and health equity. HiAP provides a means to identify and avoid the unintended impacts of public policy that can be detrimental to the health of populations or subgroups of the population; thus reducing risk.
- Policy champions and policy entrepreneurs are crucial to the HiAP approach. A policy champion is a person or team willing and able to lead and manage the policy process. Entrepreneurial policy-makers are able to break with habits and initiate new policies. Their creative acts have transformative effects on politics, policies and institutions. One of the aims of this workshop is to give participants the knowledge and confidence to become a policy champion or policy entrepreneur.

OPTIONAL GROUP ACTIVITY: EXPECTATIONS

15 MINS

For this first module, you might want to ask the participants what they expect to gain from the workshop so that you best address their needs. One way of doing this is to ask each participant to write on a piece of paper one thing they hope to learn and put their note on a wall with those of the other participants. By displaying these expectations prominently for the duration of the workshop, you will be able to refer to them regularly and hopefully respond to all by the end of the workshop.

GROUP DISCUSSION: WHAT IS HEALTH AND WELL-BEING?

20 MINS

The purpose of this group discussion is to encourage participant interaction and engagement from the very beginning of the course by exploring the fundamental concepts of health and well-being.

You might want to pose this question and write up the participants' suggestions on a whiteboard or a large piece of paper. It is suggested that you encourage, from the outset, a broad approach to the topic with follow-up questions such as, "What kind of places do you think of when we talk about health?", "What kind of people do you imagine?", "What keeps us healthy and well?" or "What place does health have in society?"

Alternatively, you might prefer a group activity such as a "word wall", where everyone places an idea or several on the wall and together, they sort the ideas into categories. This kind of activity is good for getting everyone to be active and to interact.

It is likely that the participants will provide a range of ideas associated with health such as:

- Illnesses and medical treatment;
- Hospital and medical staff;
- Pregnant women, children, the elderly;
- Food and exercise; and
- Clean environment.

After the participants come up with a broad list of ideas and issues associated with health, it is suggested that you summarize the discussion by acknowledging that health has many dimensions and is important to individuals and society.

It is recommended that you then turn to look at some formal definitions of health and well-being. You may want to start by noting that there are different ways of viewing health as articulated in different international agreements. It is suggested that you cite the following examples, especially the WHO definition, but you might want to also provide examples relevant to the country or region where the workshop is being held.

World Health Organization Constitution (1946)
"…Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity…The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition…Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures…" – Preamble

United Nations Universal Declaration of Human Rights (1948)
"…Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control…" – Article 25

International Covenant on Economic, Social and Cultural Rights (1966)
"…The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

a) The provision for the reduction of the stillbirth rate and of infant mortality, and for the healthy development of the child;

b) The improvement of all aspects of environmental and industrial hygiene;

c) The prevention, treatment, and control of epidemic, endemic, occupational and other diseases;

d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness…"

Ottawa Charter (1986)
"The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites…Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it…"

To get the participants in the correct mindset of HiAP, you should emphasize:

- Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity;
- Health is an individual right and a social justice issue;
- Health is a public good; and
- Governments have a responsibility for the health of their peoples.

If time permits, you may want to extend the duration of this group activity.

At this time, you might want to distribute to the participants a copy of the Preamble and Chapters 1–2 of the WHO Constitution in one of the official WHO languages (see Key reading for participants).

OPTIONAL GROUP ACTIVITY: FACTORS DETERMINING HEALTH

20 MINS

This purpose of this activity is to have the participants recognize and discuss some of the determinants of health. It serves as an introduction. The social determinants of health will be discussed at length later in Module 4.

It is suggested that you divide the participants into small groups and ask them to estimate the percentage contribution of the following factors to health outcomes:

- Individual behaviour;
- Clinical care;
- Socioeconomic factors; and
- Physical environment.

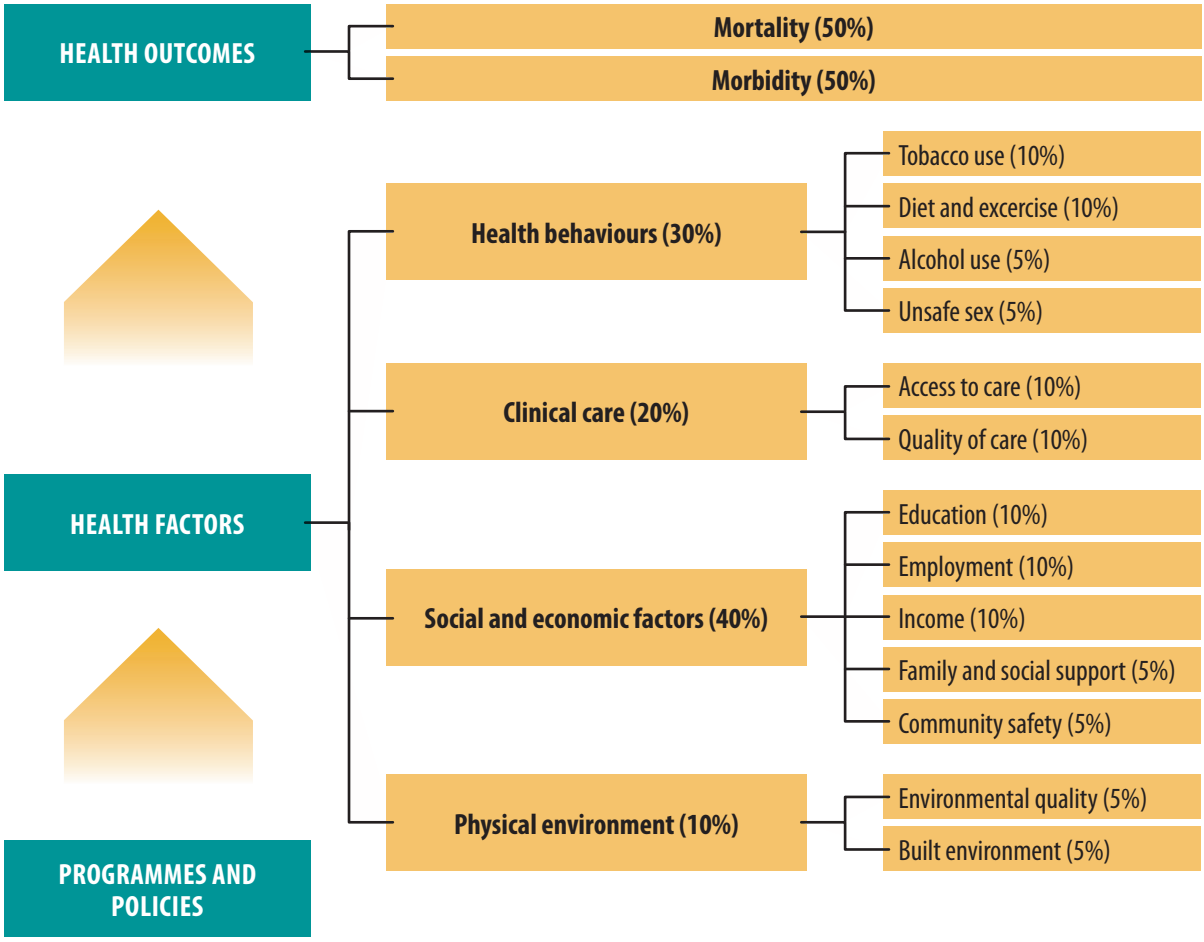
After each group has had time to reach a consensus, you may want to compare the estimates on a whiteboard or a piece of paper at the front of the class. It is suggested that you then share with the participants the estimates from a study of communities across the United States (see Figure 1.1).

While noting that each population is different, an important observation is that clinical care is less important than many people think whereas socioeconomic factors and the physical environment are quite influential. With respect to this specific study, you might want to note that genetic characteristics are not included in the model. However, this factor is also less significant than many people think.

After this short group activity, it is suggested that you introduce the determinants of health, with a particular focus on the social determinants of health.

Many factors combine to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more

Figure 1.1: Country Health Rankings model



Source: © University of Wisconsin Public Health Institute (2010) (http://www.countyhealthrankings.org/).

commonly considered factors such as access and use of health care services often have less of an impact. The determinants of health include:

- The social and economic environment;
- The physical environment; and
- A person's individual characteristics and behaviours.

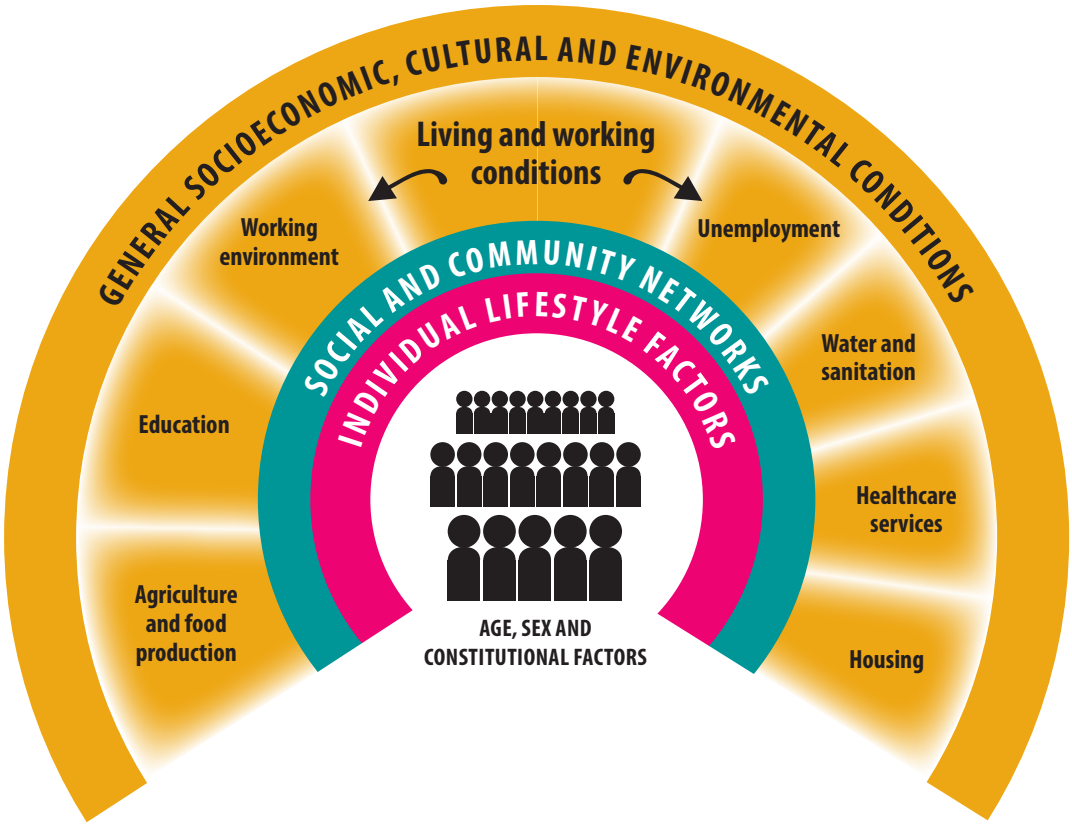
The context of people's lives determines their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate. Individuals are unlikely to be able to directly control many of the determinants of health. These determinants – or factors that make people healthy or not – include those listed above and many others:

- **Income and social status –** higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.
- **Education –** low education levels are linked with poor health, more stress and lower self-confidence.

- **Physical environment –** safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions.
- **Social support networks –** greater support from families, friends and communities is linked to better health. Culture – customs and traditions, and the beliefs of the family and community – all affect health.
- **Genetics –** inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses. Personal behaviour and coping skills – balanced eating, keeping active, smoking, drinking and how we deal with life's stresses and challenges all affect health.
- **Health services –** access and use of services that prevent and treat disease influence health.
- **Gender –** men and women suffer from different types of diseases at different ages.

You might also want to show Figure 1.2 and cite the WHO Social Determinants of Health Sectoral Briefings (see Supporting material for instructors).

Figure 1.2: The main determinants of health



Source: Dahlgren G and Whitehead M (1991) *Policies and strategies to promote social equity in health*. Stockholm, Institute of Future Studies.

If time permits, you may want to extend the duration of this group activity. You may also want to draw attention to the debate on political and commercial determinants of health.

VIDEO: SOCIAL DETERMINANTS OF HEALTH

15 **MINS**

It is strongly recommended that you give particular focus to the social determinants of health, which leads into the next module on 21st-century health dynamics and inequality. You may want to show the WHO's introductory video on the social determinants of health, WHO (2013).

15 MINS ▶ http://www.who.int/social_determinants/mediacentre/en/

QUESTIONS AND FEEDBACK

5 MINS

It is recommended that you encourage contributions and questions throughout the workshop and dedicate a small amount of time at the end of each module for feedback and clarifications. This unallocated time can be used as necessary if part of a module takes longer than expected.

module

2

21ST-CENTURY HEALTH DYNAMICS AND INEQUALITY

module

2

21st-CENTURY HEALTH DYNAMICS AND INEQUALITY

Video: Life expectancy "200 Years, 200 Countries, 4 Mins" 20

Group activity: Contemporary burden of disease 21

Lecture: Global challenges and health dynamics 23

Group activity: Health inequalities 27

Questions and feedback 29

MODULE OVERVIEW

This module explores the major global challenges impacting health, reviews the contemporary burden of disease, and explains the influence of inequality on health.

	DURATION
Video: Life expectancy "200 Countries, 200 Years, 4 Minutes"	5 mins
Group activity: Contemporary burden of disease	30 mins
Lecture: Global challenges and health dynamics	20 mins
Group activity: Health inequalities	30 mins
Questions and feedback	5 mins
TOTAL TIME	**1h 30 mins**

Learning objectives

- Explain the measurement unit "DALY" (disability-adjusted life year)
- Summarize stylized facts about the contemporary burden of disease
- Describe some of the major global challenges impacting health
- Distinguish health inequality and health inequity
- Explain how inequality influences health outcomes

Key messages

- The burden of disease is a measurement of the gap between a population's current health and the optimal state where all people attain full life expectancy without suffering major ill-health. Disability-adjusted life year (DALY) is one measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death.
- Noncommunicable diseases (NCDs) were responsible for two-thirds of all deaths globally in 2011, up from 60% in 2000. The four main NCDs are cardiovascular disease, cancers, diabetes and chronic lung diseases. Over the next decades (2011–2030), the leading NCDs are predicted to cost low- and middle-income countries close to USD 21.3 trillion, which is more than USD 1 trillion annually or the equivalent of nearly 5% of their current annual GDP.[1]
- Communicable, maternal, perinatal and nutrition conditions collectively were responsible for a quarter of global deaths, and injuries caused 9% of all deaths.
- Some of the major global challenges directly and indirectly impacting health include:
  - Globalization;
  - Socioeconomic inequality;

1 Bloom DE *et al.* (2011) *The Global Burden of Non-communicable Diseases*. Geneva, World Economic Forum, p. 29.

  - Environmental degradation;
  - Food insecurity;
  - Demographic transition; and
  - Urbanization.
- Health governance, especially at the global level, is becoming more crowded and complex with the proliferation of actors and overlapping mandates.
- Health inequity is the presence of unfair, avoidable or remediable differences in health services and outcomes among groups of people. In all countries – whether low-, middle- or high-income – there are wide disparities in the health status of different social groups. The lower an individual's socioeconomic position, the higher their risk of poor health.
- Public services, including health, often benefit the better educated and wealthier sections of society because they have greater means to access these services than those who are poor or less educated. Positive discrimination measures that prioritize the needs of the underprivileged and thereby address inequities should be an essential part of public health policy.

Key reading for participants

Recommended

- Video: Institute for Health Metrics and Evaluation, Global Burden of Disease Tool Tutorial (11 mins)
- Marmot M (2005) Social Determinants of Health Inequalities. *The Lancet*, Vol. 365, pp. 1099–1104 (6 pages)
- WHO (2011) 10 Facts on Health inequities and their causes. Geneva, WHO (2 pages)
- Rockström J *et al.* (2009) A safe operating space for humanity. *Nature*, Vol. 461, No. 24, pp. 472–475 (4 pages)
- Infographic: Gapminder (2003) Income Distribution 1970–2000

Optional

- Buxton N (2014) *State of Power*, Transnational Institute, including infographics Planet Earth: A Corporate World and The Global 0.001%
- Fuentes-Nieva R and Galasso N (2014) *Working for the Few: Political Capture and Economic Inequality*. Oxford, UK, Oxfam
- Lim *et al.* (2012) Comparative Risk Assessment of Burden of Disease and Injury Attributable to 67 Risk Factors and Risk Factor Clusters in 21 Regions, 1990–2010. *The Lancet*, Vol. 380, pp. 2224–60 (Summary)

Supporting material for instructors

- Lim *et al.* (2012) Comparative Risk Assessment of Burden of Disease and Injury Attributable to 67 Risk Factors and Risk Factor Clusters in 21 Regions, 1990–2010. *The Lancet*, Vol. 380, pp. 2224–60

- Ezzati M, Lopez AD, Rodgers A and Murray CJL (eds) (2004) *Comparative Quantification of Health Risks: Global and Regional Burden of Disease Attributable to Selected Major Risk Factors*, Volumes 1 and 2. Geneva, WHO
- Institute for Health Metrics and Evaluation:
  - › Global Burden of Disease Visualizations: http://www.healthmetricsandevaluation.org/gbd/visualizations/country
  - › Global Burden of Disease Insight: http://www.healthmetricsandevaluation.org/gbd/visualizations/gbd-insight
- Bloom DE *et al*. (2011) *The Global Economic Burden of Non-communicable Diseases.* Geneva, World Economic Forum
- WHO (2013) Handbook on Health Inequality Monitoring with a Special Focus on Low- and Middle-Income Countries. Geneva, WHO
- WHO (2010) *Global Status Report on Noncommunicable Diseases 2010*. Geneva, WHO
- WHO (2011) *Noncommunicable Diseases Country Profiles 2011*. Geneva, WHO
- WHO (2011) *From Burden To "Best Buys": Reducing The Economic Impact of NCDs in Low- and Middle-Income Countries.* Geneva. WHO
- WHO (2011) *Scaling Up Action against Noncommunicable Diseases: How Much Will It Cost?* Geneva, WHO
- WHO (2009) *Setting the Political Agenda to Tackle Health Inequity in Norway.* Copenhagen, WHO
- Baker A *et al*. (2005) Addressing Social Determinants of Health Inequities: Learning From Doing. *American Journal of Public Health*, Vol. 95, No. 5, pp. 553–555
- WHO Health Equity Country Profiles, http://www.who.int/gho/health_equity/countries/en/index.html
- Buxton N (2014) *State of Power*. Transnational Institute, Washington, D.C.
- Wilkinson, R (1996) *Unhealthy Societies: The Afflictions of Inequality.* London, Routledge

Teaching notes

This module is about exploring the relationships between the social determinants of health, which was discussed in Module 1, the burden of disease, contemporary global challenges and health inequalities. The purpose of dealing with these issues together is to highlight their complex interaction and communicate why a HiAP approach is increasingly relevant.

Given differences in the burden of disease, health inequalities and social, political and environmental challenges, it is recommended that you adapt and supplement these teaching notes with information and examples relevant to the country or region where the workshop is being held. As always, it is useful to point to the learning objectives and outline the structure of the module so that the participants know what to expect.

VIDEO: LIFE EXPECTANCY "200 YEARS, 200 COUNTRIES, 4 MINS"

5 MINS

The purpose of this suggested short video is to illustrate the dramatic improvement in life expectancy over the past 200 years throughout the world, which crudely serves to summarize much of the progress of public health to date. This then allows a transition to discussing present and future health challenges.

Before screening the video, it is suggested you quickly recap the following points from Module 1:

- Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.
- Health is an individual right and a social justice issue. It is also a public good.
- Many of the determinants of health and health inequities in populations have social, environmental and economic origins that extend beyond the direct influence of the health sector and health policies. Thus, public policies and decisions made in all sectors and at different levels of governance can have a significant impact on population health and health equity.

Video: "200 Years, 200 Countries" from Rosling H (2010) *The Joy of Stats*. Wingspan Productions.
4 MINS http://www.youtube.com/watch?v=jbkSRLYSojo

To help participants who are hearing impaired or speak English as a second language, you may want to consider adding the available subtitles.

GROUP ACTIVITY: CONTEMPORARY BURDEN OF DISEASE

30 MINS

The purpose of this group activity is to get the participants to discuss how the burden of disease has changed in the recent past and identify some of the major issues that are creating these new health dynamics. It is suggested that you concentrate on the region or country in which the workshop is taking place. This will involve modifying the template provided (see Handout 2.1).

Divide the participants into groups and distribute the above-mentioned template on the contemporary burden of disease. It is suggested that you explain the concept of "burden of disease" and describe any diseases listed that are not clear to the participants.

After the groups have had sufficient time to reach a consensus about the approximate ordering of the diseases for the two dates, it is suggested that you reveal the changes to the burden of disease and explain its significance, causes and implications.

Depending on your region or country, some points to make could include:

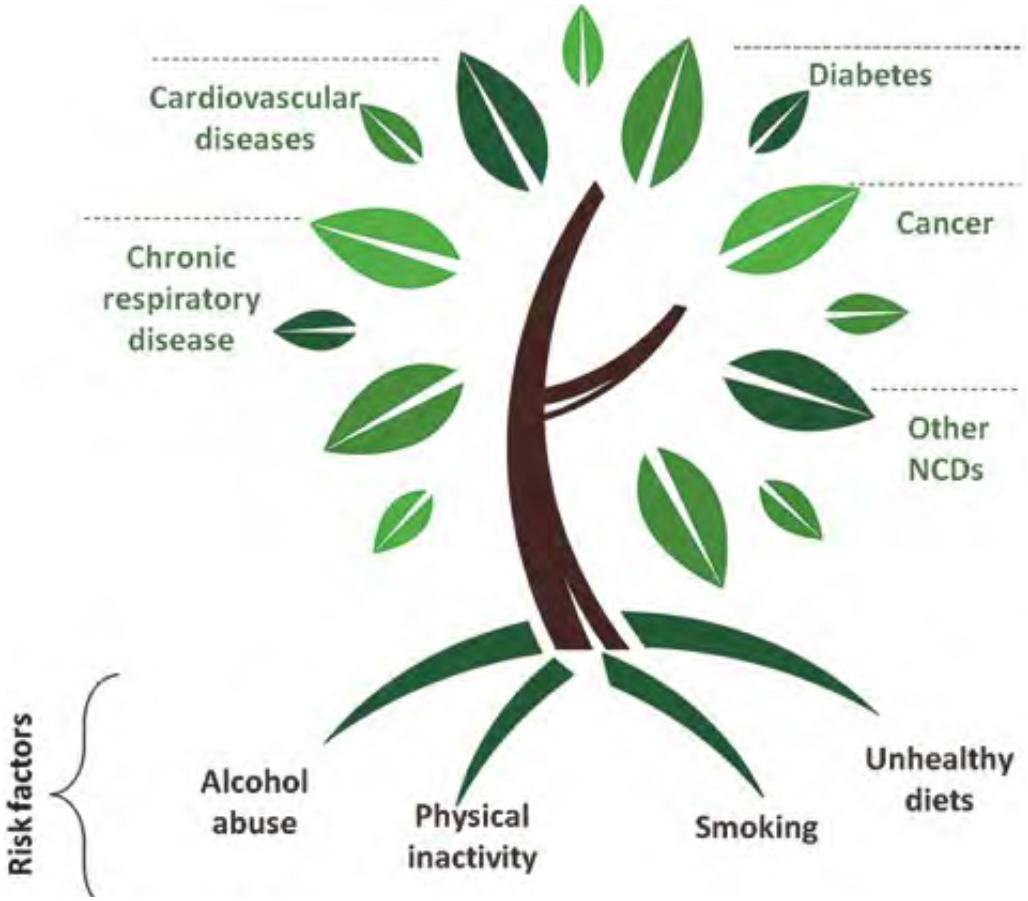
- Communicable diseases and injuries represent a declining proportion of the burden of disease. This is partly attributable to economic growth and better living conditions allowing for better nutrition, hygiene and sanitation. It is also the result of greater public health awareness and vaccine campaigns. Nevertheless, certain diseases such as HIV/AIDS and tuberculosis are on the rise.
- Noncommunicable diseases represent a growing proportion of the burden of disease. They are caused to a large extent by four behavioural risk factors: tobacco use, an unhealthy diet, insufficient physical activity and harmful use of alcohol. You may want to show Figure 2.1 to illustrate this.
- The indirect cause of the rise in NCDs is associated with global trends such as industrialization, increasing trade and economic integration, and urbanization, which are discussed further in the next section of Module 2.
- The combined burden of NCDs is rising fastest among low- and middle-income countries where NCDs are often detected later and necessary treatment is more extensive and costly. Nearly 80% of NCD deaths now occur in lower income countries and disproportionately affect younger people in the economically active age bracket.[1]
- Over the next decades (2011–2030), the leading NCDs are predicted to cost low- and middle-income countries close to USD 21.3 trillion, which is more than USD 1 trillion annually or the equivalent of nearly 5% of their current annual GDP. The cumulative cost of NCDs in terms of lost income, medical expenses, and pain and suffering is predicted to double between 2010 and 2030.[2]

1 WHO (2010) *Global Status Report on Noncommunicable Diseases 2010.* Geneva, WHO.

2 Bloom DE *et al.* (2011) *The Global Economic Burden of Non-communicable Diseases.* Geneva, World Economic Forum.

- Other changes in the burden of disease are associated with demographic transition from a relatively younger to older population, which is also discussed further in the next section of Module 2.

Figure 2.1: Most NCDs are strongly associated and causally linked with four particular risk factors



Source: http://www.emro.who.int/egy/egypt-infocus/stepwise-surveillance.html

You may want to distribute relevant WHO NCD country profiles for where the workshop is being held and demonstrate the use of data visualization tools such as the Institute for Health Metrics and Evaluation's GDB Insight and GBD Compare.

If time permits, you may want to extend the duration of this part of the module.

LECTURE: GLOBAL CHALLENGES AND HEALTH DYNAMICS

20 **MINS**

The 21st century brings many complex and interacting challenges. The aim of this part of the module is to explore the interconnection between certain global issues and health. If relevant, you might also want to add certain regional or national issues shaping health where the workshop is being held. Some of the global challenges to discuss could include:

Globalization: trade, migration and industrialization

- The world is more and more economically interconnected. Trade between countries is one indication of this. Between 1950 and 2000, the global volume of trade increased by a factor of nearly 200.[1] Trade as a share of economic activity is also increasing. Between 1960 and 2007, the value of trade in goods and services as a share of global GDP increased from 12% to 28%.[2]
- The number of people travelling and migrating is also increasing. Between 1995 and 2012, the number of international tourist arrivals annually doubled from 530 million to 1.1 billion.[3] In 2010, the number of international migrants was 214 million, and based on current trends could reach 405 million by 2050.[4]
- Over the past several decades, many low- and middle-income economies have industrialized and grown significantly. In contrast to many high-income countries, this economic transition has been far more rapid with more dramatic consequences in terms of rural to urban migration, urbanization and socioeconomic change.
- This globalization is impacting health in multiple ways. Trade, migration and travel increase the risks of global epidemics such as severe acute respiratory syndrome (SARs) and the spread of health hazards including contaminated foods and products. Rapid economic growth, for its part, places pressures on the labour force, infrastructure and the environment. This can result in more occupational accidents, poor construction and planning as well as more pollution and over-exploitation of natural resources. These issues directly and indirectly impact health.

1 Mansbach R, Rhodes E (2000) *Global Politics in a Changing World.* Boston, Houghton Mifflin Company, p. 255.

2 World Bank, World Development Indicators.

3 UNWTO (2012) *World Tourism Barometer*, Volume 11. Geneva, World Tourism Organization.

4 IMO (2010) *World Migration Report 2010 – The Future of Migration: Building Capacities for Change.* Geneva, International Organization for Migration.

Urbanization

- The world is rapidly becoming more urban. Between 2010 and 2050, the percentage of the world's population living in urban areas is predicted to increase from 50% to 70%. At present, nearly 1 billion people or 33% of the urban population live in slums.[1]
- As with rapid economic growth, urbanization can place strain on infrastructure resulting in poor living conditions for large sections of the population and an inability to properly access social services like education and medical care.
- Today, nearly 2.5 billion people still live without improved sanitation facilities, which is a primary contributing factor for many communicable diseases.[2] Some 1.3 billion people also lack access to electricity and rely on kerosene lamps. In terms of its impact on health, almost 2 million deaths annually are due to the household air pollution from rudimentary biomass and coal stoves in close to 3 billion homes worldwide.[3]
- Rapid, unplanned urbanization also creates congestion and pollution. Around 1.3 million deaths are attributed to such ambient air pollution in cities.[4] A lack of public transport and green spaces also contributes to insufficient physical activity, which is one of the four main risk factors for NCDs.

Economic growth, poverty and governance

- Despite considerable economic growth over the past half century, a large percentage of the world's population still lives in poverty. In 2005, around 2.6 billion people survived on less than USD 2 per day.[5] Increasingly, the majority of the world's poor live in middle-income countries, which challenges North-South models of development assistance and encourages more public investment in social protection.[6] The concept of universal health coverage (UHC) is critical to ensuring all people have access to the quality health services they need without the risk of financial ruin.
- In many countries, the past several decades of economic growth have also been accompanied by a shift in the discourse of public policy and governance towards neoliberalism. The policies that neoliberalism tends to favour include: strict fiscal discipline, tax reform to benefit

1 UN-Habitat (2010) *State of the World's Cities: Bridging the Urban Divide.* Nairobi, UN-Habitat.

2 WHO and UNICEF (2013) Progress on Drinking Water and Sanitation Report. Joint Monitoring Programme for Water Supply and Sanitation, New York, WHO and UNICEF.

3 Ezzati M, Lopez AD, Rodgers A and Murray CJL (eds) (2004) *Comparative Quantification of Health Risks: Global and Regional Burden of Disease Attributable to Selected Major Risk Factors*, Vol. 2. Geneva, WHO, Chapter 18.

4 Ezzati M, Lopez AD, Rodgers A and Murray CJL (eds) (2004) *Comparative Quantification of Health Risks: Global and Regional Burden of Disease Attributable to Selected Major Risk Factors,* Vol. 2. Geneva, WHO, Chapter 18.

5 Ravallion M, Chen S (2008) *The developing world is poorer than we thought, but no less successful in the fight against poverty.* World Bank, Development Research Group, Table 5, p. 30.

6 Kanbur R, Sumner A (2012) "Poor Countries or Poor People: Development Assistance and the New Geography of Global Poverty". *Journal of International Development"*, Vol. 24, pp. 686–695.

corporations and higher income individuals, market-determined exchange rates and interest rates; free trade and free capital flows, as well as state privatization and deregulation. In the health sector, this has led to less public health spending, fewer health care services and higher out-of-pocket expenses, which subsequently impact health outcomes.

Socioeconomic inequality

- Parallel to poverty, there is also socioeconomic inequality, which is discussed at greater length in the next section of Module 2.
- In 2000, 85% of the world's population were living in countries where inequality was increasing. The difference between the top and bottom 20% of the world's population has widened from 30:1 in 1945 to 60:1 in 1970 to 82:1 in 2000.[1] Today, almost half of the world's wealth is owned by just 1% of the population and the richest 85 individuals own the same amount of wealth as the bottom half of the world's population or approximately 3.5 billion people.[2]
- Socioeconomic inequality is a key social determinant of health because it shapes the conditions in which we grow, live, work and age.

Environmental degradation

- Conserving the earth's ecosystem on which human society depends is a precondition for economic and social development, including good health. Yet, growing evidence suggests that humanity is undermining the stable state of the earth's ecosystem. Specifically, human activities are pushing planetary boundaries associated with the planet's biophysical subsystems and processes (see Figure 2.2).[3] It is thought that three of these nine planetary boundaries have been exceeded and two others are close to their safe limits.
- In general, the anticipated impact of global warming of 2°C–4°C by 2100 will be greater in the more populous and poorer regions of Africa, Latin America and Asia.[4] In seasonally dry and tropical regions, crop productivity is projected to decrease for even small temperature increases, which is likely to intensify food insecurity.[5]
- Endemic morbidity and mortality due to communicable diseases associated with floods and droughts is expected to rise throughout Asia.[6]

1 George S, Bircham E and Chalton J (eds) (2001) *Anticapitalism: A Guide to the Movement*. London, Bookmarks.

2 Fuentes-Nieva R and Galasso N (2014) *Working for the Few: Political Capture and Inequality.* Oxford, UK, Oxfam.

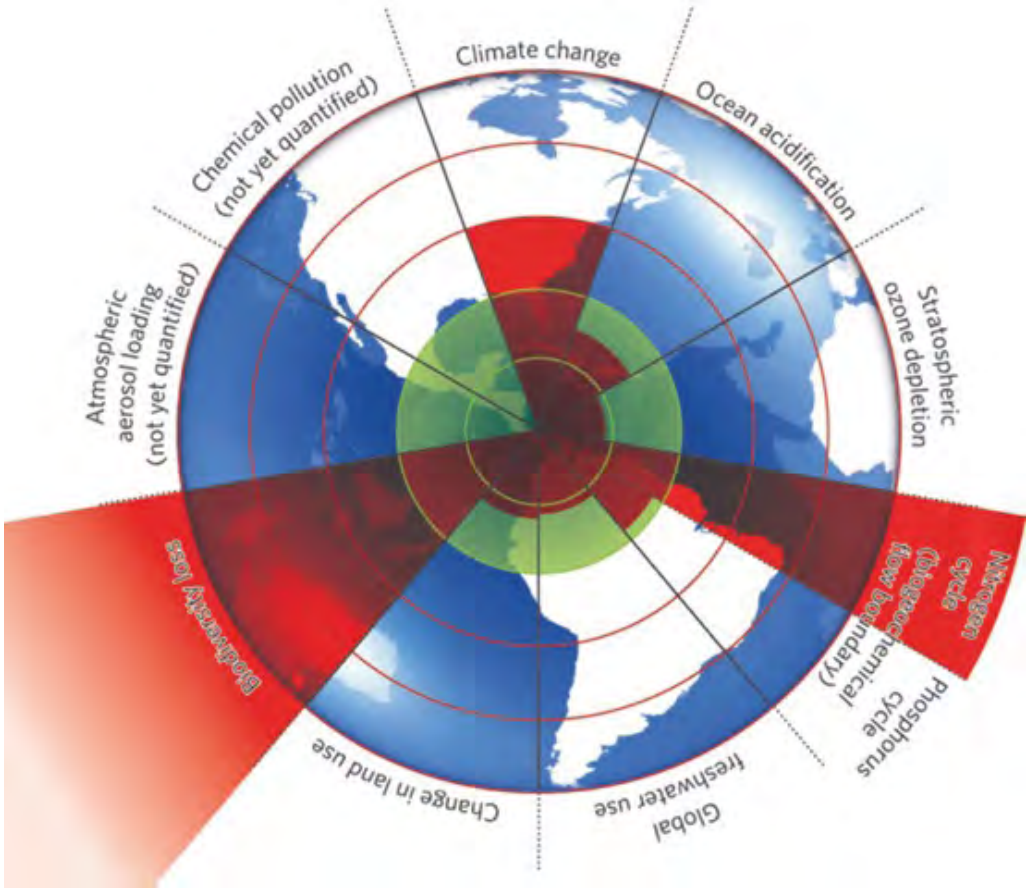
3 Rockström J *et al*. (2009) A safe operating space for humanity. *Nature,* Vol. 461.

4 IPCC (2007) *Climate Change 2007: Synthesis Report.* Geneva, International Panel on Climate Change.

5 IPCC (2007) *Climate Change 2007: Synthesis Report.* Geneva, International Panel on Climate Change.

6 IPCC (2007) *Climate Change 2007: Synthesis Report.* Geneva, International Panel on Climate Change.

Figure 2.2: Beyond the boundary



Note: The inner green shading represents the proposed safe operating space for nine planetary systems. The red wedges represent an estimate of the current position for each variable. The boundaries in three systems (rate of biodiversity loss, climate change and human interference with the nitrogen cycle) have already been exceeded.

Source: Rockström J *et al.* (2009) A safe operating space for humanity. *Nature*, Vol. 461.

Demographic transition

- According to the United Nations, the global population is predicted to increase from 6.8 billion to 9.1 billion between 2010 and 2050.[1]
- Over this period, the population of developed countries is expected to remain constant at 1.2 billion while the population of less developed countries is expected to increase from 5.6 billion to 7.9 billion.[2] By 2050, the median age in more developed countries will be approximately 46 years and in less developed countries 37 years.

1 United Nations Department of Economic and Social Affairs, Population Division (2009) *World Population Prospects, 2008 Revision: Volume 1: Comprehensive Tables.* New York, UNDESA.

2 United Nations Department of Economic and Social Affairs, Population Division (2009) *World Population Prospects, 2008 Revision: Volume 1: Comprehensive Tables.* New York, UNDESA.

- This demographic transition places strain on the health care system as more people need care, especially for chronic illnesses such as NCDs, and there is a relatively smaller workforce to support the economy.

GROUP ACTIVITY: HEALTH INEQUALITIES

30 MINS

The purpose of this group activity is to allow the participants to discuss the significance of health inequalities and the relevance of HiAP to address them.

After dividing the participants into groups, it is suggested you ask the participants to brainstorm how inequality might impact on health and why it matters. To clarify the task, you might suggest that the participants begin by listing some different types of inequality and give an example such as how the rural-urban divide can impact on the quality of care people can access.

After the groups have had some time for discussion, you should ask each group in turn to give an example of inequality and describe how it might impact on health.

Once you have introduced the topic through this activity, it is recommended you present the issue at greater length. You might include some of the following points:

- Health inequities are the unjust differences in health between persons of different social groups, and can be linked to forms of disadvantage such as poverty, discrimination and lack of access to services or goods.
- While *health inequity* is a normative concept, and thus cannot be precisely measured or monitored, *health inequality* – observable differences between subgroups within a population – can be measured and monitored, and serves as an indirect means of evaluating health inequity.
- There are several equity stratifiers that are used to distinguish groups and individuals:
    - Socioeconomic status;
    - Education;
    - Place of residence (rural, urban etc.);
    - Race or ethnicity;
    - Occupation;
    - Gender; and
    - Religion.
- One measure of health inequality is life expectancy. Life expectancy at birth between countries varies by 36 years, from 47 years in Sierra Leone to 83 years in Japan. Within countries too, there are large inequalities. In the United States and Australia, for example, there is as much as a 20-year gap in life expectancy between the most and least advantaged groups in the population. You may want to show the WHO's interactive map of life expectancy.

- Socioeconomic status can partly account for differences in life expectancy. Poor living conditions, inadequate nutrition and poor antenatal care explain the relatively high rate of child mortality in some lower income countries compared with higher income countries. More income allows people to improve the conditions in which they grow, work, live and age. For example, to live in better housing, work in conditions that are less stressful and hazardous to one's health and visit a doctor or nurse when needed.
- Other equity stratifiers like education also explain health outcomes. Education increases health literacy, which is the ability to obtain, read, understand and use health care information to make appropriate health decisions and follow instructions for treatment. In some countries, gender can make a significant difference due to social attitudes about the value of men and women. For example, parents might be more likely to take a son to get immunized than a daughter because of social customs that value men over women.
- As one might expect, equity stratifiers can overlap and it is not always possible to say, for example, whether relatively high child mortality in a poor rural area is due primarily to place of residence, socioeconomic status or education since they are related.
- An important point to take away is that there is a social gradient in health. This is clearly evident with equity stratifiers such as income and education that differ by degrees. In general, the more severe the inequality, the steeper the health gradient.
- A HiAP approach directly addresses inequalities by looking to improve the social determinants of health that the different and unequal conditions in which people grow, learn, live, work and age produce.

To illustrate this health gradient you may want to show Figure 2.3 as well as the WHO's country equity profiles relevant to where the workshop is being held. These equity profiles show different health outcomes related to child and maternal health according to equity stratifiers like income, education and place of residence.

Figure 2.3: The health gradient

Source: Taket A (1990) *Making Partners: Intersectoral Action for Health: Proceedings and Outcome of a Joint Working Group on Intersectoral Action for Health.* Copenhagen, WHO.

You might also want to use the following infographic to compare the income inequality in a selected number of low-, middle- and high-income countries.

- Infographic: Gapminder (2003) Income Distribution 1970–2000.

If time permits, you may want to extend the duration of this part of the module.

QUESTIONS AND FEEDBACK

5 **MINS**

It is recommended that you encourage contributions and questions throughout the workshop and dedicate a small amount of time at the end of each module for feedback and clarifications. This unallocated time can be used as necessary if part of a module takes longer than expected.

module

3

HEALTH IN ALL POLICIES (HiAP)

module

3

HEALTH IN ALL POLICIES (HiAP)

Part One

Recap: Key messages of Modules 1–2 36

Group activity: Health linkages with other sectors 37

Lecture: Public health, HiAP and its development including Q&A . . . 39

Part Two

Group activity: Identifying the HiAP approach 45

Group activity: WHO's HiAP Framework for Country Action 46

Questions and feedback 46

MODULE OVERVIEW

This module outlines the history, rationale and principles of the HiAP approach.

	DURATION
PART ONE	
Recap: Key messages of Modules 1–2	10 mins
Group activity: Health linkages with other sectors	20 mins
Lecture: Public health, HiAP and its development including Q&A	45 mins
PART TWO	
Group activity: Identifying the HiAP approach	25 mins
Group activity: WHO HiAP Framework for Country Action	40 mins
Questions and feedback	10 mins
PART ONE	**1h 15 mins**
PART TWO	**1h 15 mins**
TOTAL TIME	**2h 30 mins**

Learning objectives

- Define public health and HiAP
- Explain the origins and development of HiAP
- Recognize when to use a HiAP approach
- Distinguish the HiAP approach from other public policies

Key messages

- Public health refers to all organized efforts of society to prevent disease, promote health and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases.
- Approaches to public health have varied over time in the way health problems have been viewed and solved. The understanding that health is influenced by many factors (i.e. determinants) such as food, housing and working conditions outside the health sector has a long history of at least several centuries. This approach to public health has prevailed in many regions of the world.

- Historically, efforts to address the social, economic, environmental and commercial determinants of health have required collaboration across multiple sectors and often necessitated political and social struggle.
- 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. It improves the accountability of policy-makers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being.
- The three most common policy situations that favour a HiAP approach are:
  - Addressing complex health challenges;
  - Reacting to external policy proposals with a significant impact on health; and
  - Supporting high-priority government goals that positively affect multiple sectors including health.
- Issues for priority action should fulfil criteria such as:
  - Problem or issue is of major public health importance;
  - Problem or issue is amenable to change and change is feasible, i.e. there is sound evidence that it can be tackled; and
  - Potential solutions are politically and socially acceptable.
- The term HiAP emerged during the past two decades. There are many related terms, such as healthy public policies, intersectoral action, governance for health and whole-of-government, that imply addressing the determinants of health.
- As one might expect, HiAP has been implemented differently in different contexts reflecting local social and political cultures as well as government structures. It is important to share experiences and lessons learned to understand how HiAP can be most effective.

Key reading for participants

Recommended

- Baum F, Ollila E and Peña S (2013) History of HiAP in Leppo K *et al*. (eds) (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health (14 pages)
- WHO (2013) Helsinki Statement on Health in All Policies. WHO 8th Global Conference on Health Promotion (2 pages)
- WHO (2014) HiAP Framework for Country Action. Geneva, WHO (13 pages)

Optional

- Cook S, Zhang S and Yi I (2013) Health and Development: Challenges and Pathways to HiAP in Low-Income Countries in Leppo K *et al.* (eds) (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health (13 pages)

Supporting material for instructors

- Leppo K *et al.* (eds) (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health
- Rosen G (1993) *A History of Public Health*. Baltimore, Johns Hopkins University Press
- ASTHO (2013) *Health in All Policies: Strategies to Promote Innovative Leadership*. Arlington, VA, Association of State and Territorial Health Offices
- Kickbusch I and Behrendt T (2013) *Implementing a Health 2020 Vision: Governance for Health in the 21st Century – Making it Happen*. Copenhagen, WHO
- CDC (2011) Ten Great Public Health Achievements in America in *Morbidity and Mortality Weekly Report (MMWR)*, Vol. 60. No. 19. Atlanta, Centers for Disease Control and Prevention
- CDC (2011) Ten Great Public Health Achievements Worldwide in *Morbidity and Mortality Weekly Report (MMWR),* Vol. 60. No. 24. Atlanta, Centers for Disease Control and Prevention

Teaching notes

This module is about formally introducing the concept of HiAP now that all of the participants, even those from a non-health background, have a basic understanding of contemporary health challenges such as NCDs and the importance of determinants of health or "the causes of the causes". After defining the concepts of public health and HiAP, this module looks to put them in their historical context.

Given the different traditions and history of public health in different regions of the world, it is recommended that you adapt and supplement these teaching notes with information and examples relevant to the country or region where the workshop is held. As always, it is useful to point to the learning objectives and outline the structure of the module so that the participants know what to expect.

PART ONE

RECAP: KEY MESSAGES OF MODULES 1–2

10 MINS

You should remind the participants that you have now finished the introductory modules intended to give everyone an understanding of contemporary health challenges, the determinants of health and health inequality.

It is suggested that you quickly recap the key messages of Modules 1–2 before moving on to Module 3. You might want to do this in an interactive way with open questions or a group activity such as the "fish bowl" where everyone places a question and something they have learned in a container. The instructor can then take these pieces of paper and share the things learned and answer the questions.

Some important points to reiterate might include:

- Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.
- Health is an individual right and a social justice issue. It is also a public good.
- Many of the determinants of health and health inequities in populations have social, environmental and economic origins that extend beyond the direct influence of the health sector and health policies. Thus, public policies and decisions made in all sectors and at different levels of governance can have a significant impact on population health and health equity.
- The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.
- Health inequity is the presence of unfair, avoidable or remediable differences in health services and outcomes among groups of people. In all countries – whether low, middle or high income – there are wide disparities in the health status of different social groups. The lower an individual's socioeconomic position, the higher their risk of poor health.
- Policy champions and policy entrepreneurs are crucial to the HiAP approach. A policy champion is a person or team willing and able to lead and manage the policy process. Entrepreneurial policy-makers are able to break with habits and initiate new policies.

After covering the key messages of the introductory modules, you should explain that Module 3 focuses on how HiAP can help address these challenges.

GROUP ACTIVITY: HEALTH LINKAGES WITH OTHER SECTORS

20 MINS

This suggested group activity on the health linkages with other sectors is designed to get participants thinking about the central principle of HiAP – that multiple sectors have a stake in health.

You should divide the participants into small groups for a brainstorming exercise. Place a large sheet of paper around the room for each of the following sectors (i.e. eight sheets in total):

- Food;
- Water;
- Energy;
- Education;
- Economy;
- Infrastructure and transport;
- Governance; and
- Environment.

Ask each group to start with a different sheet of paper and brainstorm some of the ways that health is linked to that sector and how that sector is conversely affected by population health. For example, an insufficiency in food supply is likely to adversely affect health. A healthy population is likely to increase economic growth since the workforce will be more physically and mentally fit, more productive and be absent from work less due to illness.

Tell the groups that they will rotate and write down their ideas for each sector. At the end, you will discuss the linkages together. Start with two or three minutes for each turn and allow slightly less for the final rotations as most of the ideas will have already been written down.

After the brainstorming exercise, move from one sector to the next discussing as a group the most important linkages. You should guide the discussion if necessary pointing out valuable contributions and highlighting any important linkages that were missed.

Some linkages to underline might include:

- Food is closely linked to health. Low birth weight and early malnutrition have long-term, irreversible effects on brain development and adult health. Conversely, overconsumption and poor diets are leading risk factors for noncommunicable diseases.
- Water quality, sanitation and hygiene are also central to health. Taken together, dietary and water-sanitation risk factors are responsible for almost 10 million deaths annually and 20% of the global disease burden.

- The supply of electricity is critical for health systems. Household air pollution from solid fuels is one of the leading health risks in South Asia, South-East Asia and sub-Saharan Africa.
- Health and nutrition affect education by enhancing children's physical ability to attend school and by increasing their cognitive ability and learning.
- Better education is linked to economic growth, which in turn generates more public revenue that can be spent on health.
- A healthier workforce is more productive and more resilient because workers tend to have more energy and better mental health, and there is less absenteeism.
- Insanitary and dangerous living and working conditions contribute significantly to disease, disability and death.
- More energy-efficient transport systems prevent millions of deaths from traffic injuries and air pollution. Good transport infrastructure also makes it easier to access health care.
- Governments decide how revenue is spent and who has access to public services, including health. Health is also an issue that people value highly and which may be used to judge a government's performance.
- Climate change and environmental degradation are also increasing the risk of extreme weather events and creating greater food and water insecurity, all of which contribute to a higher burden of communicable and noncommunicable disease.

For more information on health linkages, you may wish to review the following:

- WHO (2008) Commission on Social Determinants of Health. Geneva.
- WHO (2010) Social Determinants of Health Sectoral Briefing Series. Geneva:
  - Housing;
  - Education;
  - Transport; and
  - Energy.
- WHO and UNICEF (2013) *Health in the Post-2015 Development Agenda*, Report of the Global Thematic Consultation on Health. Geneva pp. 29–39.

If time permits, you may want to extend the duration of this group activity.

LECTURE: PUBLIC HEALTH, HiAP AND ITS DEVELOPMENT INCLUDING Q&A

45 MINS

Before introducing HiAP and outlining its development, it may be useful to briefly define the concept of public health, especially if there are non-health participants attending the workshop. HiAP is one approach to public health.

Public health definition

Public health[1] refers to all organized efforts to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease. The three main public health functions are:

- The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities.
- The formulation of public policies designed to solve identified local and national health problems and priorities.
- To assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services.

Public health professionals monitor and diagnose the health concerns of entire communities and promote healthy practices and behaviours to ensure that populations stay healthy. One way to illustrate the breadth of public health is to look at some notable public health campaigns:

- Vaccination and control of infectious diseases;
- Motor vehicle safety;
- Safer workplaces;
- Safer and healthier foods;
- Safe drinking water;
- Healthier mothers and babies and access to family planning;
- Decline in deaths from coronary heart disease and stroke; and
- Recognition of tobacco use as a health hazard.

HiAP belongs to a tradition of public health approaches that focus on the social and political factors that strongly influence population health. The term HiAP emerged during the past two decades.

1 http://www.who.int/trade/glossary/story076/en/

Definition of HiAP and when to use a HiAP 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. It improves accountability of policy-makers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being.[1]

There are three general policy situations that favour a HiAP approach:

1. **Complex health challenges.** This is the most common policy situation where a HiAP approach should be considered and refers to population health, health equity or health systems challenges that require intersectoral policy solutions. It is important to have strong evidence of the problem, its causes, potential solutions involving other sectors, especially their technical feasibility, and lastly the potential costs and benefits of action from the perspective of health and society as a whole. Examples of this first scenario might include responding to NCDs, antimicrobial resistance or health risks associated with climate change.
2. **External policies with high impact on health.** This is another policy situation that favours a HiAP approach and concerns policy proposals originating from non-health sectors that could have a significant impact on health or health equity. Numerous government policies can impact on health yet the health sector has to prioritize when to engage heavily with other sectors since this requires significant resources and time. A HiAP approach can help focus and legitimize the health sector's engagement in policy decisions that have significant (indirect) impacts on health. This policy situation can equally apply to international declarations or agreements. Examples of this second scenario might include: free trade agreements and environmental protection laws.
3. **Government priority affecting many sectors.** This policy situation can arise when the government has a high priority goal that both requires intersectoral collaboration and affects the health sector. In this situation, the health sector has a valuable opportunity to promote and facilitate intersectoral action to achieve an important government objective at the same time as advancing health's own agenda. This proactive engagement can strengthen ties with other sectors and establish a reputation of expertise and reliability, which can be called upon when needed later. Examples of this third scenario might include: improving early childhood development or responding to food insecurity.

You might want to illustrate examples of the above policy situations, particularly those relevant to the region or country where the workshop is being held. It is suggested that you reassure the participants that these different policy situations will become clearer by looking at case studies during the workshop.

1 WHO (2013) Helsinki Statement on Health in All Policies. WHO 8th Global Conference on Health Promotion.

Figure 3.1: Policy situations where a HiAP approach should be considered

Source: diagram developed by authors from analysis in Leppo K *et al.* (eds) (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health, p. 329.

Within these three policy situations, it is still necessary to prioritize which issues to address. There are no permanent and certain rules but several considerations are useful. Potential issues for action should be chosen by applying criteria[1] such as:

- Problem or issue is of major public health importance;
- Problem or issue is amenable to change and change is feasible. That is, there is sound evidence that it can be tackled; and
- Potential solutions are politically and socially acceptable.

After defining public health and HiAP, and looking at when to use a HiAP approach, you may want to explain the development of HiAP and how it compares with other public health approaches.

Approaches to public health

Approaches to public health have varied over time in the way health problems are viewed and solved. In ancient times, many cultures believed that disease was caused by an imbalance in the body or by evil or sin. In ancient Greece, physicians believed health to be an internal equilibrium of the four bodily humours: blood, phlegm, black bile and yellow bile. *Dyskasia*, the disturbance of that internal equilibrium, it was believed, caused disease. In ancient Egypt, evil gods and demons were thought to be responsible for many ailments, and often the treatments involved a supernatural element, such as beginning treatment with an appeal to a deity. As such, there was no clear

1 Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health, p. 311.

distinction between the functions of a priest and a physician. And in ancient China, as in ancient Greece, the first physicians based their treatment on correcting imbalances of the five phases or elements: wood, fire, earth, metal and water. Thus, ancient approaches to public health were heavily based on religious beliefs and superstition.

Notwithstanding notable differences in medical knowledge and population health between regions and over time, medicine developed dramatically in the 1800s by advances in chemistry and laboratory techniques. Old ideas of infectious disease epidemiology were replaced with bacteriology and virology. This gave rise to what certain scholars refer to as a "biomedical approach" to public health focusing on the control and treatment of disease, especially those of a communicable nature. This biomedical approach has been prominent since the 1800s and is typified by mass vaccination campaigns and the development of new drugs to treat disease.

An alternative approach to public health, with which HiAP has ties, is the "sanitary-environmental approach" to public health. This is sometimes referred to as the salutogenic model. This approach focuses on the ensuring people live and work in healthy conditions. This means, for example, having adequate housing, proper sanitation, access to uncontaminated food and clean water, and a safe work environment.

Importantly, it has been shown that improvements in living conditions and better nutrition were primarily responsible for the dramatic reductions in mortality in European industrialized countries in the 1800s. This is because mortality rates fell and life expectancies rose prior to the introduction of most effective medical interventions. The same approach to public health focusing on healthy living conditions and basic needs can also be credited with increasing life expectancies in many developing countries. In the 1930s, many Latin American countries initiated major public interventions within and outside the health sector such as improving access to water, food and nutrition, sanitation, housing, education and transport. Other countries that made similar transitions during the mid-20th century include China, India and Indonesia (recall the video shown in Module 2).

Historically, we can say that efforts to address the social, economic and environmental determinants of health required collaboration across multiple sectors and redistribution of wealth to the poor, thus, reducing or slowing the growth of inequality. These efforts often necessitated political and social struggle. In Europe during the 1800s many social reforms were initiated by governments to placate a combative labour movement. In many developing countries during the mid-1900s, the governments of newly independent countries initiated social and economic projects as part of nation building, supported by ideologies of solidarity and egalitarianism.

Another trend in public health is the "social-behavioural approach", which focuses on lifestyles and behavioural change drawing on psychological theories to reduce disease risk factors. Examples of this approach might include campaigns against risky behaviours such as problem drinking, substance abuse, reckless driving and unprotected sexual intercourse. Such efforts to change behaviour have sometimes had success but rarely in the absence of more structural changes to the conditions shaping people's health in their everyday lives.

Recent history of HiAP

The immediate history of HiAP[1] originates from the ideas, actions and evidence that have emerged since the Alma-Ata Declaration on Primary Health Care (1978) and the Ottawa Charter for Health Promotion (1986).

The Ottawa Charter, which resulted from the First International Conference on Health Promotion, provides a cornerstone for health promotion. It identifies the paramount importance of health equity, and of five key action areas. These, in turn, became the focus of the conference in Adelaide in 1988, where principles and practices for healthy public policy were highlighted. Subsequent health promotion conferences focused on achieving health and health equity through creating a health-conducive environment, building effective partnerships, addressing social determinants and taking country action.

The HiAP approach has been reinforced in the more recent 2011 Rio Political Declaration on Social Determinants of Health and the UN General Assembly Resolution on the Prevention and Control of Non-Communicable Diseases.

Why HiAP matters

Health and health equity are values in their own right, and are also important prerequisites for achieving many other societal goals. Many of the determinants of health and health inequities in populations have social, environmental and economic origins that extend beyond the direct influence of the health sector and health policies. Thus, public policies and decisions made in all sectors and at different levels of governance can have a significant impact on population health and health equity.

The HiAP approach is, therefore, necessary to protect and promote health and health equity, particularly where there are competing interests. It ensures that health and health equity considerations become part of decision-making.

HiAP recognizes that governments are faced with a range of priorities and that health and equity may not automatically gain precedence over other policy objectives. Nonetheless, health considerations do need to be taken into account in policy-making. Efforts must be made to capitalize on opportunities for co-benefits across sectors and for society at large.

1 WHO (2014) HiAP Framework for Country Action. Geneva, WHO.

International milestones in HiAP development

To help the participants get an overview of the development of HiAP, it is suggested you distribute the Handout 3.1 – a timeline of key international events and documents over the past four decades.

Some comments to make with reference to the timeline could include:

- HiAP has been promoted systematically by international organizations in particular the WHO but also through the European Union.
- It has recently gained new prominence through the intensive debate on action for social determinants of health and because of this a particular focus has been on the equity dimension of HiAP.
- The increasing push towards more effective forms of governance and the recognition of the systemic nature of public policy in general has also led to a growing interest in HiAP as an innovative way to address health challenges though collaboration.
- HiAP has also gained prominence with the NCD agenda since, as stated in the UN political declaration, it depends on whole-of-government and whole-of-society approaches.
- Finally, the discussion on sustainable development at Rio+20 has introduced the notion of health co- benefits. HiAP is therefore continuously evolving as is the terminology that is applied.

HiAP and related terms

At the same time that you distribute the timeline, you might want to distribute Handout 3.2 which gives some definitions of key terms in the literature. It should be noted that for most purposes, many of these terms are synonyms and are used interchangeably.

It is recommended the group now takes a break before starting part two of the module.

PART TWO

GROUP ACTIVITY: IDENTIFYING THE HiAP APPROACH

25 MINS

The purpose of this group activity is to encourage the participants to reflect on the definition of HiAP and learn to distinguish the HiAP approach.

You should divide the participants into small groups and distribute printed descriptions of examples of different government projects (see Handout 3.3). Ideally, you should prepare examples of government projects from the country or region where the workshop is being held.

You should instruct the groups to read the descriptions and discuss as a group which government projects might illustrate a HiAP approach. You may also want to remind the participants to refer to the handout on terms and reflect on the different emphases of the biomedical and social-behavioural approaches to public health.

After the groups have had time to categorize the government projects, you should discuss each example together as a larger group. While projects cannot always be definitely associated with one approach to public health, it is useful to highlight the general differences between the approaches. In particular, it is important to note that HiAP:

- Focuses on the social, economic and environment determinants of health;
- Targets inequalities; and
- Promotes integration and collaboration across sectors and other non-government stakeholders.

At this point in the discussion you might also want to answer questions about different terms.

If time permits, you may want to extend the duration of this group activity.

GROUP ACTIVITY: WHO'S HiAP FRAMEWORK FOR COUNTRY ACTION

40 MINS

From the earlier group activities and lecture in this module, participants should now understand the concept of HiAP. At this point, participants might start to question how does it actually work? This is an opportunity to introduce the WHO's HiAP Framework for Country Action, which should be provided in the participants' workbook or as a handout (see Handout 3.4).

It is suggested you go through the framework and discuss each section. You may want to give special attention to why HiAP matters as well as the six components of implementation.

WHO's HiAP Framework for Country Action provides some suggestions on how to put HiAP into action. The six components of the framework are roughly associated with the modules indicated in the table below.

WHO HiAP FRAMEWORK FOR COUNTRY ACTION COMPONENTS	ASSOCIATED MODULE(S) IN THIS WORKSHOP
1. Establish the need and priorities for HiAP	Modules 5
2. Frame planned action	Modules 5, 7
3. Identify supportive structures and processes	Module 7
4. Facilitate assessment and engagement	Modules 8, 9, 10
5. Ensure monitoring, evaluation and reporting	Module 10
6. Build capacity	Modules 11, 12

QUESTIONS AND FEEDBACK

10 MINS

It is recommended that you encourage contributions and questions throughout the workshop and dedicate a small amount of time at the end of each module for feedback and clarifications. This unallocated time can be used as necessary if part of a module takes longer than expected.

module

4

THE POLICY-MAKING PROCESS

module

4

THE POLICY-MAKING PROCESS

Part One

Group discussion: What is policy? 52

Lecture: Complex social issues. 52

Group activity: Complex social problems 55

Part Two

Lecture: Policy-making and HiAP. 57

Group activity: Framing and windows of opportunity 62

Questions and feedback 62

MODULE OVERVIEW

This module explains the policy-making process in relation to HiAP including topics such as the framing of issues and managing complexity.

	DURATION
PART ONE	
Group discussion: What is policy?	10 mins
Lecture: Complex social issues	20 mins
Group activity: Complex social problems	45 mins
PART TWO	
Lecture: Policy-making and HiAP	20 mins
Group activity: Framing and windows of opportunity	45 mins
Questions and feedback	10 mins
PART ONE	**1h 15 mins**
PART TWO	**1h 15 mins**
TOTAL TIME	**2h 30 mins**

Learning objectives

- Define policy and describe the stages of the policy-making cycle
- Recognize the complex and political nature of the policy-making process
- Identify the characteristics of a "window of opportunity" for policy change
- Define a policy champion/policy entrepreneur
- Frame a complex health issue and identify its policy challenges and opportunities

Key messages

- Broadly speaking, a policy is a principle or a plan to guide decisions, actions and outcomes. Policies may be written documents or unwritten practices. Often, there can be a difference between policy as intent and policy in effect. Policies are also highly context specific and influenced by social, cultural, economic and political structures.
- There is a range of conceptual frameworks to describe the stages of the policy-making process or policy cycle. Generally speaking, the policy cycle consists of the following stages:
  - › Agenda setting (identify the problem, conduct research, set agenda);
  - › Policy formation (develop policy options and strategies, negotiate, formulate policy);

  - › Policy implementation (implement and enforce policy); and
  - › Policy review (monitoring, evaluation and reporting).
- Policy-making is complex, highly political and a continual process. It can stretch over long periods of time and usually involves many actors and interests, which may vary over the course of time. Given the complex, political nature of policy-making, it is essential to seize "windows of opportunity" that arise from changing economic, social and political realities.
- Windows of opportunity are short periods of time in which, simultaneously, a problem is recognized, a solution is available and the political climate is positive for policy change. These are critical opportunities for policy entrepreneurs to address important policy problems. Windows of opportunity can sometimes coincide with political campaigns, changes in the government's balance of power as well as crises and disasters.
- Framing refers to how an issue is defined, which can in turn influence how the issue is viewed (non-issue, problem, crisis etc.), who is considered responsible and the cause and possible solutions.
- A policy champion is a person or team willing and able to lead and manage the policy process. Policy champions proactively promote policy reforms, publicly support the policies and foster the support of others. They frame discussion of the issue, build consensus, attract resources and seize and create opportunities to move the reform forward. Change agents and policy entrepreneurs are similar terms for this concept emphasizing the creative dimension of breaking with existing ideas and initiating new policies.

Key reading for participants

Recommended

- Mannheimer L, Lentho J and Östlin P (2007) Windows of Opportunity for Intersectoral Health Policy in Sweden: Open, Half-Open or Half-Shut? *Health Promotion International,* Vol. 22, No. 4, pp. 307–315 (7 pages)

Optional

- Korn D, Gibbens R and Azmier J (2003) Framing Public Policy Towards a Public Health Paradigm for Gambling. *Journal of Gambling Studies*, Vol. 19, No. 2, pp. 235–256
- WHO's Violence Against Women Factsheet. Geneva, WHO

Supporting material for instructors

- Walt G (1994) *Health Policy: An Introduction to Process and Power.* London, Zed Press
- Ritchey T (2011) *Wicked problems: Social messes.* Berlin, Springer
- Butland B *et al*. (2007) *Tackling Obesities: Future Choices.* London, Government Office for Science,
- WHO (2009) *Setting the Political Agenda to Tackle Health Inequity in Norway.* Copenhagen, WHO

Teaching notes

This module is about explaining the policy-making process, and will lay the basis for later modules on policy formulation including preparing policy briefs, conducting stakeholder analyses and conducting negotiations before turning to monitoring and evaluation of HiAP. The module begins with a group discussion on what is policy then moves into a lecture on the policy-making process with particular emphasis on its complex and political nature. A large part of the module is then dedicated to a group activity on framing the issue of violence against women and identifying opportunities and challenges to policy change. If this subject is not appropriate, you may want to prepare an alternative issue to analyse.

This module does not assume a high level of theoretical knowledge of policy-making but it is likely that most participants will come with extensive experience working in government and many may have backgrounds in political science or public policy. As such, it is recommended that you adapt this material to the level of knowledge and experience of the participants. In particular, you may wish to cover quickly the first part of the module dealing with defining policy and the policy-making cycle to concentrate on the complex and political nature of the process. As always, it is useful to point to the learning objectives and outline the structure of the module so that the participants know what to expect.

PART ONE

GROUP DISCUSSION: WHAT IS POLICY?

10 MINS

To begin the discussion of the policy-making process, it is useful to establish a general definition of policy. You may want to do this in an interactive way with open questions or you may wish to simply communicate some key messages if time is limited or you feel that the participants have extensive public policy experience.

Some important points to note might include:

- Broadly speaking, a policy is a principle or a plan to guide decisions, actions and outcomes. However, the term policy can have a wide range of different meanings.
- Policies can be laws, documents, procedures, guiding principles, statements of intent or working frameworks. Policies may be written documents or unwritten practices. Policies can be implicit or explicit, formal or informal.
- Policy can be a way of working, a vision, a programme of action, duties, responsibilities, accountability or an unwritten cultural or ethical code.
- Public policy refers to the policy of government.
- Different environments (government departments, cities, countries etc.) have different policies and this is influenced by their unique social, economic, political and cultural context.
- Policy can be developed and implemented in different ways: through negotiation, repeated practice, decree/order or convention.
- There can often be a large (sometimes deliberate) discrepancy between policy as intent (what is planned, stated or written) and policy as practice (what actually happens).
- Policy analysis is a way of studying the way polices are created so that existing policies can be changed or new ones created.

LECTURE: COMPLEX SOCIAL ISSUES

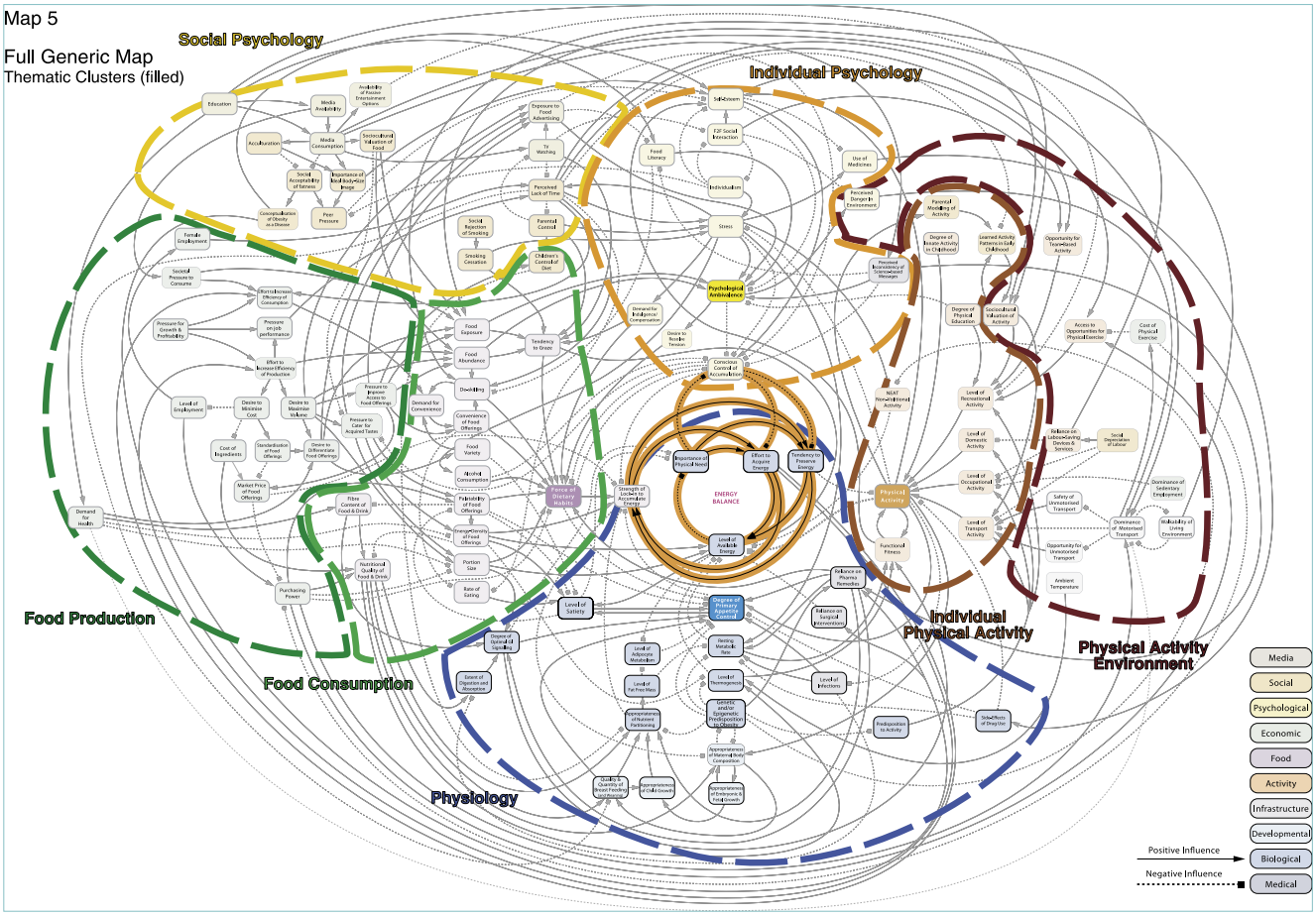
20 MINS

You might want to begin this discussion by pointing to some of the issues mentioned in earlier modules, such as health inequality and NCDs such as cancer, cardiovascular disease and mental illness. These are complex social issues: the causes are not always clear, the solutions are not

straightforward and there are many actors involved. In the scholarly literature these complex social issues are even described as "messy", "fuzzy" or "wicked".[1]

It is suggested that you focus on the example of obesity and show Figure 4.1. As the diagram illustrates, obesity is caused by a complex combination of factors: societal influences, food production, food consumption, the environment and an individual's psychology, biology and physical activity.

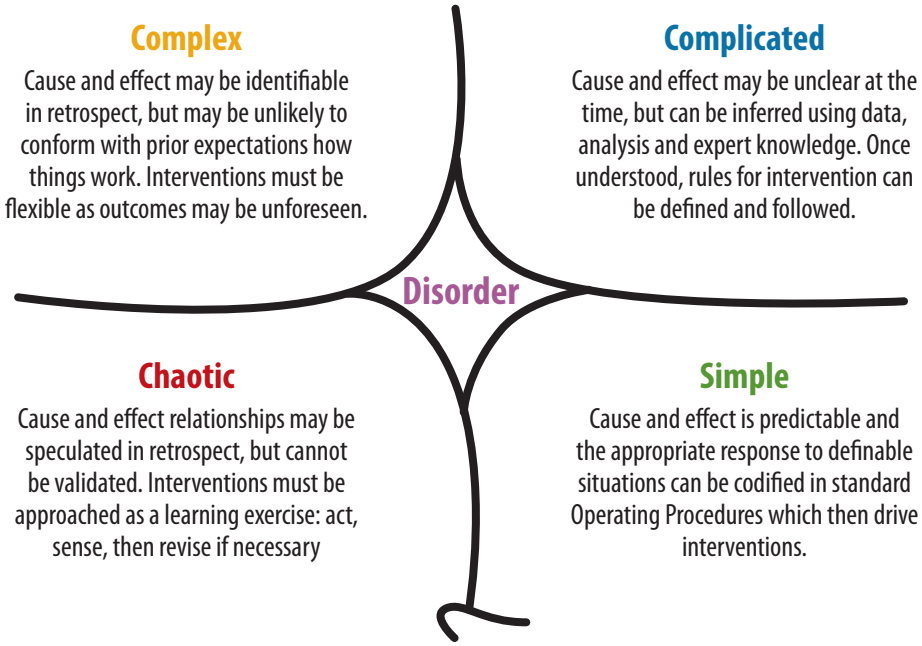
Figure 4.1: The complex combination of factors behind obesity



Source: Butland B *et al.* (2007) *Tackling Obesities: Future Choices.* London, Government Office for Science, p. 90.

1 Ritchey T (2011) *Wicked problems: Social messes.* Springer; Mitroff II and Mason R (1980) Structuring ill-structured policy issues: Further explorations in a methodology for messy problems. *Strategic Management,* Vol. 23; and Mitroff II and Featheringham TR (1974) "On systematic problem solving and the error of the third kind". *Behavioral Science,* Vol. 19, 383–393.

Figure 4.2: Problem types



Source: Snowden, D (2005) Multi-ontology sense making – a new simplicity in decision-making. *Informatics in Primary Health Care,* Vol. 13, No. 1, pp. 45–53.

Complex problems require complex solutions. For complex health solutions it is clear that a single government sector, specializing in the management of care delivery, will not have all the tools, knowledge, capacity, let alone budget, to address this complexity. Ministries of health are not equipped to deal with the "causes of the causes" such as the social determinants of health.[1]

You might also want to show Figure 4.2 and compare simple, complicated and complex problems using the following examples.

A "simple" problem (e.g. one person with a bout of gastroenteritis) would require a standard, simple solution (oral rehydration and possibly a course of antibiotics when warranted). A "complicated" problem (e.g. a salmonella outbreak in a care home for the elderly) would require investigation, data collection and analysis, and a more astute intervention (food preparation monitoring, isolation, disease management and clinical intervention). Complex and chaotic problems as encountered in 21st-health, however, require flexibility, adaptation, collaboration and a much more strategic intervention.[2]

1 Evelyne de Leeuw (2013) *HiAP Monitoring and Development Checklist*, p. 2.

2 Evelyne de Leeuw (2013) *HiAP Monitoring and Development Checklist*, p. 3.

HiAP is premised on this kind of strategic, collaborative approach to policy-making.

A key message for participants is that complex social problems require a mindset that accepts that increasingly public health problems are not suited to easy solutions. They require:

- A range of trade-offs;
- A tolerance for ambiguity and for uncertainty;
- An opportunities driven approach (discussed below); and
- A good contextual analysis – here it is helpful to differentiate between:
  - › The contextual environment: factors in the external world which impact the issue but cannot be influenced by the organization;
  - › The transactional environment: factors that are external to the organization but can be influenced by that organization; and
  - › The policy or strategy space: the internal world of an organization or system which can be controlled.

GROUP ACTIVITY: COMPLEX SOCIAL PROBLEMS

45 MINS

The purpose of this group activity is to identify examples and discuss characteristics of complex social problems, sometimes referred to as "wicked", "fuzzy" or "messy" problems.

To begin, it is suggested you give a definition such as the one below:

Complex social problems are ill-defined, ambiguous and associated with big moral, political and professional issues. They are subjective and strongly stakeholder dependent: there is often little consensus on what the problem actually is, let alone how to resolve it. Above all, these problems won't keep still: they are sets of complex, interacting issues evolving in a dynamic social context. Often, new forms of complex problems merge as a result of trying to understand or resolve one of them.

Next, you should divide the participants into small groups for the exercise. Ask each group to come up with a list of complex social problems and discuss the characteristics that they have in common and make them complex. You may want to ask certain groups to focus on health issues and other groups to come up with non-health complex issues. To assist them, you might want to provide a few examples such as:

- Antimicrobial resistance;
- Poverty;
- Climate change; or
- Drug trafficking.

You should inform the participants that each group will be asked to share a complex social problem and argue why it should be considered as such.

Some of the characteristics of complex (so-called "wicked") problems that might be suggested during the group discussion could include:

- Cannot be exhaustively formulated;
- Every formulation is a statement of a solution;
- No stopping rule;
- No true or false;
- No exhaustive list of operations;
- Many explanations for the same problem;
- Every problem is a symptom of another problem;
- No immediate or ultimate test;
- One-shot solutions;
- Every problem is essentially unique; and
- Problem solver has no right to be wrong.

If time permits, you may want to extend the duration of this group activity.

After the group presentation, it is recommended that the group takes a break before starting part two of the module.

PART TWO

LECTURE: POLICY-MAKING AND HiAP

20 MINS

This part of the module is an opportunity to outline a theoretical framework for policy-making in relation to HiAP.

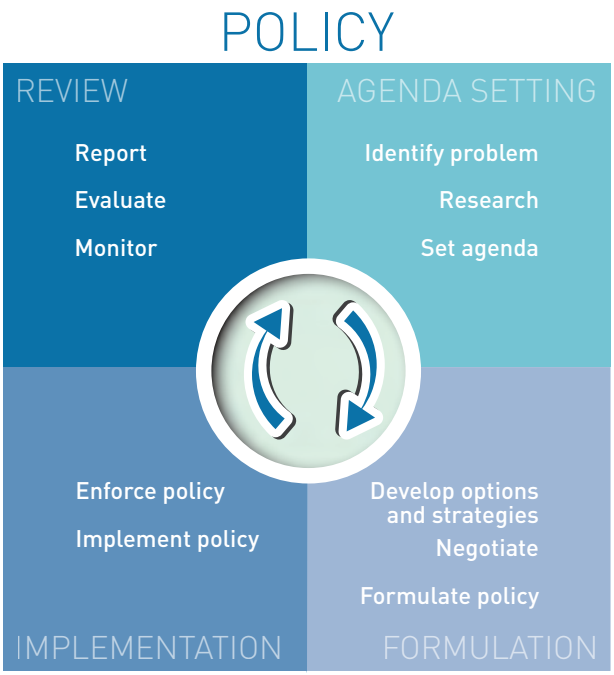
Policy-making cycle

There is a range of conceptual frameworks to describe the stages of the policy-making process or policy cycle. Generally speaking, however, the policy cycle consists of the following stages:

- Agenda setting (identify the problem, conduct research, set agenda);
- Policy formation (develop policy options and strategies, negotiate, formulate policy);
- Policy implementation (implement and enforce policy); and
- Policy review (monitoring, evaluation and reporting).

Here, it is worth noting that these stages appear in the WHO HiAP Framework for Country Action and other variations of the policy cycle in the academic literature, although they might be named slightly differently.

Figure 4.3: Stages of the policy cycle



Source: modified from http://www.geostrategis.com/images/policycycle.jpg

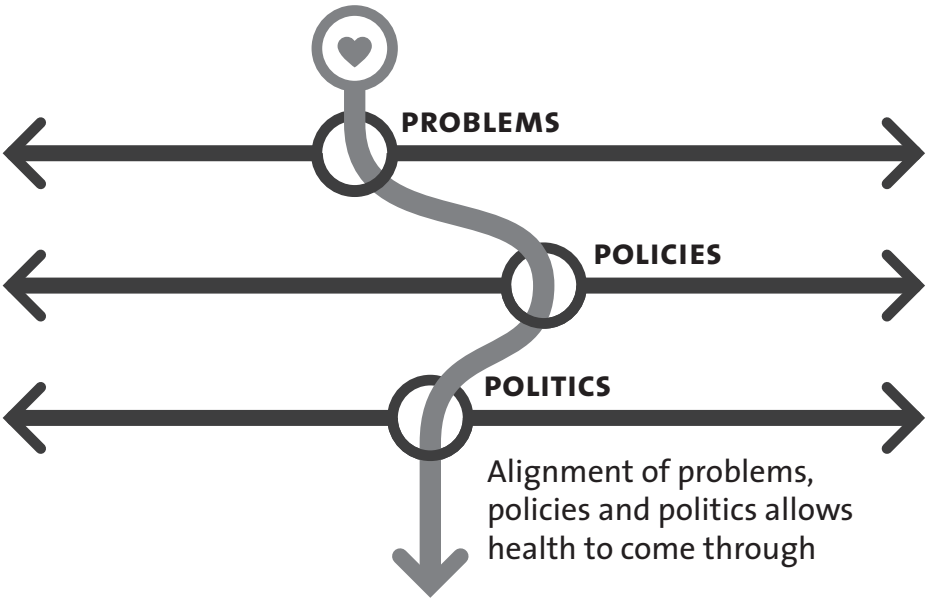
It is recommended that you again emphasize the fact that many contemporary health issues are complex and influenced by factors outside the health sector as has been discussed during Modules 1–4. HiAP is premised on the kind of strategic and collaborative approach required to address these issues. This also makes HiAP an inherently political process that involves the reallocation of resources including power and responsibilities. It can stretch over long periods of time and usually involves many actors and interests, which may vary over the course of time. This means that the HiAP is not necessarily linear. The completion of one stage does not guarantee movement to the next. Nor is progress in one stage dependent on completion of all the tasks in the previous stage. We will see this with the concept of "windows of opportunity".

Windows of opportunity and framing

Given the complex, political nature of policy-making in health, it is essential to seize "windows of opportunity" that arise from changing economic, social and political realities. This concept of windows of opportunity comes from political scientist Kingdon who proposes the existence of three non-linear streams in policy-making – problems, policies and politics – which interplay to open windows of opportunity for policy decisions.[1]

Thus, windows of opportunity are short periods of time in which, simultaneously, a problem is recognized, a solution is available and the political climate is positive for policy change. See Figure 4.4 which illustrates this alignment of problems, policies and politics.

Figure 4.4: Alignment of problems, policies and politics in creating "windows of opportunity"



Source: Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health, p. 16.

1 Kingdon JW (1995) *Agendas, Alternatives and Public Policies*. New York, Harper Collins College Publishers; Stone D (2002) *Policy Paradox: The Art of Political Decision Making*. New York, Norton Publishers.

Firstly, an issue needs to be recognized as a "problem" by politicians, policy-makers and the overall community before it can be raised in the policy-making agenda. This is most easily achieved on an ad hoc basis through focusing on events such as disasters, accidents or crises and the linked media attention. Fortunately, more deliberate or planned avenues are also possible. For instance, research results showing key information on the magnitude of the problem; worrying changes in the situation; failures to meet previous goals; or rising costs, can be very effective in raising awareness. International efforts also provide opportunities for the health sector to raise HiAP on national agendas – for example, the work of the WHO Commission on Social Determinants of Health or the 2011 United Nations High-Level Meeting on the Prevention and Control of Noncommunicable Diseases.[1]

It is important to bear in mind that opportunities may also arise from policy development within other sectors and it is essential that health policy-makers identify such gateways for action. Ideally, policy processes across sectors would be screened for major impacts on health, health equity or health systems and those of high priority would be analysed further. The rising cost of health care provision is proving to be an important factor for motivating governments to adopt a HiAP approach as one response to the perceived crisis.[2]

This recognition of a problem can also be thought of as the agenda-setting stage of the policy cycle, viewed earlier. You may want to inform the participants that this process of setting the agenda, or getting a problem recognized is all about framing, which the module will look at shortly and practise in a group activity.

Essentially, framing refers to how an issue is defined, which can in turn influence how the issue is viewed (non-issue, problem, crisis, etc.), who is considered responsible and the cause and possible solutions. Policy stakeholders can own or disown a public problem through the way they define it. Owning a problem can be an advantage to groups and organizations – it may allow for increased credibility, funding and legitimacy. Health problems often remain defined in purposely "fuzzy" terms because no stakeholder can see a benefit of owning complex problems. This often means that the ownership falls onto the "default" health actor: the ministry of health or other institutional arrangement that has a statutory requirement to deal with health. Redefining or reframing the problem allows for new ways of understanding, which can encourage new stakeholders to engage in the policy process.[3]

Next, after recognizing or framing problems, proposals for solutions are required, in other words – "policies". Often developed by policy communities (including public institutions, universities, think-tanks and/or private bodies) these provide alternative solutions for the problems. To achieve success, these policies should be technically sound, culturally and ethically acceptable and financially reasonable. Such solutions are accepted more readily if they do not conflict with other interests, and therefore, it is often worth studying other interests and pursuing such solutions.[4]

This search for solutions is the policy formulation stage of the policy cycle. You may want to inform the participants that we will be focusing on this when we prepare policy briefings, which explore and recommend policy options.

1 Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health, p. 16.

2 Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health, p. 16.

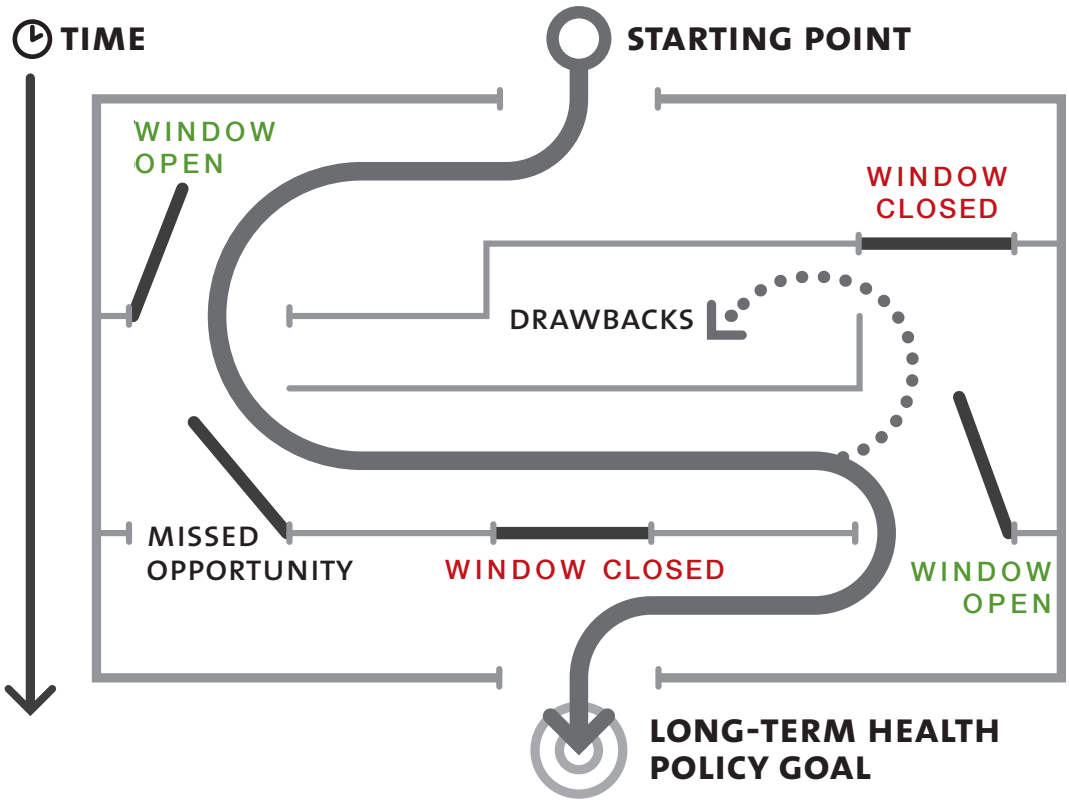
3 Evelyne de Leeuw (2013) *HiAP Monitoring and Development Checklist,* p. 5.

4 Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health, p. 17.

Finally, a policy change is possible only if the "politics" environment is right. Policy-makers need to be able to recognize appropriate moments in politics when a policy change would be most likely to be adopted. Suitable opportunities often arise in election campaigns; during the establishment of a new government; or during a change in the balance of power in parliament, such as the rise of a new coalition. A financial crisis can also provide an opportunity if, for example, raising taxes on harmful products is viewed as an appropriate option. There is also a need to identify relevant actors and policy-making processes. The political process involves negotiations between all the parties involved and the more conflicting interests there are, the more difficult the process to find a common solution.[1]

This negotiation of politics is part of both the policy formulation and policy implementation stages of the policy cycle.

Figure 4.5: "Windows of opportunity" in policy formulation and implementation



Source: Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies.* Finland, Ministry of Social Affairs and Health, p. 19.

1 Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies.* Finland, Ministry of Social Affairs and Health, p. 17.

In the context of policy-making, a long-term vision is essential to guide the policy process over the course of a longer time span and allow policy-makers to seize windows of opportunity. Progress is made by taking opportunities as they arise but, at a given political time, some windows might be closed or missed because of lack of awareness of policy processes in other sectors (see Figure 4.5). There can also be drawbacks that worsen the situation.[1]

Ecuador's introduction of restrictions and taxes on the sale of alcohol is an example of seizing a window of opportunity. The policy community had long identified Ecuador as a country with high binge-drinking rates in Latin America. But nothing was done until 50 people died and 14 were left blind due to bootleg liquor in June 2011. In response, the authorities introduced a three-day ban on alcohol sales and bought back any contaminated alcohol still in circulation. Since then, Ecuador has seen great progress: an intersectoral alcohol policy was launched in April 2012; a tax reform increased excise tax for imported alcohol significantly; and several local districts have banned alcohol sales and consumption on the streets during public festivities.[2]

Policy champions/policy entrepreneurs

At this point, it is suggested that you reintroduce and formally discuss the concept of policy champions/policy entrepreneurs, which you may have briefly touched on in Module 1.

In the context of discussing windows of opportunity and the complex, political nature of policy-making, Kingdon emphasizes the importance of policy champions. A policy champion is a person or team willing and able to lead and manage the policy process. Policy champions proactively promote policy reforms, publicly support the policies and foster the support of others. They frame discussion of the issue, build consensus, attract resources, and seize and create opportunities to move the reform forward.

Change agents and policy entrepreneurs are similar terms for this concept that highlights the creative dimension of breaking with existing ideas and initiating new policies.

It is recommended that you conclude this discussion of policy-making by re-emphasizing that the ultimate aim of this workshop is to help the participants become policy champions/policy entrepreneurs.

1 Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health, p. 18.

2 Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health, p. 18.

GROUP ACTIVITY: FRAMING AND WINDOWS OF OPPORTUNITY

45 MINS

The purpose of this group activity is for the participants to apply their understanding of the concepts of framing and windows of opportunity, which form part of the agenda-setting stage of the policy cycle.

You should divide up the participants into small groups and distribute Handout 4.1, WHO's Violence Against Women Factsheet, which participants would have ideally read as pre-reading to the course. If this subject is not appropriate, you may want to prepare an alternative issue to analyse, possibly using a different WHO factsheet.

It is suggested that you briefly reiterate the concepts of framing and windows of opportunity if necessary and pose the following questions to help the groups begin the task:

1. How can you "frame" intimate partner and sexual violence against women as a problem that requires urgent action?
2. How will you define the problem so that other sectors are encouraged to take ownership of the issue and be part of the solution?
3. What existing or future opportunities can you see to put the issue on the agenda?

If the groups find the third question difficult or rather abstract, you might want to encourage them to be creative and suggest some realistic hypothetical situations. For example, the election of a new government or the publication of a new report or another country introducing a radical new policy to address the issue are good suggestions.

You should inform the participants that after 30 minutes each group will be asked to briefly present how they would frame the issue and the opportunities they envisage to put violence against women on the policy agenda. Remember to regularly remind the groups of the time so that they can reach a consensus and agree on who will present.

If time permits, you may want to extend the duration of this group activity.

QUESTIONS AND FEEDBACK

10 MINS

It is recommended that you encourage contributions and questions throughout the workshop and dedicate a small amount of time at the end of each module for feedback and clarifications. This unallocated time can be used as necessary if part of a module takes longer than expected.

module

5

THE ROLE OF GOVERNMENT IN HiAP/ WHOLE-OF-GOVERNMENT APPROACHES

module

5

THE ROLE OF GOVERNMENT IN HiAP/ WHOLE-OF-GOVERNMENT APPROACHES

Lecture: The role of government in the HiAP approach 68

Group activity: Conditions that promote or hinder intersectoral collaboration 70

Lecture: Structures and mechanisms for intersectoral collaboration 73

Group activity: Case studies of HiAP intersectoral action 79

Questions and feedback 80

MODULE OVERVIEW

This module is about the crucial role of government in HiAP, the conditions under which whole-of-government or intersectoral action is most effective, and the government structures and mechanisms used.

	DURATION
Lecture: The role of government in the HiAP approach	10 mins
Group activity: Conditions that promote or hinder intersectoral collaboration	20 mins
Lecture: Structures and mechanisms for intersectoral collaboration	15 mins
Group activity: Case studies of HiAP intersectoral action	35 mins
Questions and feedback	10 mins
TOTAL TIME	**1h 30 mins**

Learning objectives

- Describe the role of government in the HiAP approach
- Recognize a range of terms that refer to intersectoral action
- Explain some of the barriers to closer intersectoral collaboration
- Describe conditions conducive to the HiAP approach
- List and appraise different structures and mechanisms for intersectoral action
- Discuss examples of HiAP in practice

Key messages

- Governments are responsible for the health of their peoples and have a critical leadership and stewardship role in the organized effort by society to promote health and well-being. Given this responsibility and the complexity of many contemporary health challenges, governments have a crucial role to play in the HiAP approach by:
  - › Commissioning research;
  - › Engaging stakeholders within and beyond government;
  - › Formulating and implementing intersectoral policies; and
  - › Evaluating their impact.
- Intersectoral action refers to the coordinated efforts of two or more sectors within government to improve health outcomes. This can include working across different levels of government such as district, provincial and national jurisdictions. The term intergovernment is sometimes used to refer to these horizontal and vertical linkages between levels of government within a

country. Whole-of-government, joined-up government and healthy public policies are similar terms used in the HiAP literature.

- A whole-of-society approach, in contrast, refers to coordinated efforts to improve health by multiple stakeholders within and outside government that may also be from several sectors. This dimension of HiAP is discussed at length in Module 7.
- Some of the notable barriers to successful intersectoral collaboration within government include:
  - Distracted or unstable leadership;
  - Fragmented government functions;
  - Sub-national geographical and government jurisdiction divisions;
  - Limited or misused resources (staff, funding, etc.); and
  - Restricted policy space.
- The conditions that most favour effective intersectoral collaboration include:
  - Government supports and encourages intersectoral action;
  - Sectors have shared interests or both benefit from cooperation;
  - Issue has high political importance and requires urgent addressing;
  - Proposed policy has public support;
  - Strong, effective leaders in the bureaucracy (policy champions/entrepreneurs);
  - Intersectoral action is well-planned with clear objectives, roles and responsibilities;
  - Laws exists or are planned to support the proposed policy;
  - Sufficient resources are available; and
  - There are plans to monitor and sustain outcomes.
- Some of the most common structures and mechanisms for intersectoral action include:
  - Cabinet committees and secretariats;
  - Parliamentary committees;
  - Interdepartmental committees and units;
  - Mega-ministries and merges;
  - Joint budgeting; and
  - Intersectoral policy-making procedures.

Key reading for participants

Recommended

- Lin V *et al.* (2012) Synthesizing the Evidence: How Governance Structures can Trigger Governance Actions to Support Health in All Policies in McQueen DV *et al.* (2012) *Intersectoral Governance for Health in All Policies*. WHO (30 pages)
- Leppo K *et al.* (2013) Lessons for Policy-Makers in Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies.* Finland, Ministry of Social Affairs and Health (12 pages)

Optional

- WHO Social Determinants of Health Sectoral Briefings:
  - WHO (2011) *Housing: Shared Interests in Health and Development – Social Determinants of Health Sectoral Briefing Series One.* Geneva, WHO
  - WHO (2011) *Education: Shared Interests in Well-Being and Development – Social Determinants of Health Sectoral Briefing Series Two.* Geneva, WHO
  - WHO (2011) *Transport (Road Transport): Shared Interests in Sustainable Outcomes – Social Determinants of Health Sectoral Briefing Series Three.* Geneva, WHO
  - WHO (2012) *Social Protection: Shared Interests in Vulnerability Reduction and Development – Social Determinants of Health Sectoral Briefing Series Four.* Geneva, WHO
  - WHO (2013) *Energy: Shared Interests in Sustainable Development and Energy Services – Social Determinants of Health Sectoral Briefing Series Four*. Geneva, WHO

Supporting material for instructors

- McQueen DV *et al.* (2012) *Intersectoral Governance for Health in All Policies.* WHO
- Leppo K *et al*. (2013*) Health in All Policies: Seizing Opportunities, Implementing Policies.* Finland, Ministry of Social Affairs and Health
- Kickbusch I and Behrendt T (2013) *Implementing a Health 2020 Vision: Governance for Health in the 21st Century.* Copenhagen, WHO
- Gray, B (1985) Conditions Facilitating Interorganizational Collaboration. *Human Relations,* Vol. 38, No. 10, pp. 911–936

Teaching notes

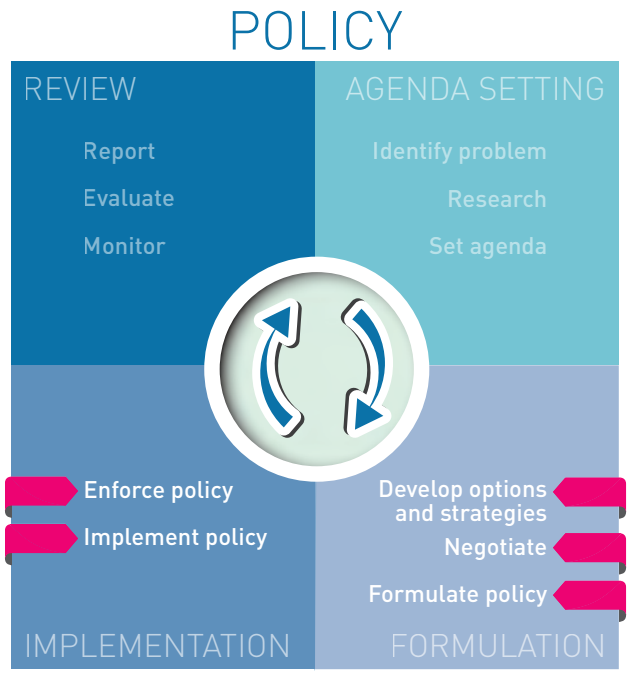
This module is about discussing the critical role of government in HiAP. It begins with a recap of a key message in Module 2 that governments have a responsibility for the health of their populations and summarizes the range of terminology for intersectoral action. It is suggested that you use a group activity to explore the circumstances and contexts that hinder or support working across departments and levels of government since the participants will likely have direct experience of this. You may then want to outline some of the formal structures and mechanisms used in practice then conduct another group activity where participants can either share their experiences or discuss case studies. Given the importance of participants exchanging experiences and lessons learned, it will be important for you to facilitate the discussion, manage time and underline some of the important observations and messages. As always, it is useful to point to the learning objectives and outline the structure of the module so that the participants know what to expect.

LECTURE: THE ROLE OF GOVERNMENT IN THE HiAP APPROACH

10 MINS

The theme of this module is the implementation of HiAP from the perspective of government. In general terms, this corresponds to the formulation and implementation stages of the policy cycle (see Figure 5.1). The review stage of the policy cycle, which also involves government, is discussed later in Module 10.

Figure 5.1: The role of government in HiAP – policy formulation and implementation



Source: modified from http://www.geostrategis.com/images/policycycle.jpg

The role of government in HiAP

It is suggested that you start the module by recapping the following key messages from Module 2 to re-emphasize government responsibility for the health of the population.

- Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity;
- Health is an individual right and a social justice issue;
- Health is a public good; and
- Governments have a responsibility for the health of their peoples.

Historically, the principle of government responsibility for the health of its population has been central to public health. In most countries, the efforts of government have been fundamental to addressing the social, economic and environmental determinants of health. The redistributive powers of government have also been critical for redressing health inequalities. The government's role in health is therefore a matter of principle and pragmatism. Here, you might want to illustrate examples, particularly those relevant to the region or country where the workshop is being held.

If time permits, and you believe it is relevant, you may wish to touch on the changing discourse of governance and health, which is only briefly summarized below.

Since the 1970s, there has been a shift in the discourse of public policy and governance, which has attempted to minimize the responsibility of government for the health of its people. This ideological shift, which has close ties to managerialism and neoliberalism, has led in some countries to greater deregulation and privatization in the health sector. More generally, the push toward "small government", including limiting interventions in the economy and spending on social welfare has restricted policy space and permitted inequalities to increase. At the same time, social movements in many countries have called for greater participation, transparency and accountability in policy decision-making and the number of health actors has increased, especially at the international level. As a consequence, health is an increasingly contested and congested policy space.

Given government responsibility for health and the complexity of many contemporary health challenges, governments have several crucial roles to play in the HiAP approach including but not limited to:

- Commissioning research;
- Engaging stakeholders within and beyond government;
- Formulating and implementing intersectoral policies; and
- Evaluating their impact.

Terminology

If you did not discuss in detail some of the terminology associated with HiAP in Part One of Module 3, it is suggested you clarify some of the following terms.

Intersectoral action refers to the coordinated efforts of two or more sectors within government to improve health outcomes. This can include working across different levels of government such as district, provincial and national jurisdictions.

The term **intergovernmental** is sometimes used to refer to these horizontal and vertical linkages between levels of government within a country. Whole-of-government, joined-up government and healthy public policies are similar terms used in the HiAP literature.

A **whole-of-society approach,** in contrast, refers to coordinated efforts to improve health by multiple stakeholders within and outside government that may also be from several sectors. This dimension of HiAP is discussed at length in Module 7.

GROUP ACTIVITY: CONDITIONS THAT PROMOTE OR HINDER INTERSECTORAL COLLABORATION

20 MINS

The purpose of this group activity is for the participants to discuss the conditions and context that support or hinder working across departments and levels of government. It is likely that participants will have direct experience, both positive and negative, of intersectoral collaboration.

It is suggested that you divide the participants into small groups and ask them to come up with a list of conditions or situations that promote or hinder working across sectors and levels of government. You should tell the participants that someone in each group will be asked to share the group's ideas and remind them of the time.

To start the discussion, you might give a few examples such as "good personal contacts or regular meetings with other departments" or "passionate and knowledgeable politicians". Conversely, "limited or misused resources" and "competing or conflicting interests" might make intersectoral collaboration difficult. Depending on how you observe the groups develop their lists, you might need to ask them to generalize their observations or be more specific so that the group can prepare a list that applies to most contexts.

You may also want to encourage the participants to share relevant personal experiences. However, it is important to ensure these examples are appropriate and don't identify any individuals or judge certain groups in the room such as representatives from a particular sector, department or country.

After the groups have had time to come up with their lists, each group should present. You should guide the discussion if necessary, pointing out valuable contributions and highlight any important points missed. You might also want to illustrate examples, particularly those relevant to the region or country where the workshop is held.

Some notable barriers to successful intersectoral collaboration within government are likely to include:

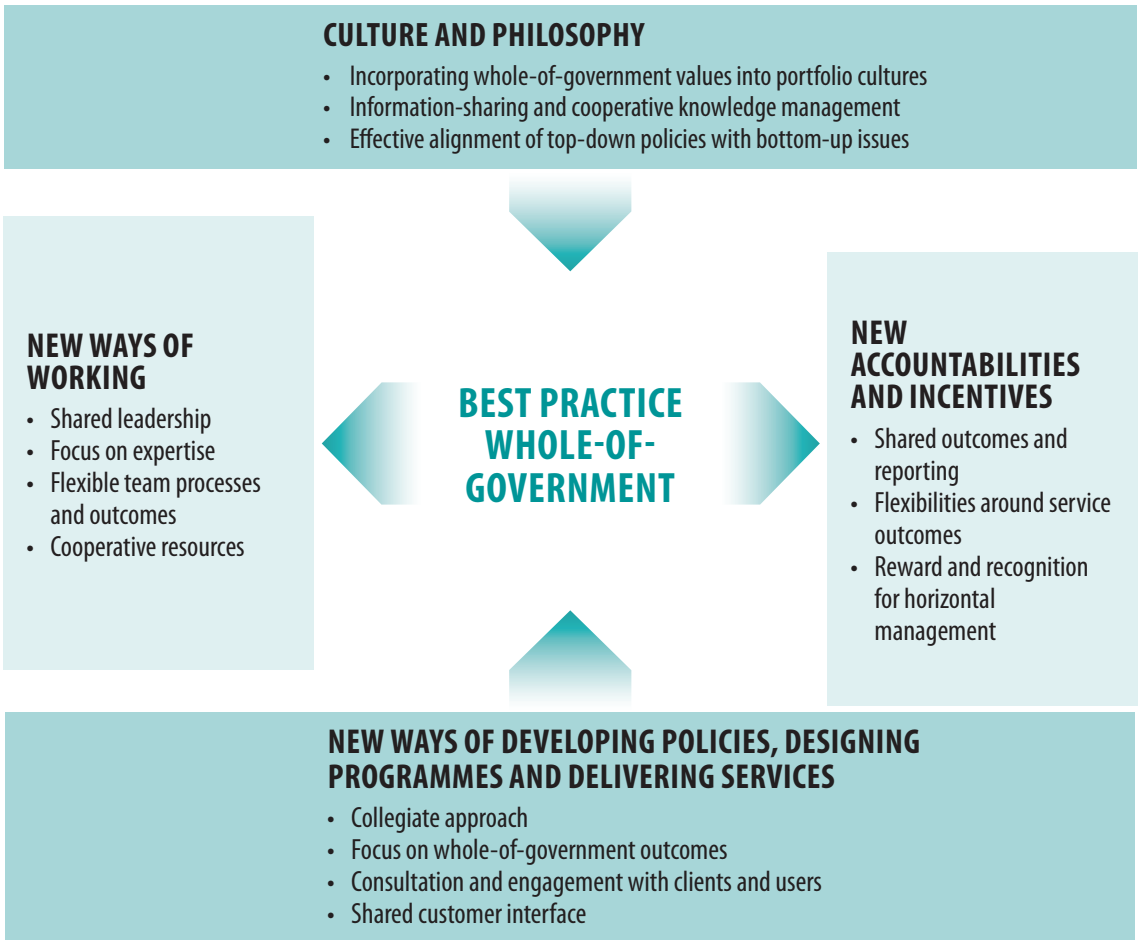
- Distracted or unstable leadership;
- Conflicting personalities;
- Fragmented government functions;
- Sub-national geographical and government jurisdiction divisions;
- Sectors appearing to have competing interests;
- Limited or misused resources (staff, funding, etc.); and
- Restricted policy space.

Intersectoral collaboration is often most effective under the following conditions:

- Government supports and encourages intersectoral action;
- Sectors have shared interests or both/all benefit from cooperation;
- Issue has high political importance and requires urgent addressing;
- Proposed policy has public support;
- Strong, effective leaders in the bureaucracy (policy champions/entrepreneurs);
- Intersectoral action is well planned with clear objectives, roles and responsibilities;
- Laws exist or are planned to support the proposed policy;
- Sufficient resources are available; and
- There are plans to monitor and sustain outcomes.

You may want to display the following summary of best practice for intersectoral collaboration (Figure 5.2). However, it might be too abstract and unhelpful for some audiences.

Figure 5.2: Best practice for intersectoral collaboration summary



Source: Grant J (2004) The Australian Experience: Priorities and Possibilities for Connected Government, in Kaczorowski W (ed.) ***Connected*** *Government.* London, Premium Publishing.

If time permits, you may want to extend the duration of this group activity.

LECTURE: STRUCTURES AND MECHANISMS FOR INTERSECTORAL COLLABORATION

15 MINS

It is suggested that you start this part of the module by recapping the policy scenarios that favour a HiAP approach.

Figure 5.3: Policy situations where a HiAP approach should be considered

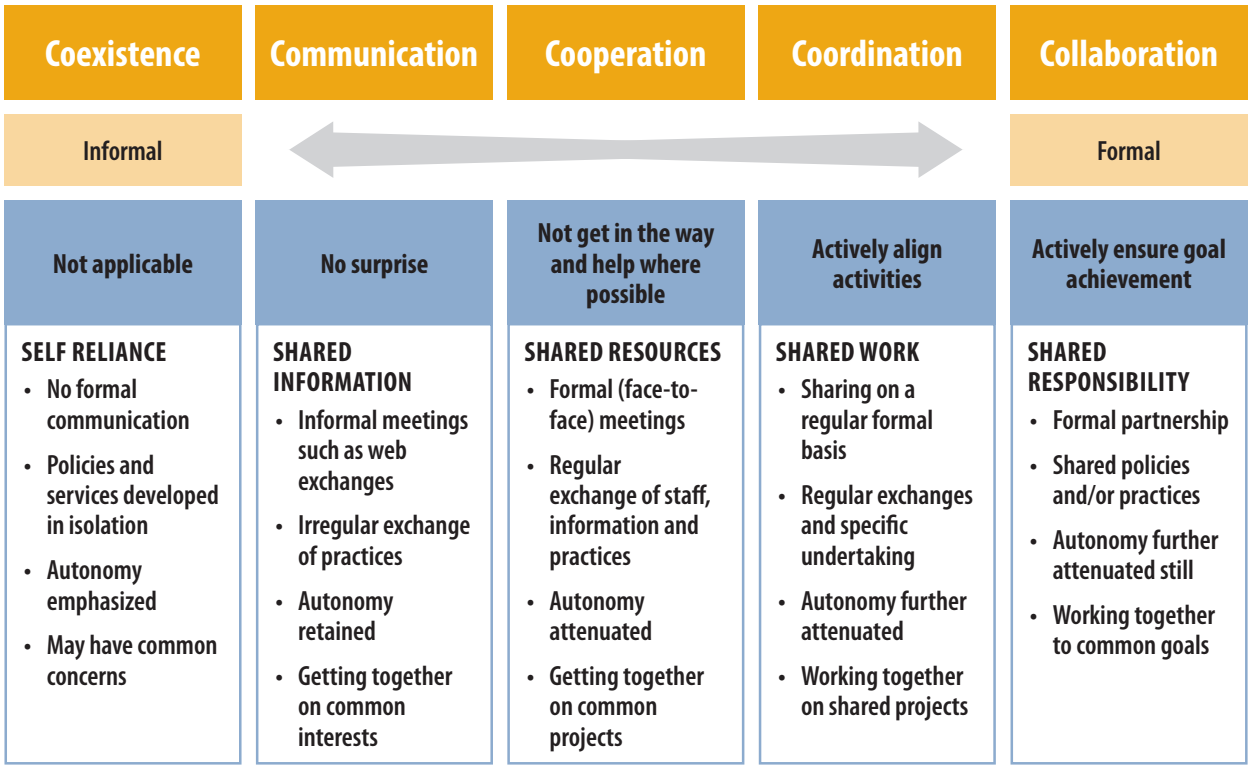
Source: developed from analysis in Leppo K *et al.* (eds) (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies.* Finland, Ministry of Social Affairs and Health, p. 329.

Next, you may want to emphasize that HiAP has been implemented differently in different contexts reflecting local social and political cultures as well as government structures. Nevertheless, it is possible to make some generalizations about the structures and mechanisms commonly used for intersectoral action.

An important point is that the amount of collaboration can vary significantly from no collaboration to temporarily working together to permanent collaboration. If you find it relevant and helpful, you might want to show Figure 5.4.

Before moving to the group activity where the participants will discuss the benefits and limitations of various structures and mechanisms, it is recommended that you give a brief outline of each. Wherever possible, it is strongly recommended that you illustrate with examples, particularly those relevant to the region or country where the workshop is being held.

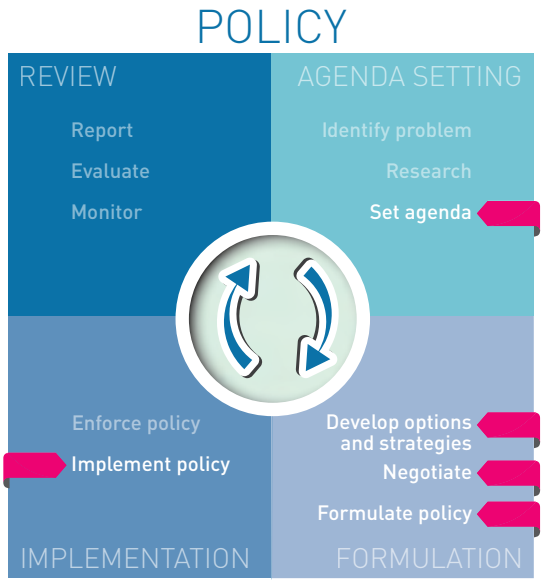
Figure 5.4: Degrees of collaboration



Source: Boston J, Gill D (2011) Joint or shared accountability: Issues and options. Wellington, Institute of Policy Studies (Working paper 11/03, http://igps.victoria.ac.nz/publications/files/83e71189c2b.pdf, accessed 9 May 2014).

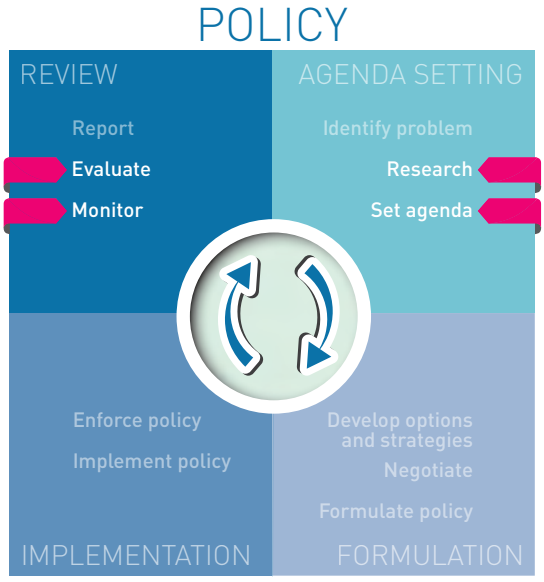
1. Cabinet committees and secretariats

Cabinet committees allow ministers to engage with policy issues of cross-departmental significance and offer a mechanism for ministers to work with outside interests. Cabinet secretariats coordinate and facilitate collective decision-making on behalf of all government ministers and directorates to ensure that proper and timely collective consideration of policy is carried out before decisions are taken. While some governments may use more informal mechanisms to facilitate cross-departmental engagement, cabinet committees are recognized for being able to facilitate dialogue and reach agreement on shared policy issues. Owing to the confidential nature of cabinet committees, the evidence to support their ability to influence governance actions for HiAP is necessarily limited to anecdotes. Nevertheless, as cabinet committees and secretariats are one of the highest decision-making bodies, they do have the potential to promote and implement a HiAP approach, especially in the presence of competent and charismatic political leaders and policy champions/entrepreneurs. Cabinet committees and secretariats are likely to have the most notable influence on the agenda-setting and policy formation stages of the policy cycle.[1]



2. Parliamentary committees

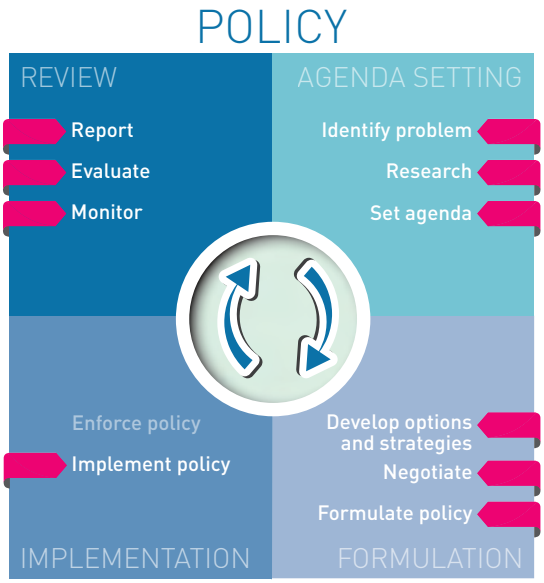
In democratic countries with robust debate, parliamentary committees of elected representatives can play a role in agenda setting, promoting wider political ownership of issues and reviewing policy decisions. Committees consisting of multiple parties, including the opposition, can enhance the potential influence of findings and can support the longevity of an issue as a political priority despite a change of government. Parliamentary committees are likely to have the most notable influence on the agenda setting and policy review stages of the policy cycle.[2]



1 McQueen DV *et al.* (2012) *Intersectoral Governance for Health in All Policies.* WHO, pp. 59–67.

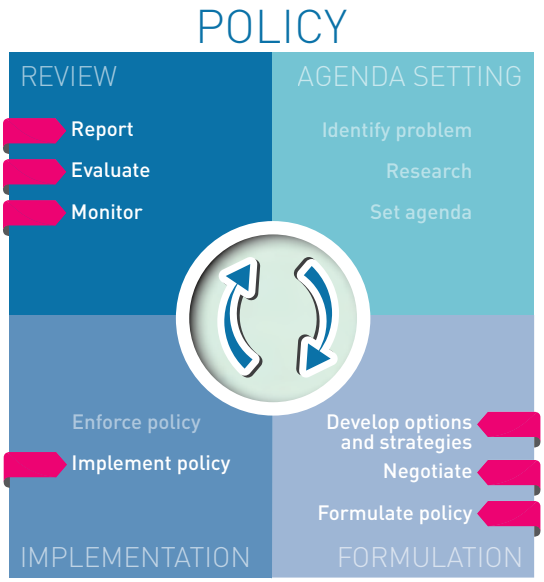
2 McQueen DV *et al.* (2012) *Intersectoral Governance for Health in All Policies.* WHO, pp. 69–84.

3. Interdepartmental committees and units



Interdepartmental committees and units are two of the most common mechanisms for intersectoral collaboration. They operate at the bureaucratic level and aim to re-orient ministries around a shared priority. Both interdepartmental committees and units are primarily made up of civil servants; however, committees can include political appointees and units can include people from outside of government. The appeal of such committees and units is that they provide a forum for problem solving and debate. The effectiveness of interdepartmental committees and units depends heavily on the context, particularly the relative importance of the issue and level of political support. This mechanism for intersectoral collaboration can potentially influence the entire policy cycle.[1]

4. Mega-ministries and merges

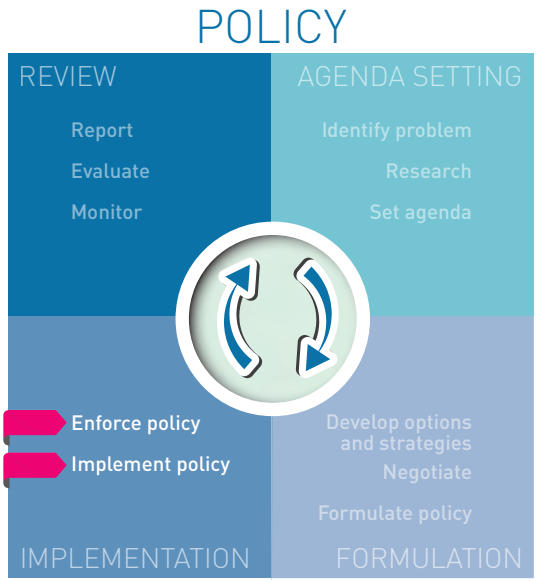


Certain reorganizations of ministries aim to bring different areas of government closer together and thereby improve collaboration and policy-making. Often, however, reorganization is a sign of internal politics of parties and coalitions. Examples of "mega-ministries" – a grouping of several large government functions such as health, transport, labour, social security and education – are rare. It is more common to merge smaller units or portfolios such as sport or culture with a larger ministry. The costs of large reorganizations tend to be high and the benefits are contested.[2]

1 McQueen DV *et al.* (2012) *Intersectoral Governance for Health in All Policies*. WHO, pp. 85–99.

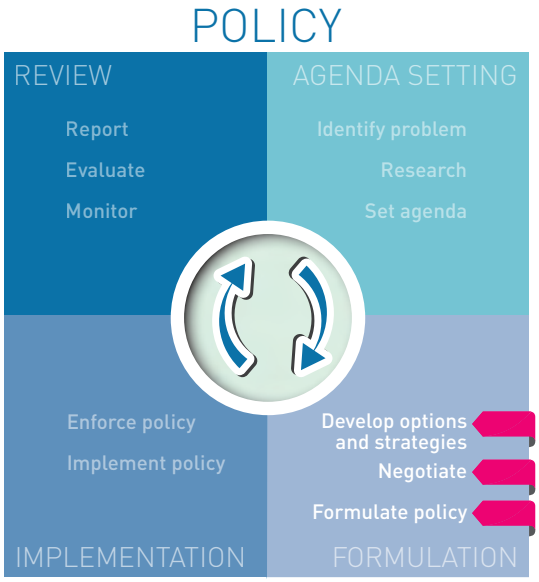
2 McQueen DV *et al.* (2012) *Intersectoral Governance for Health in All Policies*. WHO, pp. 102–110.

5. Joint budgeting



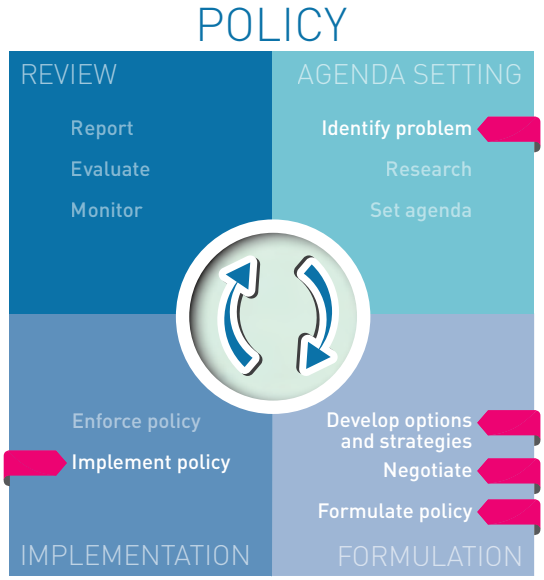
The term "joint budgeting" can itself cover a number of quite different mechanisms, involving two or more government departments and/or levels of government, in order to help achieve one or more shared goals. They can range from fully integrated budgets for the provision of a service or policy objective to loose agreements between sectors to align resources for common goals, while maintaining separate accountability regarding the use of funds. Another limited approach can be to have jointly funded posts to help coordinate intersectoral policies. Agreements on joint budgeting can be mandatory or voluntary in nature and operate at a national, regional and/or local level. They may be accompanied by legislation and regulatory instruments. While challenging to implement because it needs to be well planned with clear objectives, roles and responsibilities, joint budgeting is a promising way to promote and implement HiAP. This is especially the case where other sectors will co-benefit and the health sector, which is usually a relatively large spender of government revenue, offers a large share of the joint funding. This mechanism has the potential to mainly influence the implementation stage of the policy cycle.[1]

6. Intersectoral policy-making procedures



This category groups many of the remaining bureaucratic measures to promote intersectoral collaboration and includes procedures such as impact assessments and policy proposals circulating through multiple ministries for comment prior to review by the responsible minister. These procedures differ significantly between countries and can be mandatory or voluntary. Such mechanisms tend to influence the policy formation stage and represent a relatively low but regular level of intersectoral action.

1 McQueen DV *et al.* (2012) *Intersectoral Governance for Health in All Policies.* WHO, pp. 111–127.



7. Non-government stakeholder engagement

Government engagement with non-government stakeholders is a crucial component of the HiAP approach and is discussed separately in Module 7. While non-government stakeholders can play a role at all stages of the policy cycle, stakeholder engagement as a government mechanism is most common during the agenda setting, policy formation and policy implementation stages.

Figure 5.5: Structures and mechanisms for intersectoral collaboration

	Agenda setting			Policy formation			Policy implementation		Policy review		
	Identify problem	Research	Set agenda	Develop options and strategies	Negotiate	Formulate policy/ guidance	Implement policy	Enforce policy	Monitor	Evaluate	Report
1. Cabinet committees and secretariats			■	■	■	■	■				
2. Parliamentary committees		■	■						■	■	
3. Interdepartmental committees and units	■	■	■	■	■	■	■	■	■	■	■
4. Mega-ministries and merges				■	■	■	■		■	■	■
5. Joint budgeting							■	■			
6. Intersectoral policy-making procedures				■	■	■					
7. Non-government stakeholder engagement	■			■	■	■	■				

Source: based on analysis in McQueen DV *et al.* (2012) *Intersectoral Governance for Health in All Policies.* WHO.

GROUP ACTIVITY: CASE STUDIES OF HiAP INTERSECTORAL ACTION

35 MINS

The purpose of this group activity is for the participants to discuss examples of HiAP in practice and appraise different structures and mechanisms used to implement a HiAP approach. If the participants have prepared written case studies in advance of the workshop or have some experience in HiAP, it is recommended that you base the group activity on a discussion of these examples. Alternatively, you may wish to distribute some of the published case studies of HiAP or discuss unpublished examples that you are familiar with and ideally relate to the region or countries where the workshop is held.

Some case studies demonstrating the role of the government in HiAP are included in Handout 5.1.

You may want to divide the participants into small groups or discuss the examples as a group, especially if participants are giving a case study presentation. If you decide to hold small group discussions, it is strongly recommended that you give careful thought to the group dynamics including which sectors or countries are grouped together and the level of experience of different participants. You will also need to be careful managing the time.

After the discussion, you may want to underline some observations and messages. In the published case studies of HiAP in practice, the following points are often made:

- High-level government support is fundamental to the success of a HiAP approach.
- Strong, effective leaders in the bureaucracy are also important – personalities matter.
- Intersectoral collaboration relies on finding co-benefits but can sometimes also work with neutral interests. Intersectoral cooperation between sectors with seemingly conflicting or competing interests requires trade-offs and is rare.
- Different structures and mechanisms for intersectoral collaboration have different benefits and limitations so it is important to consider the desired horizontal and vertical linkages to find the best fit.
- Intersectoral collaboration is rarely effective or sustainable if it relies on only one structure or mechanism. A HiAP approach works best using multiple channels.
- Familiarity with the institutional processes and priorities of other actors, in both government and at other levels of governance, is fundamental to the ability to contribute in a timely manner. It is also necessary to identify the appropriate level of engagement.
- It is important to identify networks, contacts and "gatekeepers" in other government sectors to establish more direct and effective lines of communication and be able to respond rapidly when needed.
- It is also crucial to understand the goals, languages and processes of other government sectors, as the incentives for action are often linked to particular policy processes and priorities at a given time. Successful engagement of other government sectors requires the development of trust and the establishment of a consensus on shared goals and policies.

- HiAP benefits from legislation that supports the planned policies and outcomes. Without legal backing, a change in government can shift priorities and support. Development of national legislation (constitutions, laws, norms and regulations) can find support from international treaties and conventions. Technical assistance from international organizations such as the WHO and the International Labour Organization (ILO) can prove valuable.

Should certain countries or regions want to expand on this manual, this could be a potential additional module.

- HiAP can be implemented in countries of all levels of income. The majority of published case studies come mainly from high-income countries but there are also notable examples in low- and middle-income countries.

If time permits, you may want to extend the duration of this group activity.

QUESTIONS AND FEEDBACK

10 **MINS**

It is recommended that you encourage contributions and questions throughout the workshop and dedicate a small amount of time at the end of each module for feedback and clarifications. This unallocated time can be used as necessary if part of a module takes longer than expected.

module

6

PREPARING POLICY BRIEFS

module

6

PREPARING POLICY BRIEFS

Lecture: Effective writing and policy briefs 85

Optional group activity: Appraise examples of policy briefs 89

Group activity: Policy brief writing 90

Group activity: Class presentations 91

MODULE OVERVIEW

This module explores the characteristics of effective policy writing and provides the participants an opportunity to apply these insights by developing and presenting a policy brief.

	DURATION
Lecture: Effective writing and policy briefs	15 mins
Optional group activity: Appraise examples of policy briefs	15 mins
Group activity: Policy brief writing	60 mins
Group activity: Class presentations	30 mins
TOTAL TIME	**1h 45 mins**
WITH OPTION	**2h 00 mins**

Learning objectives

- Explain the purpose of a policy brief in the context of policy-making
- Summarize characteristics of effective writing and influential policy briefs
- Describe three common approaches to prioritizing health in policy discourses
- Develop and present a policy brief

Key messages

- A policy brief is a document which outlines the rationale for choosing a particular policy alternative or course of action in a current policy debate. It is part of the agenda-setting and policy formation stages of the policy cycle.
- An influential policy brief is:
  - Focused and limited in scope;
  - Professional rather than academic;
  - Evidence-based;
  - Succinct, understandable and accessible; and
  - Practical and feasible.
- Three common approaches to prioritizing health in policy discourses are:
  - Health argument – health has intrinsic value;
  - Health-to-other-sectors argument – improved health and equity can support realization of mandates and goals of other government sectors; and
  - Health-to-societal-goal argument: – improved health and equity can also contribute to wider societal gain, including well-being, economic and social development and financial and environmental sustainability.

Key reading for participants

Optional

- WHO (2013) *Communicating the Economics of Social Determinants of Health and Health Inequalities*. Geneva, WHO

Supporting material for instructors

- Young E and Quinn L (undated) The Policy Brief described
- IDRC (undated) How to Write a Policy Brief. International Development Research Centre
- Writing effectively for WHO: Course guide:
  - Course Outline
  - Module 1: Effective Writing
  - Module 2: Correspondence, Records and Notes
  - Module 3: Reports and Proposals
- WHO Capacity Building Workshop Material for Evidence-Informed Policy-Making
- Sample policy briefs:
  - ODI policy brief – food insecurity
  - RWJF policy brief – transport
  - NCD Alliance policy brief – human rights and NCDs

Teaching notes

This module is heavily focused on learning-by-doing and aims to reinforce the participants' ability to write influential policy briefs. It is suggested you begin the module by describing the importance of effective policy writing and outline the characteristics and structure of a persuasive policy brief. You may want to conduct a short group activity to analyse some examples of good policy briefs. The majority of the module is then dedicated to preparing a policy brief in small groups. It is likely you will often need to remind the groups to manage their time well. The remainder of the module's time is for each group to present their policy brief. It is recommended that you give thought to the policy brief topic(s) so that they have the most relevance to participants and the context in which they work. A number of topics with supporting material are suggested here as examples. As always, it is useful to point to the learning objectives and outline the structure of the module so that the participants know what to expect.

LECTURE: EFFECTIVE WRITING AND POLICY BRIEFS

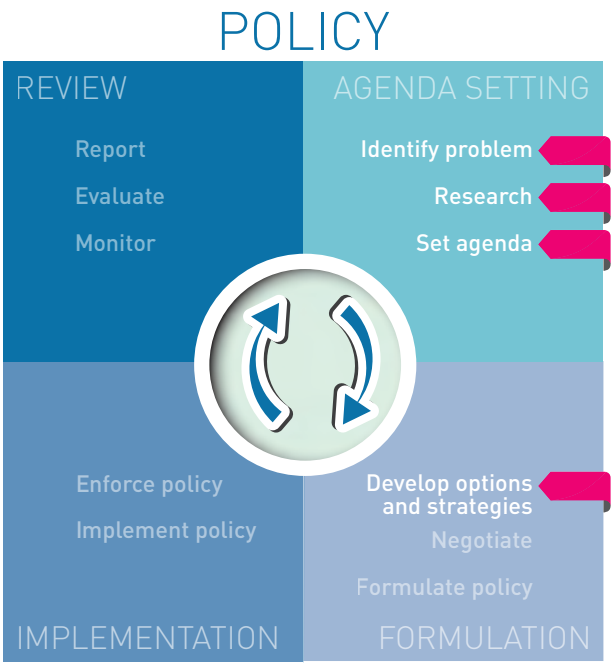
15 **MINS**

To put discussion of policy briefs in context, it is recommended that you recap certain key messages from Module 4 on the policy-making process, particularly the concept of windows of opportunity.

- Windows of opportunity are short periods of time in which, simultaneously, a problem is recognized, a solution is available and the political climate is positive for policy change. These are critical opportunities for addressing important policy problems.
- It is essential to be prepared as opportunities can only be seized and used to advance a policy agenda if adequate groundwork has been laid. This can involve longer term processes of scientific evidence gathering, advocacy and awareness raising, and building of technical capacity.
- Often several decades of persistent and sustained effort, at both national and international levels, will have been necessary to persuade politicians and policy-makers to address an issue. Such effort will have included systematic accumulation of scientific evidence and indicators to assess the magnitude of a problem and provide feedback to policy-makers on key trends in population health. For example, the Global Burden of Disease Study (a WHO initiative) was highly instrumental in challenging the misconception that mental health was not a major issue in low- and middle-income countries.[1]

Although policy changes are often reliant on windows of opportunity as mentioned above and policy briefs can seem rather routine documents, a policy brief has the potential to directly influence a decision-maker and can thus be a critical tool. As shown in Figure 6.1, policy briefs are most prevalent during the agenda setting and policy formation stages of the policy cycle although they can be useful at other times also.

Figure 6.1: Policy briefs – agenda setting and policy formulation



Source: modified from http://www.geostrategis.com/images/policycycle.jpg

1 Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health, p. 228.

Characteristics of effective policy briefs

A policy brief[1] is a document that outlines the rationale for choosing a particular policy alternative or course of action in a current policy debate. The purpose of the policy brief is to convince the target audience of the urgency of the current problem and the need to adopt the preferred alternative or course of action outlined and therefore, to serve as an impetus for action.[2]

With this purpose to persuade, policy briefs must communicated effectively. Influential policy briefs typically display the following characteristics:

1. Focus

All aspects of the policy brief (from the message to the layout) need to strategically focus on achieving the intended goal of convincing the target audience. For example, the argument provided must build on what the audience knows about the problem, provide insight about what they don't know about the problem and be presented in language that reflects their values, i.e. using ideas, evidence and language that will convince them.

2. Policy-minded rather than academic

The common audience for a policy brief is not interested in the research/analysis procedures conducted to produce the evidence, but is very interested to know the writer's perspective on the problem and potential solutions based on the lastest evidence.

3. Strong evidence

The policy brief is a communication tool produced by policy analysts and therefore, all potential audiences not only expect a rational argument but will only be convinced by argumentation supported by evidence that the problem exists and the consequences of adopting particular alternatives.

4. Limited scope

To provide adequately comprehensive but targeted arguments within a limited space, the focus of the brief needs to be limited to a particular problem or aspect of a problem.

5. Succinct

The type of audiences targeted commonly do not have the time or inclination to read an in-depth 20-page argument on a policy problem. Therefore, it is common that policy briefs do not exceed 6–8 pages in length (i.e. usually not longer than 3000 words).

1 Young E and Quinn L (undated) The Policy Brief described.

2 Young E and Quinn L (undated) The Policy Brief described.

6. Understandable

This not only refers to using clear and simple language (i.e. not the jargon and concepts of an academic discipline) but also to providing a well explained and easy to follow argument targeting a wide but knowledgeable audience.

7. Accessible

The writer of the policy brief should facilitate the ease of use of the document by the target audience and therefore, should subdivide the text using clear descriptive titles to guide the reader.

8. Promotional

The policy brief should catch the eye of the potential audience in order to create a favourable impression (e.g. professional, innovative, etc.). To achieve this, many brief writers adopt many of the features of the promotional leaflet (use of colour, use of logos, photographs, slogans, illustrative quotes etc.).

9. Practical and feasible

The policy brief is an action-oriented tool targeting policy practitioners. As such, the brief must provide arguments based on what is actually happening in practice with a particular policy and propose recommendations which seem realistic to the target audience.

Structure of policy briefs

The common structure of a policy brief[1] is as follows.

1. Executive summary

The executive summary aims to convince the reader that the brief is worth in-depth investigation. It is especially important for an audience that is short of time to clearly see the relevance and importance of the brief in reading the summary. As such, a one- or two-paragraph executive summary commonly includes:

- A description of the problem addressed;
- A statement on why the current approach/policy option needs to be changed; and
- Recommendations for action.

2. Context and importance of the problem

The purpose of this element of the brief is to convince the target audience that a current and urgent problem exists which requires them to take action. The context and importance of the problem is both the introductory and first building block of the brief. As such, it usually includes the following:

- A clear statement of the problem or issue in focus;

1 Young E and Quinn L (undated) The Policy Brief described.

› A short overview of the root causes of the problem; and

› A clear statement of the policy implications of the problem that clearly establishes the current importance and policy relevance of the issue. It is worth noting that the length of the problem description may vary considerably from brief to brief depending on the stage of the policy process in focus (e.g. there may be a need to have a much more extensive problem description for policy at the evaluation stage than for the option stage).

3. Critique of policy option(s)

The aim of this element is to detail shortcomings of the current approach or options being implemented and therefore, illustrate both the need for change and focus of where change needs to occur. In doing so, the critique of policy options usually includes the following:

› A short overview of the policy option(s) in focus; and

› An argument illustrating why and how the current or proposed approach is failing. It is important for the sake of credibility to recognize all opinions in the debate of the issue.

4. Policy recommendations

The aim of the policy recommendations element is to provide a detailed and convincing proposal of how the failings of the current policy approach need to be addressed. As such, this is achieved by including:

› A breakdown of the specific practical steps or measures that need to be implemented; and

› Sometimes includes a closing paragraph re-emphasizing the importance of action.

5. Appendices

Although the brief is a short and targeted document, authors sometimes decide that their argument needs further support and so include an appendix. Appendices should be included only when absolutely necessary.

Prioritizing health in the policy discourse

If you believe it relevant, you might want to describe some of the common approaches to arguing for health to be given greater importance in policy discourses.[1] This issue can be raised at many points during the workshop, including but not limited to here and in Module 8 on negotiations.

In general, there are four types arguments that can be persuasive in encouraging policy actors to take health into account in public policies:

1 Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies.* Finland, Ministry of Social Affairs and Health, pp. 331–332.

1. **Health argument.** Health has intrinsic value. A powerful argument for policy-makers to act can arise from understanding of the health impacts deriving from a particular risk factor (e.g. tobacco or alcohol consumption, occupational health hazards) or determinant of health. Failure to comply with obligations arising from ratified international laws or constitutional rights can also be used to build this argument. For example, all WHO Member States acknowledge that governments are responsible for the health of their populations.

2. **Health-to-other-sectors argument.** Improved health and equity can support realization of the mandates and goals of other government sectors. The evidence shows that complementary interventions are also prerequisites for successful implementation. This is about highlighting co-benefits to get other sectors on board.

3. **Health-to-societal-goal argument.** Improved health and equity can also contribute to wider societal gain, including well-being, economic and social development and financial and environmental sustainability.

4. Finally, in support of all three arguments is **economic evidence.** For example, assessing the financial benefits for health and social care, productivity gain or increased tax revenues is important. It can also make explicit the trade-offs arising from different policy choices.[1] Recall Module 3 in which the costs of NCDs were cited.

OPTIONAL GROUP ACTIVITY: APPRAISE EXAMPLES OF POLICY BRIEFS

15 MINS

The purpose of this initial group activity is to allow the participants to review examples of policy briefs and discuss their merits. It is suggested that you divide the participants into the groups that they will remain in for the policy brief and its presentation. This will allow them some time to work together before starting on their own policy brief.

The following policy briefs are suggested as examples to give to the groups to analyse. However, you may want to provide alternatives that are more relevant to the work of the participants.

- ODI policy brief – food insecurity
- RWJF policy brief – transport
- NCD Alliance policy brief – human rights and NCDs

1 WHO (2013) *Communicating the Economics of Social Determinants of Health and Health Inequalities.* Geneva, WHO.

Depending on time, you may want to give each group just one policy brief to review or several. It is suggested that you ask the participants to discuss the structure of the policy brief, the way evidence is "translated" for the decision-maker and how the key messages are targeted with purpose.

GROUP ACTIVITY: POLICY BRIEF WRITING

60 MINS

The topic of obesity and overweight is suggested for the policy brief because it is a global issue that people readily understand and there are many policy recommendations available. Nevertheless, you may want to prepare an alternative topic or multiple topics that are possibly more relevant to the work of the participants.

The background information on obesity and overweight, which you should distribute to the participants if you adopt this issue, is taken from a WHO factsheet (see Handout 6.1a). The policy recommendations in the original WHO factsheet have been removed since proposing solutions is one of the main tasks of the activity. For the writing exercise, it is suggested that you distribute a template for writing the policy brief (see Handout 6.1b).

Given the limited time available and the challenges of writing in a group, you should explain that the exercise is a shortened, simplified version of a policy brief. Using the background material and the template provided, the participants are asked to write between 400 and 800 words that explain the importance of addressing obesity and overweight, the key facts and policy recommendations. The policy brief should be targeted at the health minister as the decision-maker. It is suggested that you give the participants permission to copy text directly from the background sheet to allow them to concentrate on the arguments and structure of their policy brief.

You should remind the groups regularly the time remaining and ask them to nominate a presenter. If possible, it is suggested that you conduct this group activity immediately before an extended break so that groups who have not managed to finish may have slightly more time to prepare.

If time permits, you may want to extend the duration of this group activity.

GROUP ACTIVITY: CLASS PRESENTATIONS

30 **MINS**

The purpose of this follow-up activity to the policy brief writing is to allow the participants to share their work and emphasize the need to sometimes communicate policy recommendations in a meeting format. It is recommended that you allow each group a maximum of five minutes to present their brief. After each group presents, you might want to provide some feedback or wait until the end to make general comments.

If time permits and you feel that it is helpful, you might want to distribute the original WHO factsheet on obesity and overweight, including its policy recommendations (see WHO Fact Sheet No. 311, updated August 2014, Obesity and overweight).

The following policy brief could also be useful for the group discussion.

- NCD Alliance policy brief – food, nutrition, diet and NCDs.

module

7

THE ROLE OF NON-GOVERNMENTAL STAKEHOLDERS IN HiAP/ WHOLE-OF-SOCIETY APPROACHES

module

7

THE ROLE OF NON-GOVERNMENT STAKEHOLDERS IN HiAP/WHOLE-OF-SOCIETY APPROACHES

Alternative One

Recap: Whole-of-government vs whole of society approaches 98

Lecture: Stakeholder engagement. 99

Optional activity: Civil society and private sector panel discussion and Q&A 104

Alternative Two

Recap: Whole-of-government vs whole-of-society approaches ... 104

Lecture: Stakeholder engagement. 104

Group activity: Stakeholder engagement case studies 105

Group activity: Stakeholder analysis 105

Questions and feedback 108

MODULE OVERVIEW

This module is about the role of non-government stakeholders in HiAP, the benefits and costs of consulting widely, the principles of effective stakeholder engagement and how to conduct a stakeholder analysis.

	DURATION
ALTERNATIVE ONE	
Recap: Whole-of-government vs whole-of-society approaches	5 mins
Lecture: Stakeholder engagement	15 mins
Optional: Civil society and private sector panel discussion and Q&A	1h 10 mins
ALTERNATIVE TWO	
Recap: Whole-of-government vs whole-of-society approaches	5 mins
Lecture: Stakeholder engagement	15 mins
Group activity: Stakeholder engagement case studies	20 mins
Group activity: Stakeholder analysis	60 mins
Questions and feedback	5 mins
ALTERNATIVE ONE	**1h 30 mins**
ALTERNATIVE TWO	**1h 45 mins**

Learning objectives

- Define a stakeholder and provide examples
- Explain the benefits and challenges of non-government stakeholder engagement
- List principles for effective and accountable stakeholder consultation
- Identify formal and informal mechanisms for non-government stakeholder involvement in HiAP
- Recognize strategies used by actors to counteract efforts to improve health and inequity
- Prepare a stakeholder analysis

Key messages

- A stakeholder is a person, or group of persons, who have an interest or concern in a particular process or issue due to direct or indirect involvement. Examples include government ministries, politicians, non-government organizations, religious organizations, research institutes, labour unions, professional associations and businesses.

- There are both benefits and costs of widely consulting stakeholders, which should be carefully considered as part of the policy-making process.
- Some of the benefits of stakeholder engagement include:
  - Assessing support and opposition to a policy;
  - Giving government activities visibility and legitimacy;
  - Empowering the marginalized;
  - Increasing collaboration and more efficient use of resources; and
  - Ensuring the sustainability of interventions.
- Some of the challenges or risks of wide stakeholder consultation include:
  - Prolonging policy-making;
  - Increasing costs of intervention;
  - Polarizing interest groups; and
  - Creating unmanageable expectations.
- Some principles for effective stakeholder engagement include:
  - Empowerment;
  - Accountability;
  - Transparency;
  - Cost-effectiveness; and
  - Resources.
- Corporate interests can be powerful in permeating the policy dialogue and undermining government actions.
- A stakeholder analysis is a process of systematically gathering and assessing qualitative information about stakeholders to categorize their relative importance as actors and develop strategies on how to involve them in the development and/or implementation of a HiAP policy or programme.

Key reading for participants

Recommended

- WHO (2005) Bangkok Charter for Health Promotion in a Globalized World (6 pages)
- CommGap (2009) Multi-Stakeholder Dialogue. World Bank (5 pages)
- Reich M. (2002) Introduction: Public-Private Partnerships for Public Health in Reich M (ed.) *Public-Private Partnerships for Public Health*, Harvard Series on Population and International Health. Cambridge, MA, Harvard University Press, pp. 1–18 (15 pages)
- NCD Alliance (2012) Key Points of UN Political Declaration on the Prevention and Control of Non-Communicable Diseases (2 pages)

Optional

- Gauvin F (2012) Involving the Public to Facilitate or Trigger Governance Actions Contributing to HiAP in McQueen DV *et al.* (2012) *Intersectoral Governance for Health in All Policies.* WHO, pp. 147–164 (12 pages)

- CommGap (2009) Coalition Building. World Bank, (9 pages)
- CommGap (2009) Changing Public Opinion. World Bank (5 pages)
- CommGap (2009) Media Effects. World Bank (6 pages)
- Video: CommGap Media Effects. World Bank (3 mins)

Supporting material for instructors

- WEF (2013) Multi-Stakeholder Collaboration for Healthy Living. Geneva, World Economic Forum
- Buse K and Waxman A (2001) Public-Private Health Partnerships: A Strategy for WHO. *Bulletin of the World Health Organization,* Vol. 79, No. 8, pp. 748–754
- OECD (2005) *Evaluating Public Participation in Policy Making.* Paris, Organisation for Economic Co-operation and Development, pp. 85–108
- WHO (2011) *Noncommunicable Diseases Country Profiles 2011*. Geneva, WHO
- UN Political Declaration on the Prevention and Control of Non-Communicable Diseases, A/RES/66/2
- NCD Alliance (2012) Key Points of UN Political Declaration on the Prevention and Control of Non-Communicable Diseases

Teaching notes

This module explores the merits and process of multi-stakeholder engagement in HiAP. Although the concept of stakeholders can be applied widely to include different government ministries as well as different parts of the health ministry itself, this module focuses on *external,* non-government stakeholders such as civil society and the private sector. Module 5 on the role of government focuses on this other kind of *internal* stakeholder engagement. The terms whole-of-government and whole-of-society are also used to distinguish between these two areas of consultation and involvement in policy-making.

The module provides two alternative structures. The first alternative is based around a short lecture and a longer panel discussion by representatives from civil society and the private sector sharing their experiences and lessons learned from those involved in HiAP. The second alternative combines the same lecture with supplementary group activities. It begins with a recap of some of the key messages from Module 5 to illustrate its continuity with Module 7. It is then suggested that you use a group activity to get the participants to define a stakeholder, come up with some examples and list ways that they formally and informally influence policy-making. You may then want to present some of the reasons for multi-stakeholder engagement and considerations to keep in mind. It is recommended that you conclude the module with another group activity based on developing a stakeholder analysis. The UN Declaration on the Prevention and Control of NCDs, with support material, is suggested as a topic for the exercise. However, you may want to prepare an alternative issue to analyse depending on the background of the participants. As always, it is useful to point to the learning objectives and outline the structure of the module so that the participants know what to expect.

ALTERNATIVE ONE

RECAP: WHOLE-OF-GOVERNMENT VS WHOLE-OF-SOCIETY APPROACHES

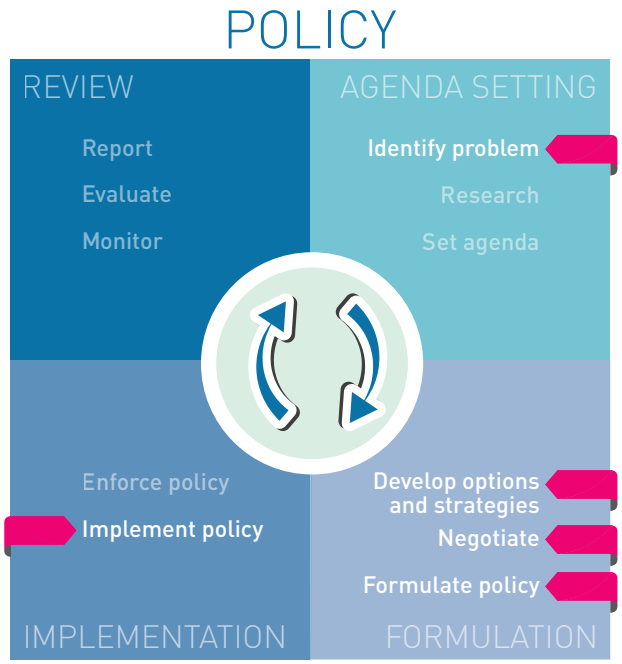
5 MINS

To highlight the continuity between Modules 5 and 7, it is suggested that you recap some of the key messages from Module 5 and reiterate the distinction between whole-of-government and whole-of-society approaches.

- Governments are responsible for the health of their peoples and have a critical leadership and stewardship role in the organized effort by society to promote health and well-being.
- However, the social determinants of health imply that many non-government stakeholders have an interest or concern in health. Whereas labour unions have an interest in ensuring safe working conditions, the activities of certain private companies can cause considerable harm to human health.
- Governments, thus, have a crucial role to play in the HiAP approach by engaging stakeholders within and beyond government.
- Module 5 focused on intersectoral collaboration or *internal* government stakeholder engagement. This is also referred to as a whole-of-government approach.
- Module 7 looks at *external* non-government stakeholder engagement. This is also referred to as a whole-of-society approach. This is where government involves a range of actors in the development, implementation and monitoring of health and equity issues using a HiAP approach.

You may also want to place this module primarily within the formation and development stages of policy cycle with reference to Figure 7.1. Strictly speaking, however, the engagement of non-government stakeholders can play a role at all stages.

Figure 7.1: Policy formulation and development – the role of non-governmental stakeholders



Source: modified from http://www.geostrategis.com/images/policycycle.jpg

LECTURE: STAKEHOLDER ENGAGEMENT

15 MINS

To begin the discussion on stakeholder engagement, you might want to offer one or more definitions, emphasizing that not all stakeholders have the same importance and necessary involvement in the formation, development and evaluation of health policies. You can also explain that the stakeholder analysis activity will help clarify how to distinguish different actors.

An initial distinction can be made between:

- A primary stakeholder is one who, without continuing participation, the policy or issue could not succeed or be addressed. For example, schools might be a primary stakeholder when dealing with the issue of healthy foods for children.
- A secondary stakeholder is one who has some influence or is affected by the policy or issue. However, their engagement is not essential to address the issue or to take policy action. For example, car manufacturers might be a secondary stakeholder when addressing road safety and drink driving.

Why is stakeholder consultation important?

In principle, a government's engagement with external stakeholders increases accountability to its citizens and is an indicator of good governance. There are also practical policy benefits, such as:

- Assessing support and opposition to a policy;
- Giving government activities visibility and legitimacy;
- Empowering the marginalized;
- Increasing collaboration and more efficient use of resources; and
- Ensuring the sustainability of interventions.

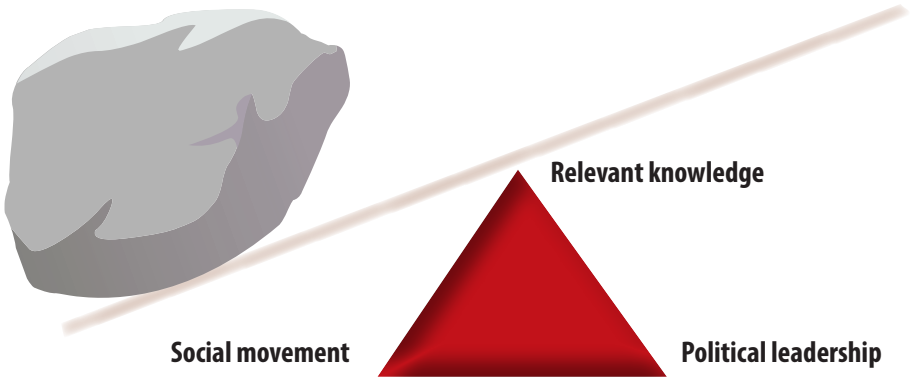
As the WHO Bangkok Charter for Health Promotion in a Globalized World states,

> "An integrated policy approach within government and international organizations, as well as a commitment to working with civil society and the private sector and across settings, are essential if progress is to be made in addressing the determinants of health."[1]

Engaging with supportive external stakeholders such as research institutions and non-government health organizations can also help accumulate evidence and public support for radical measures to improve population health and inequity. This can be especially important for health ministries with limited political influence and resources. Here, it is suggested that you again reference the concept of windows of opportunity.

This combination of knowledge, social pressure and government leadership has been called the "triangle that moves mountains" (see Figure 7.2).

Figure 7.2: The triangle that moves mountains



Source: based on Wasi P (2000) Triangle that moves the mountain and health systems reform movement in Thailand. *Human Resources for Health Development Journal,* Vol. 4, No. 2, pp. 106–110 (http://www.who. int/hrh/en/HRDJ_4_2_06.pdf).

1 WHO (2005) Bangkok Charter for Health Promotion in a Globalized World.

Challenges of stakeholder engagement

Parallel to the above-mentioned benefits, there are also challenges.

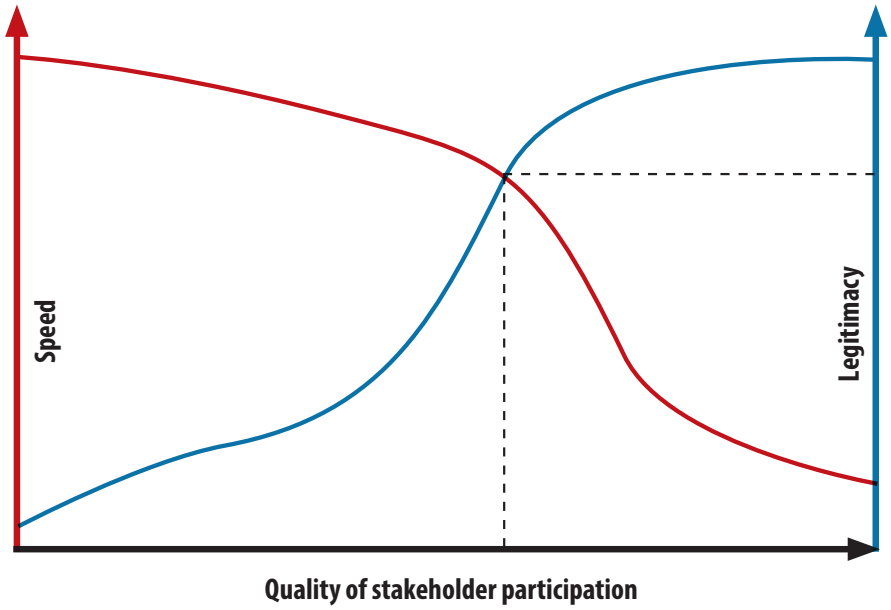
A comprehensive multi-stakeholder process can give high legitimacy to an initiative, but it also entails significant transaction costs. The more stakeholders at the table, the more difficult and time-consuming the process can be to reach a common understanding and position.

Some of the challenges or risks of stakeholder engagement can include:

- Prolonging policy-making;
- Increasing costs of intervention;
- Polarizing interest groups; and
- Creating unmanageable expectations.

One of the balances to find in consulting with external actors is between speed and legitimacy; fewer actors make policy formulation and implementation faster but stakeholders may be reluctant to accept or support a policy in which they had no say or influence. You might want to show Figure 7.3 to illustrate this point.

Figure 7.3: Finding the balance in stakeholder engagement



Source: Vallejo N and Hauselmann P (2004) *Governance and Multi-stakeholder Processes.* International Institute for Sustainable Development, p. 6.

Principles of stakeholder engagement

Given the potential value of stakeholder engagement and the reputational risks and possibly long-term problems if done incorrectly, it is sensible to consider the following principles:

- Empowerment;
- Accountability;
- Transparency;
- Cost-effectiveness; and
- Resources.

After you have provided a background on stakeholder engagement, it is recommended that you illustrate some examples of how government involvement of other actors can contribute to effective health interventions. It is suggested that you look at both an example from civil society and one from the private sector.

Civil society

Looking at the contribution of civil society to HiAP, or the whole-of-society approach, it is important to reiterate that civil society is a broad term that can encompass many actors including non-government organizations, faith-based groups, philanthropic foundations, labour unions, professional associations, cooperatives and research institutes. The single characteristic that these actors share is that they are not-for-profit.

Private sector

Alongside discussing civil society, it is suggested that you talk about the value of engaging the private sector.

Unlike civil society, the characteristic that the private sector ultimately shares is the pursuit of profit. This creates a complicated, often conflictual relationship with the public health sector given the principles of health as a matter of social justice and a public good as discussed in Module 1.

While on the one hand, the private sector might have considerable resources, expertise and technology to potentially direct towards public health, there are numerous issues such as neglected diseases and the commercial determinants of health that should suggest scepticism and caution.

One issue that you may want to critically discuss in this session is the concept of public-private partnerships (PPPs).

A PPP is defined by Reich[1] as:

1. The collaborations should involve at least one public organization and one private profit-making organization. The public organization could include national government bodies and

1 Reich M (ed.) (2002) *Public-Private Partnerships for Public Health*, Harvard Series on Population and International Health. Cambridge, MA, Harvard University Press.

international agencies such as the WHO, World Bank or a United Nations agency. The "private sector" normally would extend to any type of profit-making corporation.

2. The partners will have certain common goals for a particular health problem.
3. The different partners will divide the workload and mutually receive benefits.

It is recommended that you give some examples of private sector involvement in HiAP to help the participants recognize it if they haven't come across PPPs before. You might want to refer to published case studies, but examples relevant to where the workshop is held would probably be preferable if there is adequate information available.

Further to this, it is suggested that you outline some of the ways in which corporate interests can be powerful in permeating the policy dialogue and undermine government actions.[1]

This can include:

- Casting doubt on scientific evidence and misleading the public by denying negative health effects.
- Promoting ineffective policy solutions. For example, the alcohol industry has promoted corporate social responsibility, a policy intervention that has been proven to be ineffective as the incentives favour irresponsibility rather than responsibility.
- Permeating and, at times, infiltrating other sectors or decision-making levels by lobbying policy-makers and politicians or recruiting former civil servants with credibility among their peers. Tobacco lobbyists might also reach other sectors (e.g. trying to persuade policy-makers of benefits for tobacco growers' livelihoods or of potential revenue losses following a tax increase) and ultimately permeate their political discourse.
- Participating as an actor in the policy arena. Engagement can be negative and, even where positive, is often limited or superficial.
- Using litigation at national and international levels to challenge policy decisions.
- Creating alliances with other business sectors for example, hospitality, gambling, retail and advertising in the case of the tobacco industry.
- Moving to countries with least resistance. Markets are dynamic so regulatory efforts in one country can lead to expanding markets in others. Actors can accept decreases in one region as long as overall consumption of harmful products increases. For example, reductions in North American or some European markets may be compensated for by aggressive marketing elsewhere.

Should countries or regions want to expand on this section, it would be valuable to critically assess the effectiveness of some of the voluntary agreements that the private sector has signed up to as part of government efforts to address some certain NCDs.

Here, you may want to anticipate Module 8 and explain to the participants that many of these tactics will come up again as one of the four common negotiation strategies: avoidance, which is often used by actors seeking to stop or reduce the impact of state regulation.

1 Leppo K *et al.* (2013) Lessons for Policy-Makers in Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health, pp. 332–333.

OPTIONAL ACTIVITY: CIVIL SOCIETY AND PRIVATE SECTOR PANEL DISCUSSION AND Q&A

1 H 10 MINS

Following on from the lecture is the panel discussion. It is suggested that you invite civil society and private sector representatives who have been involved in health initiatives to discuss their experience and share their insights and lessons learned.

It is strongly recommended that you carefully select the speakers and brief them about the purpose and content of the workshop. It is also suggested you give them a time limit and reminders during the presentation to ensure each of the guests gets equal opportunity to speak and there is time remaining for questions and answers.

ALTERNATIVE TWO

RECAP: WHOLE-OF-GOVERNMENT VS WHOLE-OF-SOCIETY APPROACHES

5 MINS

To reiterate the distinction between whole-of-government and whole-of-society approaches it is suggested that you recap some of the key messages (see Alternative One of this module).

LECTURE: STAKEHOLDER ENGAGEMENT

15 MINS

It is suggested that you explain stakeholder engagement using the same material as in Alternative One of this module.

GROUP ACTIVITY: STAKEHOLDER ENGAGEMENT CASE STUDIES

20 **MINS**

In the absence of a panel discussion, it is suggested that you outline some examples of multi-stakeholder, whole-of-society approaches. You may want to use published case studies, such as those in Handout 7.1. However, examples relevant to where the workshop is being held would be preferable if there is adequate information available.

GROUP ACTIVITY: STAKEHOLDER ANALYSIS

60 **MINS**

The purpose of this section is to allow the participants to conduct a stakeholder analysis for a health issue involving many actors and ideally where a whole-of-society HiAP approach could be used. Responding to the UN Declaration on the Prevention and Control of NCDs is suggested as a topic for the exercise. However, you may want to prepare an alternative issue to analyse depending on the background of the participants.

It is suggested that you give a short introduction to stakeholder analysis and then allow the participants to learn by doing.

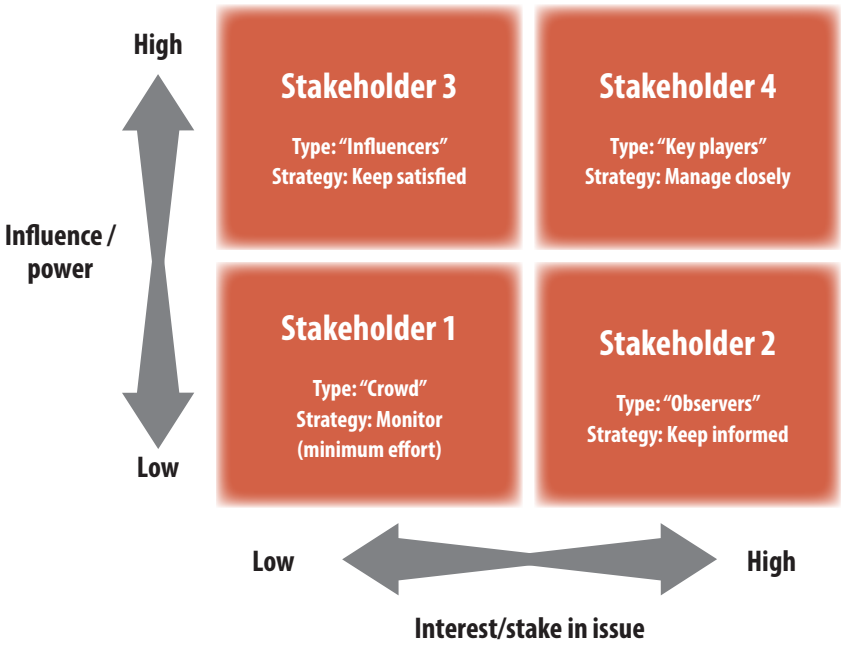
Purpose of stakeholder analysis

A stakeholder analysis is a process of systematically gathering and assessing qualitative information about stakeholders to categorize their relative importance as actors and develop strategies on how to involve them in the development and/or implementation a HiAP policy or programme. There are many templates and tools for analysing stakeholders but they share this essential purpose.

Identifying and categorizing stakeholders

Using the matrix (Figure 7.4) to assess a stakeholder's potential to support or oppose a public health intervention, it is possible to categorize stakeholders into four,[1] each with a corresponding engagement strategy.

Figure 7.4: Stakeholder categories matrix



Source: with authors' modification based on CommGap (2009) Multi-Stakeholder Dialogue. World Bank.

Stakeholder type 1: Crowd

Description: The "crowd" are those marginal stakeholders who have a small level of interest or stake in the issue and little influence or power.
Strategy: Engage if resources permit. Monitor with minimum effort. Do not communicate excessively.

Stakeholder type 2: Observers

Description: This type of stakeholder has a high level of interest or a significant stake in the issue but little influence or power over outcomes; they are reluctant observers to what occurs.
Strategy: Engage these stakeholders, especially if supportive. Keep informed of developments.

Stakeholder type 3: Influencers

Description: Influencers are those stakeholders who have significant influence or power but don't necessary exercise it due to a low level of interest or minimal stake in the issue.
Strategy: Keep non-supportive stakeholders satisfied to defend against them investing more in the issue and becoming hostile key players. Engage supportive stakeholders and encourage better involvement.

1 CommGap (2009) Multi-Stakeholder Dialogue. World Bank.

Stakeholder type 4: Key players

Description: This type of stakeholder is likely to influence the outcome of an issue because of their high level of interest and influence.

Strategy: Fully engage. These stakeholders must be managed closely. Defend against hostile key players and encourage supportive stakeholders with influence and interest.

Figure 7.5: Shows a stakeholder analysis done on the multisectoral nutrition programme of Nepal

Name of stakeholder	Influence/power (high or low)	Interest/stake in issue (high or low)	Likely position in relation to nutrition programme	Engagement priority (high, medium or low)
Ministry of Health	High	High	Positive	High
Other ministries (eg Education, Agriculture, Finance)	High	High	Positive but possible conflicts of interest	High
Other levels of government (regional, local)	High	High	Differs per region	High
UN agencies	High	High	Positive	Medium
Major donors	High	Low	Positive but could be negative depending on conflicts of interest and investment in programme	High
NGOs	Low	High	Positive	High
Civil society	Low	High	Positive	High
Media	Low	High	Positive	High

Source: stakeholder categories based on World Health Organization (2013) Nutrition and nutrition-sensitive interventions as an opportunity for institutionalizing HiAP: the Multisectoral Nutrition Programme in Nepal in Moving towards Health in All Policies: a compilation of experiences from Africa, South-East Asia and the Western Pacific.

After providing an initial background, divide the participants into small groups. As members of the NCD unit in a health ministry, the task for the participants is to conduct a stakeholder analysis in preparation for implementing the recommendations of the UN Declaration on the Prevention and Control of NCDs. It is suggested that you nominate a country, preferably one relevant to participants, to make the activity more specific and realistic. It is also recommended that you distribute the following reading material well in advance of the group activity.

Pre-reading for role play

- NCD Alliance (2012) Key Points of UN Political Declaration on the Prevention and Control of Non-Communicable Diseases
- WHO (2011) *Noncommunicable Diseases Country Profiles 2011*. Geneva, WHO (for the nominated specific country)

You should also distribute Handout 7.2, which is a template with instructions.

You should then explain to the groups that they should identify stakeholders who are likely to be interested or affected by the health ministry moving to address NCDs through a whole-of-society HiAP approach. This list could be large so the participants might want to group similar actors together to make it more manageable. Using the template, the participants should then discuss and write down the level of interest and influence of each stakeholder as well as their likely position in relation to the health ministry's initiative. For each stakeholder, the participants should assess the importance of engaging them as high, medium or low. If time permits, they might also wish to map the stakeholders using a matrix.

It is recommended that you allocate at least 40 minutes to the actual task. You should regularly remind the groups of the time remaining and encourage them to think about different ways to group and engage stakeholders.

It is suggested that you conclude the activity by asking the groups to name the most important stakeholders they identified and explain their assessment. You should use the opportunity to explain that the next module (8) will look at negotiations.

QUESTIONS AND FEEDBACK

5 MINS

It is recommended that you encourage contributions and questions throughout the workshop and dedicate a small amount of time at the end of each module for feedback and clarifications. This unallocated time can be used as necessary if part of a module takes longer than expected.

module

8

NEGOTIATING FOR HEALTH

module

8

NEGOTIATING FOR HEALTH

Lecture: Policy negotiations 114

Group activity: Negotiation role play – megacities and cardiovascular disease. 120

Group discussion: Debrief. 122

MODULE OVERVIEW

This module is about the principles, strategies and skills for policy negotiation and applying them to a role play of a HiAP issue.

	DURATION
Lecture: Policy negotiations	15 mins
Group activity: Negotiation role play – megacities and cardiovascular disease	60 mins
Group discussion: Debrief	30 mins
TOTAL TIME	**1h 45 mins**

Learning objectives

- List the major stages of the negotiation process
- Describe several approaches to policy negotiation
- Explain the characteristics of cooperative or value-added negotiating
- Apply knowledge of negotiation to a role play

Key messages

- Arguments on the intrinsic value of health or health's contribution to sectoral or societal gains can be useful in discussions with politicians and policy-makers across sectors. However, it is important to search for co-benefits.
- The four main approaches to policy negotiation are:
  - **Competitive.** The premise of this approach is to maximize one's gains and minimize concessions to other parties. This amounts to trying to take as much of the "pie" as possible. Competitive negotiators assume a "zero-sum" game and behave in an assertive and non-cooperative manner.
  - **Haggling.** This common approach to negotiating, which often lies somewhere between the competitive and cooperative approaches, aims to secure a pre-determined position by making trade-offs or concessions. This amounts to trying to get as much of the "pie" as possible but being prepared to give up some. Haggling negotiators assume a "zero-sum" game and behave in a guarded and manipulative way.
  - **Avoidance.** The aim of this approach to negotiating is to defer or postpone decisions on difficult or unfavourable issues. This amounts to trying to stop the negotiating parties from discussing the "pie". Avoidance negotiators are usually dynamic and reply on a combination of subtlety and assertiveness to divert or derail the negotiations.

  - **Cooperative.** This approach to negotiating seeks mutual gains for all parties by joint problem solving. It amounts to searching for ways to make the "pie" bigger so everyone gets a larger piece. Cooperative negotiators assume there are "win-win" solutions and behave in an open and collaborative way.

- HiAP is best served by a cooperative or value-added approach to negotiating.
- The main stages of the negotiation process are:
  - Recognize and study a problem;
  - Identify stakeholders and their interests;
  - Consult with stakeholders;
  - Establish a negotiation agenda;
  - Develop positions and strategies;
  - Negotiate with stakeholders; and
  - Assess proposed agreement.
- Negotiation styles, like communication, are influenced by social and cultural norms. Individuals with similar backgrounds such as class, gender, profession or nationality tend to exhibit similar negotiation styles. This can include their directness, use of body language and expression of emotion. Understanding these differences makes for a more effective negotiator.

Key reading for participants

Recommended

- Smith S *et al.* (2012) *Urbanization and Cardiovascular Disease: Raising Heart-Healthy Children in Today's Cities*. Geneva, The World Health Foundation, Chapters 1, 2 and 3 (13 pages)
- Umiker W (2007) Negotiating Skill for Health Care Professionals in Kongstvedt P (2007) *Essentials of Managed Health Care Handbook,* Fourth Edition. Aspen Publishers (6 pages)
- Video: CommGap, Negotiation (5 mins)
- Video: WHO (2011) Unite in the Fight Against NCDs (2 mins)

Optional

- CommGap (2009) Intercultural Communication. World Bank (6 pages)
- CommGap (2009) Non-Verbal Communication. World Bank (5 pages)

Supporting material for instructors

- Drager N *et al.* (2000) *Negotiating Health Development: A Guide for Practitioners.* Geneva, Conflict Management Group and WHO
- Saner R (2000) *The Expert Negotiator: Strategy, Tactics, Motivation, Behaviour, Leadership.* Kluwer Law International
- Bhattacharya D (2005) Least Developed Countries in Trade Negotiations: Planning Process and Information Needs in *Asia-Pacific Trade and Investment Review,* Vol. 1, No. 1
- Gilson L and Erasmus E (2007) Health Policy and Policy Analysis Training, Sessions 10 and 11. Centre for Health Policy, Johannesburg, University of the Witwatersrand
- CommGap Publications. World Bank

Teaching notes

This module is about policy negotiations and the principles and strategies that are most favourable to a HiAP approach. The module begins with a background on policy negotiations, including common approaches and the major stages of the process. It is recommended that you try to underline good negotiation practices and techniques such as detailed preparation, sharing information and offering multiple agreement opportunities. A large part of the module is then dedicated to applying this knowledge to a role play of an issue amenable to a HiAP approach. It is recommended that you give thought to the negotiation issue so that is has the most relevance to the participants and the context in which they work. The issue of urban transport and its impact on health and the environment, including supporting material, is suggested here as an example. It is strongly suggested that you allocate some time at the end of the module for the participants to debrief from their role-play negotiations. As always, it is useful to point to the learning objectives and outline the structure of the module so that the participants know what to expect.

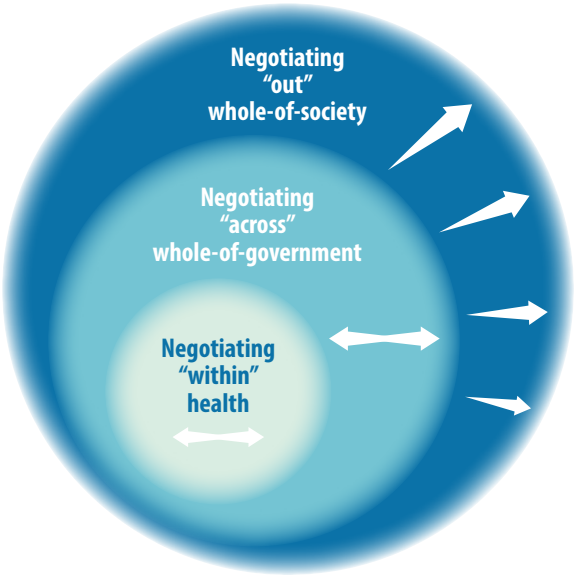
LECTURE: POLICY NEGOTIATIONS

15 MINS

To begin this module on policy negotiations and put it in context, you may want to recap some of the key messages from Modules 5 and 7, emphasizing that negotiations are relevant to both whole-of-government and whole-of-society approaches. Given the nature of contemporary health challenges, which are complex and influenced by multiple sectors as discussed in Modules 1 and 2, dialogue and collaboration between health and other stakeholders is critical. Adopting a HiAP approach means health policy-makers must acquire negotiating skills.

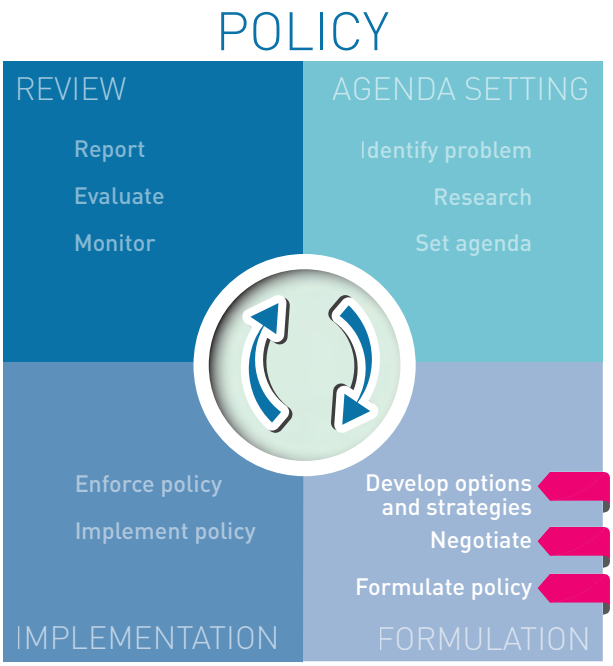
- Intersectoral action or a whole-of-government approach refers to the coordinated efforts of two or more sectors within government to improve health outcomes. This can include working across different levels of government such as district, provincial and national jurisdictions.
- A whole-of-society approach, in contrast, refers to coordinated efforts to improve health by multiple stakeholders within and outside government that can also be from several sectors.
- It cannot be taken for granted that sectors and organizations will bring the same priorities, interests and attitudes to the table. It also cannot be taken for granted that different parts of the health sector can agree on a HiAP approach. Indeed, experience shows that it is more probable that they will not. It is, therefore, essential that the policy champions and advocates involved in the HiAP process acquire the negotiating skills necessary to move the HiAP agenda forward.
- This means "negotiating across" to achieve national policy coherence through a whole-of-government approach and negotiating "out" for a whole-of-society approach which means building coalitions with diverse actors. It also means negotiating "within" the health sector, which will be addressed in Module 11.

Figure 8.1: The scope of negotiating



After providing some context, you might want to remind the participants of the primary place of negotiations in the policy cycle although negotiations can take place frequently and elsewhere. It is suggested that you then define the concept of policy negotiation, describe its stages, explain the main approaches to negotiating and outline some of the positive negotiation techniques for a HiAP approach.

Figure 8.2: The place of negotiation in the policy cycle



Source: modified from http://www.geostrategis.com/images/policycycle.jpg

Policy negotiation definition

The term "negotiation" originates from the Latin word *negotiari,* which means "done in the course of business". Negotiation may be defined as a process whereby two or more parties seek an agreement to establish what each shall give or take, or perform and receive in a transaction between them. Alternatively, it is an act of discussing an issue between two or more parties with competing interests, with an aim to identify acceptable trade-offs for coming to an agreement.[1]

Stages of negotiation process

While there are many ways to breakdown the negotiation process, it generally includes the following stages:

1. Understanding a problem raised in agenda setting

- Negotiations occur after a problem or opportunity has been identified, which corresponds to the agenda-setting stage of the policy cycle.

1 Bhattacharya D (2005) Least Developed Countries in Trade Negotiations: Planning Process and Information Needs. *Asia-Pacific Trade and Investment Review,* Vol. 1, No. 1, p. 71.

- At the beginning of the negotiation process, it is also fundamental to determine whether negotiations are necessary or possible. On rare occasions, a single actor might be able to address an issue unilaterally. For example, a health minister might ban a product scientifically linked to health problems. In contrast, there might be situations where this same actor has limited policy space or other priorities.
- The negotiation process and successful outcomes are closing linked to windows of opportunity, discussed earlier in Module 4.

2. Identify stakeholders and their interests

- Once the problem is well understood, one has to identify who may benefit and who may lose in the negotiation. It is particularly important to recognize whether there are any powerful interest groups that may either support the efforts to negotiate a solution to the problem or strongly oppose the negotiations.
- A stakeholder analysis, like the one discussed in Module 7, is used in this stage of the negotiation process.

3. Consult with stakeholders

- Once stakeholders and their interests have been identified, it is important to plan and organize an effective consultation process to further understand their needs and gather information to develop a negotiating agenda and determine a position on each of the issues to be negotiated.
- This stage of the negotiation process might be delayed until or repeated after a negotiation agenda is clearly established and before negotiations commence. Consultation with stakeholders, especially those that are supportive or neutral, is important for building coalitions.

4. Establish negotiation agenda

- Before negotiations can begin an agenda defining the issues open for discussion is usually agreed upon by the parties. Often this agenda is set by a politician or senior decision-maker overseeing the process. On other occasions, this agenda might be set by external events or negotiated by the stakeholders themselves voluntarily coming together to address an issue.
- At the same time as establishing a negotiation agenda, it is normal to designate representative negotiators for the participating stakeholders and decide upon a format for the process, including location, timing and resources for facilitation.

5. Develop positions and strategies

- On the basis of available information, continuing analysis and consultations, negotiating positions and strategies may be formulated. The selection of a negotiating objective at the very beginning of this step is highly recommended in order to provide a clear focus for both the preparatory work leading to a negotiation and to the management of the negotiation itself.
- Steps involved in developing a negotiating strategy may include:
  - › Establishing outcomes and priorities for oneself;
  - › Estimating outcomes and priorities for other parties;
  - › Identifying and assessing major trade-offs; and
  - › Constructing and evaluating as many possible combinations of outcomes and consequences.

- A strategy or approach to the negotiations is decided upon at this point (see below). However, it is important to note that strategies can change during negotiations.
- Evaluating the consequence of a failure to reach an agreement can be an overlooked challenge of negotiation planning.

6. Negotiate with stakeholders

- It is during this stage that the stakeholders implement their strategies, propose agreements, offer concessions and compromises are reached.
- The chosen negotiation strategies of the stakeholders, as discussed below, will heavily influence the tone of the discussions and the potential agreements that can be reached.

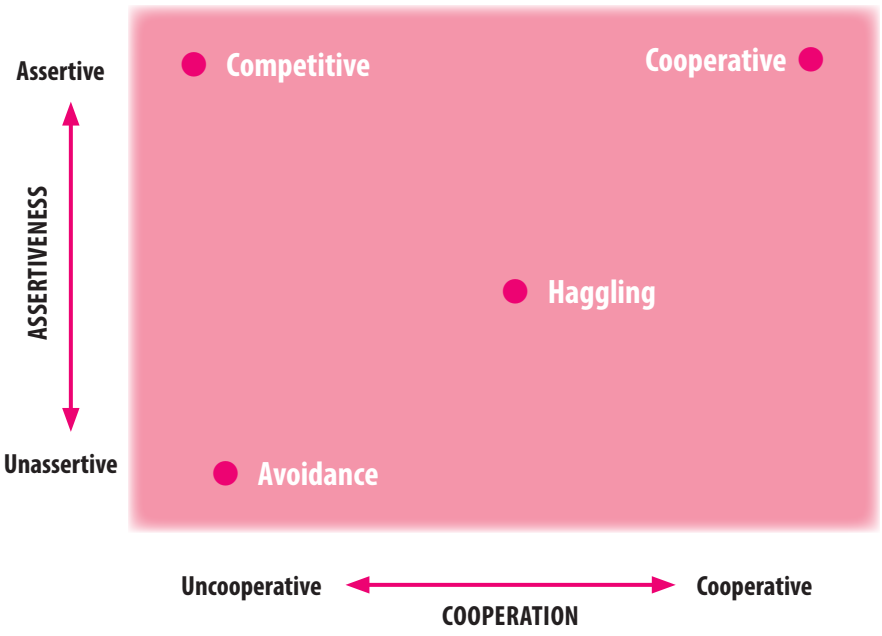
7. Assess proposed agreement

- After the actual negotiation has finished and the elements of an agreement have been put together, a short evaluation of the whole outcome becomes necessary to decide whether a successful agreement is possible or whether another round of negotiations might be needed.
- Individuals external to the negotiation, especially technical experts and lawyers, are sometimes involved in making this assessment to ensure the proposed agreement is legal and viable.

Approaches to negotiations

There are four main approaches to policy negotiation.

Figure 8.3 The four main approaches to policy negotiation



Source: Thomas KW and Kilmann RH (1977) Developing a forced-choice measure of conflict handling behaviour: the mode instrument. *Educational and Psychological Measurement*, 37.

1. Competitive

- The premise of this approach is to maximize one's gains and minimize concessions to other parties. This amounts to trying to take as much of the "pie" as possible. Competitive negotiators assume a "zero-sum" game and behave in an assertive and non-cooperative manner.
- Some of the tactics used by competitive negotiators include:
  - Arguments to encourage concessions;
  - Firm commitment to demands;
  - Refusal to reveal/share information;
  - Delays;
  - Misrepresentation;
  - Rejection of the other's demands for concessions;
  - Withholding of concessions;
  - Refusal to exchange offers; and
  - Threaten walk out or retaliate.

2. Haggling

- This common approach to negotiating, which often lies somewhere between the competitive and cooperative approaches, aims to secure a pre-determined position by making trade-offs or concessions. This amounts to trying to get as much of the "pie" as possible but being prepared to give up some. Haggling negotiators assume a "zero-sum" game and behave in a guarded and manipulative way.
- Some tactics hagglers use include:
  - Never making their best offer at the start;
  - Asking for more than they expect to get;
  - Expecting a direct gain in return for concession;
  - Offering only one-sided solutions;
  - Exaggeration and manipulation; and
  - Ultimatums and deadlines.

3. Avoidance

- The aim of this approach to negotiating is to defer or postpone decisions on difficult or unfavourable issues. This amounts to trying to stop the negotiating parties from discussing the "pie". Avoidance negotiators are usually dynamic and reply on a combination of subtlety and assertiveness to divert or derail the negotiations.
- Some tactics used by avoidance negotiators include:
  - Disseminating misinformation;
  - Casting doubt on scientific evidence;
  - Provocative or lengthy statements to distract;

- › Prioritizing less contentious agenda items;
- › Focusing on small details;
- › Using procedural mechanisms to delay discussion; and
- › Promoting ineffective policy solutions.

4. Cooperative

- This approach to negotiating seeks mutual gains for all parties by joint problem solving. It amounts to searching for ways to make the "pie" bigger so everyone gets a larger piece. Cooperative negotiators assume there are "win-win" solutions and behave in an open and collaborative way.
- The tactics of cooperative negotiators include:
  - › Signalling a desire for agreement;
  - › Exchanging information about needs and priorities;
  - › Consulting widely;
  - › Brainstorming and jointly assessing options;
  - › Focusing on co-benefits beyond short term; and
  - › Valuing the maintenance of a partnership.

Negotiation techniques for a HiAP approach

In discussing the negotiation process, it is important that you emphasize value of cooperative negotiating from the perspective of a HiAP approach. You may want to suggest to the participants some good techniques for effective negotiating in a HiAP context.

In addition to the above-mentioned tactics of cooperative negotiators, you might include:

- Study the problem in detail and analyse stakeholders thoroughly;
- State objectives or interests rather than positions;
- Listen carefully for what is said, what is not said and watch body language;
- Keep proposals as simple as possible;
- Articulate ideas and arguments concisely;
- Assume the best of other stakeholders;
- Anticipate and respond to objections;
- Present multiple proposals;
- Remain assertive but not aggressive;
- Use body language knowingly to communicate; and
- Persist with negotiations in goodwill but walk away if necessary.

Cooperative and ethical negotiating

It is recommended that you distribute the following handouts to assist the participants understand the characteristics of cooperative or added-value and ethical negotiating.

- Handout 8.1; and
- Handout 8.2.

With respect to the following ethics of negotiating, it could also be worthwhile discussing public health ethics and which health principles can be negotiable and which cannot be compromised. This could be a potential additional module should certain countries or regions want to expand on this manual.

Noting that communication styles are influenced by social and cultural norms, you might also want to discuss some of the common differences between negotiators of different backgrounds such as class, gender, profession and nationality. You may want to do this as a group discussion based on the participants' experiences, especially if there is a diversity of backgrounds.

Some points of comparison could include:

- Diplomacy and directness;
- Literal and coded language; and
- Reserve and emotion.

You may also want to reference the optional key reading for the participants on intercultural and non-verbal communication (CommGap, 2009) as well as interpersonal influence.

GROUP ACTIVITY: NEGOTIATION ROLE PLAY – MEGACITIES AND CARDIOVASCULAR DISEASE

60 MINS

The purpose of this group activity is for the participants to apply their knowledge and skills of negotiation to a health issue that can be addressed through a HiAP approach. The issue of cardiovascular disease is suggested here as a topic for the negotiation role play because the causes of this NCD are deeply rooted in the social determinants of health, involve many stakeholders, and favour a HiAP approach. Nevertheless, you may want to prepare an alternative scenario that is more relevant to the work of the participants.

Given the short amount of time available and the focus on negotiation skills, it is recommended that you distribute the following reading material well in advance of the group activity.

Pre-reading for role play

- Background information on cardiovascular disease
  - › Smith S *et al.* (2012) *Urbanization and Cardiovascular Disease: Raising Heart-Healthy Children in Today's Cities.* Geneva, World Health Foundation, Chapters 1, 2 and 3 (13 pages)
- Information specific to each group
  - › Smith S *et al.* (2012) *Urbanization and Cardiovascular Disease: Raising Heart-Healthy Children in Today's Cities.* Geneva, World Health Foundation, Chapter 4 relevant city profile
    - (São Paulo pp. 23–25)
    - (Shanghai pp. 25–26)
    - (Mexico City pp. 26–28)
    - (Buenos Aires pp. 28–30)
    - (Mumbai pp. 30–32)
    - (Tehran pp. 32–34)
    - (Nairobi pp. 34–36)
  - › Role play stakeholder descriptions (see Handout 8.3)
    - Mayor (chairperson/facilitator) (all cities)
    - Health ministry (all cities)
    - Education ministry (all cities)
    - Infrastructure, transport and housing ministry (all cities)
    - Finance ministry (all cities) (optional)
    - NGO (all cities)
    - Tobacco lobby (Mexico City, Shanghai, Nairobi, Tehran, all cities (optional))
    - Food and beverages lobby (Mumbai, Buenos Aires and Mexico City (optional))
    - Cattle farmers association (São Paulo, Buenos Aires)

It is also suggested that you tell the participants on the first day that they should prepare for the negotiating module by:

- Reading the background material;
- Listing the interests and objectives of the stakeholder they are representing;
- Identifying the likely interests and objectives of the other stakeholders in their group; and
- Considering potential alliances and agreements.

You should give some thought to which roles you will allocate to each participant as this will influence the dynamic of the negotiations. For example, the same well-spoken confident participant playing the role of health ministry or tobacco lobby can potentially change the outcomes of the negotiation. Depending on the size of the group, their backgrounds and your preparation time before the course, you may want to have several small groups negotiate as the same combination

of stakeholders for the same city. One benefit of this is that the participants can more easily relate to the experiences of other groups during the debriefing. Alternatively, you might want to have groups negotiate as unique combinations of stakeholders from different cities. Another arrangement for the activity you should consider is whether to get pairs of participants to represent a stakeholder. This can help the participants devise strategies and negotiate but it makes the groups larger and there's a risk that one of the partners does most of the preparation and negotiating.

To begin the role play, it is suggested that you form the group of stakeholders negotiating with each other and instruct them to re-familiarize themselves with the scenario and spend 10 minutes alone devising two or three "package deals", thinking about co-benefits and the other stakeholders they might be able to work with.

Once the participants have had 10 minutes to prepare, you should encourage them to consult with the other stakeholders. It is likely that the participants will find it difficult to consult with all of the other parties in this short time so you should remind them of the time and to consider prioritizing their consultations.

At this point, you might want to also highlight that this part of the activity represents the first five stages of the negotiation process in a condensed and accelerated form.

It is suggested that you allocate at least 40 minutes to the actual negotiation between all of the stakeholders. You should regularly remind the groups of the time remaining and encourage them to outline a specific agreement if time permits.

GROUP DISCUSSION: DEBRIEF

30 MINS

It is strongly recommended that you allocate some time immediately after the group activity for the participants to debrief from their role play negotiations. This is an occasion for the participants to evaluate the agreements they reached or didn't reach and reflect on the experience. If the number of groups permits, it is suggested that you hold a group discussion with everyone so that the participants can hear the experiences and insights of other groups.

You may want to pose questions to each group in turn such as:

- Which stakeholders are satisfied with the agreement or non-agreement?
- Why were certain proposals rejected or accepted?
- What negotiation tactics were adopted by the different stakeholders? Were they consistent with the role they were allocated?
- What influence or impact did the chairperson/facilitator have on the negotiations?
- What role did individual personalities have in the discussion?

During the debriefing or as a summary of the module, it is suggested that you re-emphasize the key messages of the module, particularly the importance of cooperative negotiating for a HiAP approach.

module

9

HiAP IMPLEMENTATION AT LOCAL, REGIONAL AND GLOBAL LEVELS

module

9

HiAP IMPLEMENTATION AT LOCAL, REGIONAL AND GLOBAL LEVELS

Alternative One

Participant presentations of local and regional HiAP case studies 128

Alternative Two

Recap: Modules 5–8 128

Lecture: HiAP implementation at global, regional and local levels 130

Lecture: Challenges of HiAP implementation 135

Questions and feedback 136

MODULE OVERVIEW

This module is about exploring the lessons and challenges of HiAP at local, regional and global levels.

	DURATION
ALTERNATIVE ONE	
Participant presentations of local and regional HiAP case studies	1h 30 mins
ALTERNATIVE TWO	
Recap: Modules 5–8	10 mins
Lecture: HiAP implementation at global, regional and local levels	60 mins
Lecture: Challenges of HiAP implementation	15 mins
Questions and feedback	5 mins
ALTERNATIVE ONE	**1h 30 mins**
ALTERNATIVE TWO	**1h 30 mins**

Learning objectives

- Discuss examples of HiAP implementation at the local, regional and/or global level
- Identify some of the challenges of implementation

Key messages

- Many of the determinants of health are shaped by regional and global issues, which necessitate international cooperation.
- HiAP can also be successfully implemented at the local level.
- As one might expect, HiAP has been implemented differently in different contexts reflecting local social and political cultures as well as government structures. It is important to share experiences and lessons learned to understand how HiAP can be most effective.
- Some of the difficulties with implementing HiAP can include:
  - Lack of institutional support;
  - Ineffective leadership in the bureaucracy;
  - Poorly planned or unclear objectives and responsibilities;
  - Impediments of hostile stakeholders;
  - Shifting political priorities;

- Weak enforcement;
- Limited resources and capacity; and
- Unrealistic time frames.

Key reading for participants

Recommended

- Koivusalo M *et al.* (2013) Globalization and National Policy Space for Health and a HiAP approach in Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health (16 pages)

Optional

- WHO (2013) *Health in All Policies: Report on Perspectives and Intersectoral Actions in the African Region*. Brazzaville, WHO
- WHO (2013) *Health in All Policies: Report on Perspectives and Intersectoral Actions in the South-East Asia Region*. New Delhi, WHO
- WHO (2013) *Health in All Policies: Report on Perspectives and Intersectoral Actions in the Western Pacific Region*. Manila, WHO
- British Academy (2014) *If You Could Do One Thing: Nine Local Action to Reduce Health Inequalities*. London, The British Academy (Executive Summary) (4 pages)

Supporting material for instructors

- WHO regional HiAP reports
- WHO country HiAP case studies:
  - WHO (2013) Moving Towards Health in All Policies: A Compilation of Experiences from Africa, South-East Asia and the Western Pacific. Geneva, WHO
  - WHO (2013) Opportunities for scaling up and strengthening the health-in-all-policies approach in South-eastern Europe. Copenhagen, WHO
  - WHO (2013) Health in All Policies. Summary of experiences from the Americas. The 8th Global Conference on Health Promotion 2013, Helsinki, Finland, 10 to 14 of June. Washington, D.C., Pan American Health Organization
- WHO (2003) Framework Convention on Tobacco Control (AR) (CN) (ES) (FR) (RU)
- WHO (2005) International Health Regulations (AR) (CN) (ES) (FR) (RU)
- Video: WHO (2012) World No Tobacco Day – Sponsorship (1 min) (AR) (CN) (ES) (FR) (PT) (RU)

- Video: WHO (2012) World No Tobacco Day – Advertising (1 min) (ES) (FR)
- Video: WHO (2008) World No Tobacco Day – Fashion (1 min)
- Video: WHO (2008) World No Tobacco Day – Film (1 min)
- Video: WHO (2013) Tobacco Control Measures (3 mins)
- Video: WHO (2012) International Health Regulations (4 mins)
- Video: WHO (2014) Responding to International Health Threats (7 mins)
- Video: WHO (2013) Towards Making Every City a Healthy City (6 mins)

Teaching notes

This model explores the challenges of HiAP implementation and has two alternative structures.

In the interests of sharing experiences, it is suggested that the participants with experience of HiAP give a short presentation of how they applied the principles and what others can learn from it. The entire module would be dedicated to these presentations and the ensuing discussion. It is highly recommended that you follow up case studies with a lot of detail or interesting lessons with the view that they might be circulated beyond the workshop or even published.

Alternatively, it is suggested that you present and discuss a number of published or known case studies on HiAP at the local, regional and global level. The WHO Framework Convention on Tobacco Control (WHO FCTC), the International Health Regulations and Healthy Cities project are provided as examples with support material. However, it is strongly recommended that you find issues that have relevance to the participants and the context in which they work. You may want to prepare additional material and discuss different case studies. As always, it is useful to point to the learning objectives and outline the structure of the module so that the participants know what to expect.

ALTERNATIVE ONE

PARTICIPANT PRESENTATIONS OF LOCAL AND REGIONAL HiAP CASE STUDIES

1 H 30 MINS

ALTERNATIVE TWO

RECAP: MODULES 5–8

10 MINS

You should remind the participants that you have now finished the modules on policy formation and that the workshop will now focus on implementation then monitoring and evaluation.

To reinforce the lessons of earlier modules, it is suggested that you quickly recap the key messages of Modules 5, 6, 7 and 8. You may want to do this in an interactive way with open questions or a group activity such as the "fish bowl" as explained in Module 3.

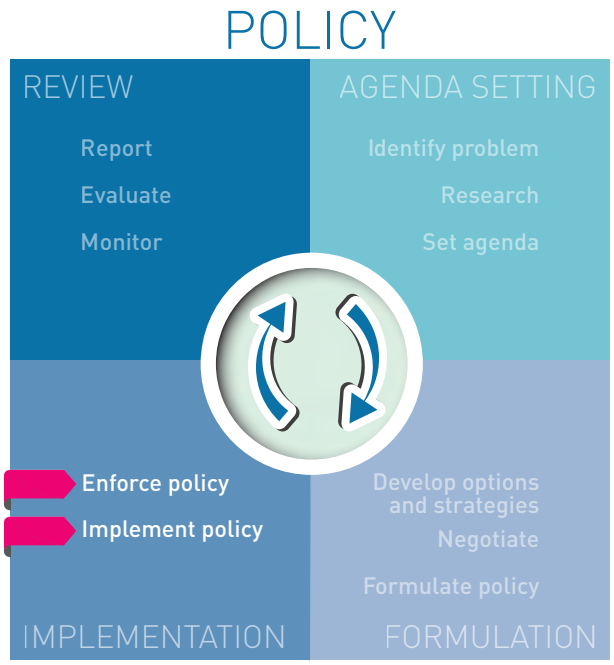
Some important points to reiterate might include:

- Intersectoral action refers to the coordinated efforts of two or more sectors within government to improve health outcomes. This can include working across different levels of government such as district, provincial and national jurisdictions. This is also referred to as a whole-of-government approach.
- A whole-of-society approach refers to coordinated efforts to improve health by multiple stakeholders within and outside government which may also be from several sectors.
- A stakeholder is a person, or group of persons, who have an interest or concern in a particular process or issue due to direct or indirect involvement. Examples include government ministries, politicians, non-government organizations, religious organizations, research institutes, labour unions, professional associations and businesses.

- There are both benefits and costs of widely consulting stakeholders, which should be carefully considered as part of the policy-making process.
- The conditions that most favour effective intersectoral collaboration include:
  - Government supports and encourages intersectoral action;
  - Sectors have shared interests or all benefit from cooperation;
  - Issue has high political importance and requires urgent addressing;
  - Proposed policy has public support;
  - Strong, effective leaders in the bureaucracy (policy champions/entrepreneurs);
  - Intersectoral action is well-planned with clear objectives, roles and responsibilities;
  - Laws exist or are planned to support the proposed policy;
  - Sufficient resources are available; and
  - There are plans to monitor and sustain outcomes.

You might also want to remind the participants of where implementation fits within the policy cycle.

Figure 9.1 The policy implementation stage of the policy cycle



Source: modified from http://www.geostrategis.com/images/policycycle.jpg

LECTURE: HiAP IMPLEMENTATION AT GLOBAL, REGIONAL AND LOCAL LEVELS

60 MINS

The purpose of this section of the module is to explore the experiences of HiAP implementation. After presenting a case study, it is strongly recommended that you allow time for group discussion and encourage the participants to reflect on how the case studies might apply to their own work.

HiAP implementation at the global level

International Health Regulations

As discussed in Module 2, there are many global trends such as globalization, urbanization and increasing international trade that impact health. Emerging infectious diseases like SARS and health hazards such as the contamination of traded goods as well as chemical and nuclear accidents highlight the importance of international cooperation to prevent and control such events.

In 2005, WHO Member States negotiated new International Health Regulations (IHR) (2005). This legally binding agreement contributes to global public health security by providing a framework for the coordination of the management of the kinds of events mentioned above. The purpose of the IHR (2005) is to improve the capacity of all countries to detect, assess, notify and respond to public health threats of international concern.

The IHR (2005) include many rights and obligations for States/Parties. These cover activities ranging from surveillance and response, to notification and verification to WHO of certain public health events and risks, to rules on application of health measures for international travellers, trade and transportation, requirements for sanitary conditions and services at international ports, airports and ground crossings and development of minimum public health capacities for surveillance, assessment, response and reporting for a broad range of risks throughout the territories of all States/Parties.

To further explain the IHR (2005), you may want to show the following videos:

WHO (2012) International Health Regulations:
4 MINS http://www.youtube.com/watch?v=70T9_-276vc

WHO (2014) Responding to International Health Threats:
7 MINS https://www.youtube.com/watch?v=wndsRFjfbgc

WHO Framework Convention for Tobacco Control

Another global challenge is addressing commercial determinants of health such as tobacco. The WHO Framework Convention on Tobacco Control is an example of successful international efforts to regulate a transnational health hazard. It is the first treaty negotiated under the auspices of the World Health Organization. The WHO FCTC is an evidence-based treaty that reaffirms the right of all people to the highest standard of health. The WHO FCTC represents a paradigm shift in developing a regulatory strategy to address addictive substances; in contrast to previous drug control treaties, the WHO FCTC asserts the importance of demand reduction strategies as well as supply issues.

The WHO FCTC was developed in response to the globalization of the smoking epidemic. The spread of the smoking epidemic is facilitated through a variety of complex factors with cross-border effects, including trade liberalization and direct foreign investment. Other factors such as global marketing, transnational tobacco advertising, promotion and sponsorship, and the international movement of contraband and counterfeit cigarettes have also contributed to the explosive increase in tobacco use.

The core demand reduction provisions in the WHO FCTC are contained in articles 6–14:

- Price and tax measures to reduce the demand for tobacco; and
- Non-price measures to reduce the demand for tobacco, namely:
  - › Protection from exposure to tobacco smoke;
  - › Regulation of the contents of tobacco products;
  - › Regulation of tobacco product disclosures;
  - › Packaging and labelling of tobacco products;
  - › Education, communication, training and public awareness;
  - › Tobacco advertising, promotion and sponsorship; and,
  - › Demand reduction measures concerning tobacco dependence and cessation.

The core supply reduction provisions in the WHO FCTC are contained in articles 15–17:

- Illicit trade in tobacco products;
- Sales to and by minors; and,
- Provision of support for economically viable alternative activities.

The WHO FCTC opened for signature from 16–22 June 2003 in Geneva, and thereafter at the United Nations Headquarters in New York, the depositary of the treaty, from 30 June 2003 to 29 June 2004. The treaty, which is now closed for signature, has 168 signatories, including the European Community, which makes it one of the most widely embraced treaties in UN history.

Tobacco control is one of the health issues that the HiAP literature covers most extensively, in particular the whole-of-government efforts to implement the FCTC. If you use this example of HiAP implementation, it is suggested you discuss national examples from the region where the workshop is being held.

You may also want to show some of the following videos:

WHO (2013) Tobacco Control Measures:
3 MINS https://www.youtube.com/watch?v=7hpjhmN4L1w

WHO (2012) World No Tobacco Day – Sponsorship (AR) (CN) (ES) (FR) (PT) (RU):
1 MIN https://www.youtube.com/watch?v=HSvoF8IfzRY

WHO (2012) World No Tobacco Day – Advertising (ES) (FR):
1 MIN https://www.youtube.com/watch?v=rdp8IZWWAT0

WHO (2008) World No Tobacco Day – Fashion:
1 MIN https://www.youtube.com/watch?v=21-90RXKbTw

WHO (2008) World No Tobacco Day – Film:
1 MIN http://www.youtube.com/watch?v=UATECZKXqyI

HiAP implementation at the local level

Healthy Cities project

HiAP can also be successfully implemented at the local level. The WHO's Healthy Cities project is a good example of this, for which there is significant literature that you may want to use. Healthy Cities is a long-term international development initiative that aims to place health high on the agendas of decision-makers and to promote comprehensive local strategies for health protection and sustainable development. Basic features include community participation and empowerment, intersectoral partnerships and participant equity. A Healthy City aims to:

- Create a health-supportive environment;
- Achieve a good quality of life;
- Provide basic sanitation and hygiene needs; and
- Supply access to health care.

Healthy Cities is arguably the best known and largest of the settings approach, which is consistent with a social determinants of health approach. A setting is where people actively use and shape the environment; thus it is also where people create or solve problems relating to health. Settings can normally be identified as having physical boundaries, a range of people with defined roles and an organizational structure. Examples of settings include schools, work sites, hospitals, villages and cities. Action to promote health through different settings can take many forms. Actions often involve some level of organizational development, including changes to the physical environment or to the organizational structure, administration and management.

Starting in 1986, the first Healthy Cities programmes were launched in high-income countries. Around 1994, low- and middle-income countries used the resources and implementation strategies of initial successes to begin their own programmes. Implementation strategies are quite individual by city, though they follow the basic ideas of involving many community members, having various stakeholders and getting the commitment of municipal officials to achieve widespread mobilization and efficiency. Today, thousands of cities worldwide are part of the Healthy Cities network in all WHO regions.

You might want to show the following video:

WHO (2013) Towards Making Every City a Healthy City:
6 MINS http://www.youtube.com/watch?v=IqluZPlako8

LECTURE: CHALLENGES OF HiAP IMPLEMENTATION

15 MINS

To conclude this module, it is suggested that you explore some of the common difficulties implementing HiAP, using examples relevant to the context of where the workshop is being held and the work of the participants.

Some potential challenges worth discussing could include:

- Policy complexity;
- Lack of institutional support;
- Ineffective leadership in the bureaucracy;
- Poorly planned or unclear objectives and responsibilities;
- Impediments of hostile stakeholders;
- Shifting political priorities;
- Weak enforcement;
- Limited resources and capacity; and
- Unrealistic time frames.

QUESTIONS AND FEEDBACK

5 MINS

It is recommended that you encourage contributions and questions throughout the workshop and dedicate a small amount of time at the end of each module for feedback and clarifications. This unallocated time can be used as necessary if part of a module takes longer than expected.

module

10

MEASURING PROGRESS IN HEALTH

module

10

MEASURING PROGRESS IN HEALTH

Group discussion: Reasons for M&E and health indicators 143

Lecture: M&E, HiAP, HIA and HLA 144

Group activity: HIA 149

Optional group discussion: Data sources for HiAP 151

Questions and feedback 155

MODULE OVERVIEW

This module is about monitoring and evaluating (M&E) population health and health inequity, suggesting data sources for health policy-making and introducing participants to two different approaches to evaluation for generating evidence-based recommendations: health impact assessment (HIA) and health lens analysis (HLA).

	DURATION
Group discussion: Reasons for M&E and health indicators	10 mins
Lecture: M&E, HiAP, HIA and HLA	15 mins
Group activity: HIA	60 mins
Optional group discussion: Data sources for HiAP	15 mins
Questions and feedback	5 mins
TOTAL TIME	**1h 30 mins**
WITH OPTION	**1h 45 mins**

Learning objectives

- List reasons for monitoring and evaluation
- Recognize different types of monitoring and evaluation related to health
- Distinguish between inputs, outputs, outcomes and impact
- Explain the purpose and key steps involved in health impact assessment and health lens analysis
- Conduct a mock health impact assessment or health lens analysis
- Identify sources of health data and policy advice

Key messages

- Monitoring can be defined as the systematic collection of data about an indicator or variable of interest. Evaluation, in contrast, involves a judgement about the value of or change in that variable.
- Monitoring and evaluation can focus on different aspects of health and health policy-making. For instance:
  - › Population health (e.g. incidence of disease and life expectancy);
  - › Epidemiology (e.g. risk factors and exposure levels);
  - › Determinants of health (e.g. income and living conditions);
  - › Health system performance (e.g. access and quality of health services); and
  - › Health policy (e.g. impact on health outcomes and health inequity).

- From the perspective of HiAP, the purpose of monitoring and evaluation is to determine the impact of policies, programmes and practices, and, subsequently, to indicate whether policy change is needed.
- Generally speaking, the five stages of the cycle of health monitoring are:
    1. Selecting relevant indicators;
    2. Obtaining data;
    3. Analysing data;
    4. Reporting results; and
    5. Implementing changes.
- Just as monitoring and evaluation can focus on different aspects of health and policy-making, indicators often correspond to different stages of a policy intervention and can be categorized as a "results chain" as follows:
    - "Inputs" – the resources used to initiate a policy or project;
    - "Outputs" – processes, products and services that immediately result from a policy or project;
    - "Outcomes" – short- to medium-term results of a policy or project; and
    - "Impacts" – long-term effects produced by a policy or project.
- The World Health Organization uses the "results chain" to evaluate the influences of health inputs and outputs on universal health coverage. In this performance assessment framework, the social determinants of health are construed as influencing health system inputs and outputs, as well as how the users of health systems demand and utilize health services.
- A health impact assessment is a combination of procedures, methods and tools that assess the potential effects of a policy or project on the health of a population and the distribution of those effects within the population. HIAs also identify appropriate actions to manage those effects.
- The health lens analysis is an emerging methodology used to translate the HiAP concept into action. It differs from health impact assessment in its emphasis on relationship building and mutually beneficial outcomes, and the emphasis on navigating the recommendations through the decision-making process. Building evaluation into any policy recommendations is a key aspect of the methodology.
- Emphasizing co-benefits between health and another policy focus on area is an important technique to be used in either HIA or HLA. This refers to situations where health gains and sustainability objectives can be mutually reinforcing.
- There are many valuable public sources of data and policy advice to inform HiAP development and implementation.

Key reading for participants

Recommended

- WHO (2013) *Handbook on Health Inequality Monitoring with a Special Focus on Low- and Middle-Income Countries.* Geneva, WHO (Introduction) (15 pages)
- Quigley R *et al.* (2006) *Health Impact Assessment International Best Practice Principles* Special Publication Series No. 5. International Association for Impact Assessment (4 pages)
- WHO (2014) HiAP Framework for Country Action. Geneva, WHO (Annex 1) (1 page)
- WHO (2011) Health in All Policies. South Australia's country case study on action on the social determinants of health. Produced for the World Conference on Social Determinants of Health, Rio de Janeiro, Brazil.
- International Health Partnership and WHO (2011). Monitoring, evaluation and review of national health strategies. A country-led platform for information and accountability. Geneva, WHO

Supporting material for instructors

- Quigley R (2010) Role of Health Impact Assessment in HiAP in Kickbusch I and Buckett K (2010) *Implementing Health in All Policies.* Department of Health, Government of South Australia
- WHO (2003) *Bulletin of the World Health Organization.* Geneva, WHO, Vol. 81, No. 6, pp. 387–472
- WHO (2005) Health Impact Assessment Toolkit for Cities, Training Module. Copenhagen, WHO
- Lee J, Röbbel N and Dora C (2013) Cross-Country Analysis of the Institutionalization of Health Impact Assessment. Social Determinants of Health Discussion Paper Series 8. Geneva, WHO
- IFC (2009) Introduction to Health Impact Assessment (HIA). International Finance Corporation, World Bank Group
- UNDP (2011) *Handbook on Planning, Monitoring and Evaluating for Results.* New York, UNDP (AR) (FR) (ES) (RU)
- WHO (2011). Health in the green economy: health co-benefits of climate change mitigation - housing sector. Geneva, WHO
- WHO (2011). Social Determinants of Health Sectoral Briefing Series. Housing: shared interests in health and development. Geneva, WHO
- Loewenson R (2013) Evaluating intersectoral processes for action on the social determinants of health: learning from key informants (Social Determinants of Health Discussion Paper 5: Policy & Practice). Geneva, WHO
- Technical Paper for World Health Organization, written for the 8th Global Conference on Health Promotion, June 2013, Helsinki
- Baum F, Lawless A, Delany T, MacDougall C, Williams C, Broderick D, Wildgoose D, Harris E, McDermott D, Kickbusch I, Popay J and Marmot M (2014) Evaluation of Health in All Policies: concept, theory and application. *Health Promotion International*, Vol 29

Teaching notes

The purpose of this module is to convey the importance of M&E for HiAP and introduce the participants to some key concepts and the use of HIA and HLA tools. Given the potential complexity of M&E, the module omits many otherwise important issues such as choosing appropriate indicators, setting targets and attributing changes to a particular policy. For those participants with an interest in M&E, it is suggested that you provide references to further reading and training. If you assess that the participants already have a high level of understanding of M&E, you may want to concentrate on the second half of the module looking at HIA and HLA.

The module begins with a group discussion about why M&E is essential and identifies some examples of indicators of health and health policy. You should then explain some key M&E concepts and introduce the HIA tool and the HLA. Using a fictional policy scenario, it is suggested that you conduct a group activity to allow the participants to apply and discuss some of the procedures of a HIA or a HLA.

To conclude, the module reviews some of the primary sources of data for policy-making. As always, it is useful to point to the learning objectives and outline the structure of the module so that the participants know what to expect.

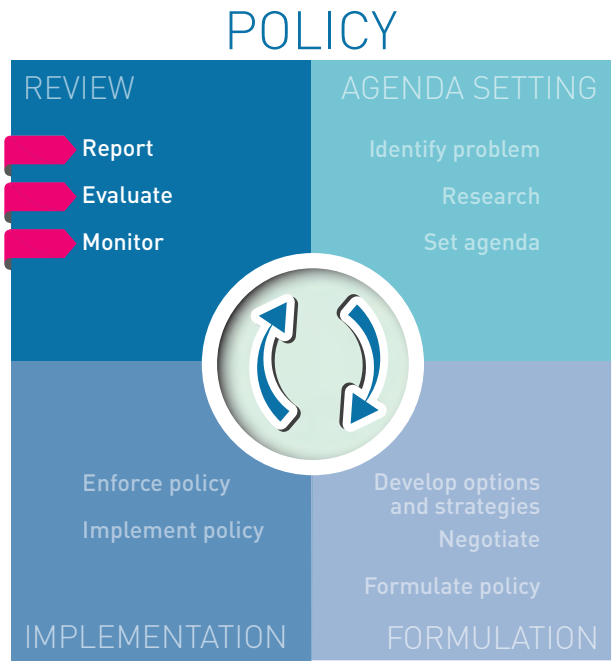
GROUP DISCUSSION: REASONS FOR M&E AND HEALTH INDICATORS

10 MINS

At this point, it is suggested that you explain to the participants that this module on measuring progress in health is looking at a different stage of the policy cycle. You may find it useful to show Figure 10.1 and emphasize that M&E is an iterative and cyclical process that operates continuously.

It is recommended that you start the module by facilitating a discussion on why M&E is important and list some different examples of health measures. This interactive discussion will be useful for getting participants to think about the topic, especially those with minimal direct experience of this part of the policy cycle or who are non-health professionals unfamiliar with common health indicators.

Figure 10.1: M&E in the review stage of the policy cycle



Source: modified from http://www.geostrategis.com/images/policycycle.jpg

It is suggested that you ask the participants to give reasons for the health ministry to do M&E, which the group should reflect on. Some reasons might include:

- Tracking population health and health inequity;
- Studying the factors that contribute to or undermine health and universal health coverage;
- Improving the effectiveness and efficiency of policies and projects;
- Understanding why particular interventions work or don't work;

- Assessing the outcomes and impacts of policies and projects;
- Ensuring transparency and accountability; and
- Increasing the visibility of the government's work.

After outlining the rationale for M&E, you might want to discuss specific examples of health indicators as this will help consolidate what can sometimes be an abstract concept. It is suggested that you ask the participants to suggest examples of measures of health and health policy. You may need to give examples or remind the participants of health indicators you have already discussed in previous modules, such as life expectancy and incidence of disease. Importantly, you should encourage the participants to think broadly about health and not simply focus on measures related to population health. You should try to ensure that measures for the determinants of health, health system performance and the health policy are raised.

To conclude the group discussion, you may want to distribute Handouts 10.1a, 10.1b and 10.2 that illustrate how health can be monitored directly and indirectly from many angles. It is suggested that you give particular attention to the annex of the WHO Framework for Country Action because it looks largely at M&E policy processes. You should emphasize that it is important to measure whether the HiAP approach is working and not simply monitor the desired impact of a healthier, more equitable society. Without M&E policy processes, it is difficult to claim partial responsibility for positive changes; they might have occurred independently or be due to the efforts of someone else!

- Handout 10.1a: Direct and indirect health indicators for reproductive maternal and child health monitoring
- Handout 10.1b: Direct and indirect indicators for monitoring health
- Handout 10.2: HiAP Key Results Annex, WHO Framework for Country Action

LECTURE: M&E, HiAP, HIA AND HLA

15 MINS

The aim of this section of the module is to provide the participants with an understanding of some key M&E concepts and explain the purpose and procedure of a health impact assessment and health lens analysis.

It is suggested that you begin by defining M&E and describe the cycle of health monitoring. You should note that there are different definitions of M&E and its stages, but for the purposes of a general discussion the following definition and model is adequate.

Definition of M&E and the cycle of health monitoring

Monitoring can be defined as the systematic collection of data about an indicator or variable of interest. Evaluation, in contrast, involves a judgement about the value of or change in that variable.

Health monitoring is the process of tracking the health of a population and the health system that serves that population. Monitoring and evaluation can focus on different aspects of health and health policy-making. For instance:

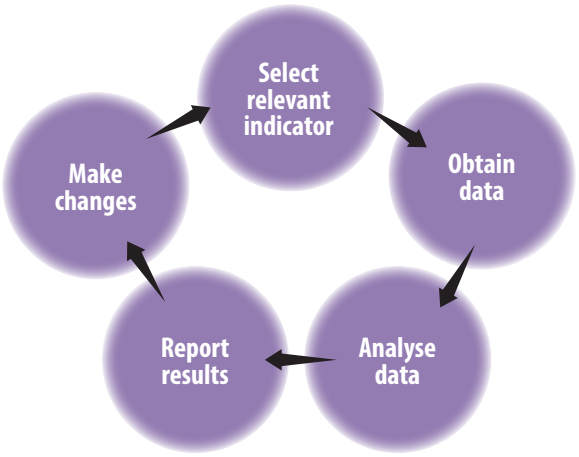
- Population health (e.g. incidence of disease and life expectancy);
- Epidemiology (e.g. risk factors and exposure levels);
- Determinants of health (e.g. income and living conditions);
- Health system performance (e.g. access and quality of health services); and
- Health policy (e.g. impact on health outcomes and health inequity).

Here you might want to reference again how this is reflected in the different indicators in the previous discussion.

Generally speaking, there are five stages of the cycle of health monitoring:

1. **Selecting relevant indicators.** The process begins by identifying indicators that are relevant to the desired type of monitoring as mentioned above. These measures can be quantitative or qualitative and the appropriate selection can often be a complicated task that requires consideration of what is easily monitored, analytically robust and communicates the issue to the public and other policy-makers.
2. **Obtaining data.** The next step, of collecting data, should occur regularly. The methodology for this collection will depend on the purpose of the M&E and could include, for example, scientific research and trials, epidemiological studies, household surveys, analysis of policy processes, interviews and project case studies.
3. **Analysing data.** This means interpreting the data and can involve preparing summary statistics, modelling, literature reviews and political analysis of policy processes and issues such as the social determinants of health and barriers to health care access.
4. **Reporting results.** Reporting can come in many forms, ranging from internal memos to press releases, technical reports and academic publications, each including various methods of presenting data (such as tables, graphs, maps or text). The goal should be to ensure that the results of the monitoring process are communicated effectively, and can be used to inform policies, programmes and practice.
5. **Implementing changes.** Based on monitoring results, changes may be implemented that will improve health policy, maximize the net health benefits of activities outside the health sector and thus, enhance population health and reduce health inequities.

Figure 10.2: Five stages of the health monitoring cycle



Source: WHO (2013) *Handbook on Health Inequality Monitoring with a Special Focus on Low- and Middle-Income Countries.* Geneva, WHO, p. 2.

If time permits and you feel that it is relevant, it is suggested that you explain the difference between different levels of monitoring. Just as M&E can focus on different aspects of health and policy-making, indicators often correspond to different stages of a policy intervention and can be categorized as:

- "Inputs" – the resources used to initiate a policy or project;
- "Outputs" – processes, products and services that immediately result from a policy or project;
- "Outcomes" – short- to medium-term results of a policy or project; and
- "Impacts" – long-term effects produced by a policy or project.

You might want to use the diagram from Handout 10.1a, to illustrate these differences. You should emphasize that the distinction is not always black and white. Also note that this M&E concept can take time to grasp.

Health impact assessment

Given many of the determinants of health and health inequities in populations have social, environmental and economic origins that extend beyond the direct influence of the health sector and health policies, it is important to monitor the activities of other sectors for significant health consequences. As the WHO's Commission on Social Determinants of Health recommends, routine consideration of health and health equity impacts in policy development is one way to achieve a reduction in health inequalities. A common approach to achieve this is using a health impact assessment.[1]

1 http://www.who.int/hia/en/

Definition and purpose

A HIA is a combination of procedures, methods and tools that assesses the potential effects of a policy or project on the health of a population and the distribution of those effects within the population. HIAs also identify appropriate actions to manage those effects. Many different people and organizations have defined HIA. Each definition is similar, differing through the emphasis given to particular components of the HIA approach. There is no correct definition – what follows is merely a selection of ways to describe HIA. Here it is suggested you cite the WHO's work on the institutionalization of HIA in different countries to illustrate how it has been applied in different contexts.[1]

HIAs look not only for negative impacts (to prevent or reduce them), but also for impacts favourable to health. This provides decision-makers with options to strengthen and extend the positive features of a proposal, with a view to improving the health of the population.

HIA is an important and useful tool within HiAP as it provides a tangible way for government departments to actually work together rather than just talking about working together.

HIA is suitable for use at many different levels. HIA can be used on projects, programmes (groupings of projects) and policies, though it has most commonly been used on projects. The flexibility of HIA allows these projects, programmes and policies to be assessed at either a local, regional, national or international level – making HIA suitable for almost any proposal. However, choosing the right moment to carry out an HIA is important.

HIA is based on four values that link the HIA to the policy environment in which it is being undertaken.

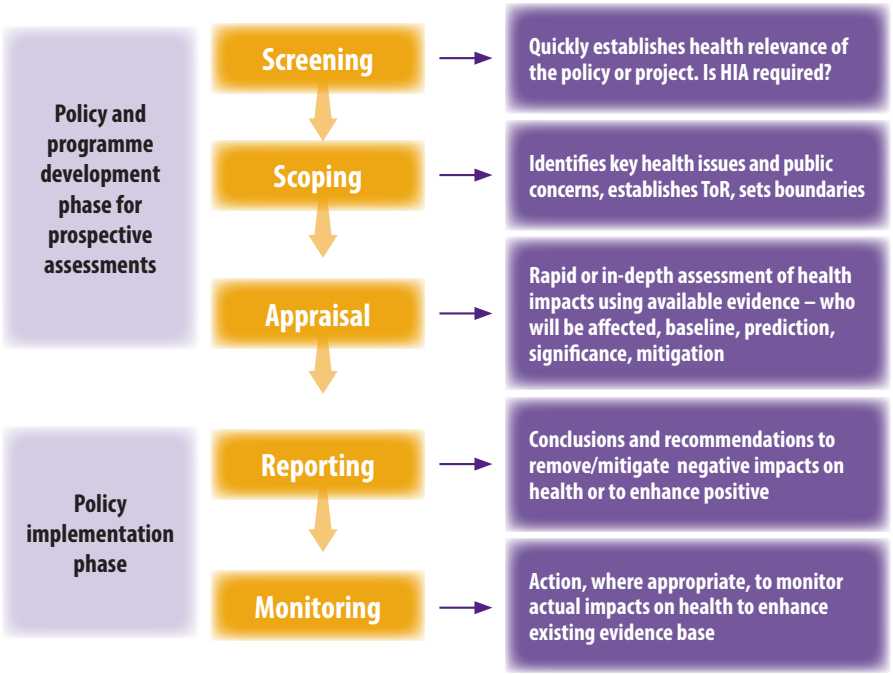
- **Democracy –** allowing people to participate in the development and implementation of policies, programmes or projects that may impact on their lives.
- **Equity –** HIA assesses the distribution of impacts from a proposal on the whole population, with a particular reference to how the proposal will affect vulnerable people (in terms of age, gender, ethnic background and socioeconomic status).
- **Sustainable development –** that both short- and long-term impacts are considered, along with the obvious and less obvious impacts.
- **Ethical use of evidence –** the best available quantitative and qualitative evidence must be identified and used in the assessment. A wide variety of evidence should be collected using the best possible methods.

1 Lee J, Röbbel N and Dora C (2013) Cross-Country Analysis of the Institutionalization of Health Impact Assessment. Social Determinants of Health Discussion Paper Series 8. Geneva, WHO.

Procedure

There are five stages to carrying out a HIA (see Figure 10.3).

Figure 10.3: The five stages of conducting HIA



Source: http://www.who.int/hia/tools/en/

Health lens analysis

Definition and purpose

The HiAP health lens analysis process builds on traditional health impact assessment methodology by incorporating a suite of additional methods (e.g. economic modelling) to allow the process to deliver both rigour and flexibility that accommodates the operational culture and policy imperatives of the partner agency. As a consequence, the methodology employed for a health lens is modified for each target area. Evaluation, an essential component of the HiAP process, is built into each individual health lens.

Procedure

The emerging methodology for the health lens analysis, as is being promoted in South Australia, consists of a series of steps that underpin its effectiveness and ability to deliver mutually beneficial outcomes:

1. **Engage:** establishing and maintaining strong collaborative relationships with other sectors. Determine agreed policy focus.
2. **Gather evidence:** establishing impacts between health and the policy area under focus, and identifying evidence-based solutions or policy options.

3. **Generate:** producing a set of policy recommendations and a final report that are jointly owned by all partner agencies.
4. **Navigate:** helping to steer the recommendations through the decision-making process.
5. **Evaluate:** determining the effectiveness of the health lens.

Refer to the Government of South Australia web site on health lens analysis for more information.

The case study examples (Handout 10.3) describe two different examples of institutionalization of measurement and evaluation. The first relates to an institutionalized process for monitoring via tracking socially determined health inequities in Norway. The second relates to an institutionalized process for evaluation and accountability in Thailand. Both national level processes were inspired through the actions of visionary public health actors.

GROUP ACTIVITY: HIA

60 MINS

The purpose of this group activity is to allow the participants to gain a practical understanding of the steps involved in a HIA, in particular, the stages of scoping and appraisal. The policy scenario provided is that of a city deciding whether to put itself forward as the new site of a large car manufacturing factory. However, you may want to prepare an alternative scenario that is more relevant to the work of the participants.

It is suggested that you divide the participants into small groups and distribute the description of the case study policy scenario (Handout 10.4a). After becoming familiar with the brief, the groups should set the scope of the HIA by identifying stakeholders to engage and the potential health risks and other issues that should be assessed. As part of preparing the terms of reference for the HIA, the participants should try to identify indicators or measures for data collection as well as questions they might ask different stakeholders. You may want to ask participants to use a template (Handout 10.4b).

The participants will have around 30 minutes to draft their TORs, which they will then share with the group. It is suggested that you move around the groups and ensure that their TORs are thorough yet realistic. Participants should also remember to include benefits and possible unintended consequences from various determinants of health. You should remind the groups of the time and indicate that they should each nominate a presenter.

Some of the stakeholders that the groups might list could include:

- Local government representatives;
- Trade and foreign affairs departments;
- Environment department;
- Transport/infrastructure department;
- Tourism department;

- Automobile workers union(s); and
- Automobile technical college.

The health impacts and other issues might include:

- Transformation of the landscape;
- Increase in the amount of waste generated;
- Increase in the volume of motor vehicle transport;
- Primary benefits of jobs;
- Pressure on housing, schools, hospitals if workers come from elsewhere;
- Potential for technology transfer;
- Secondary economic benefits such as parts suppliers;
- Deterioration in air and water quality;
- Potential pressure on city's utilities such as electricity and water; and
- Sustainability of car-making industry.

Some of the indicators and questions that the HIA might investigate could include:

- Air pollution and CO_2 emissions – what amounts of pollution and CO_2 emissions are likely?
- Noise levels – what levels of noise will the factory create and during what hours?
- Volume of waste – how much waste and of what kind will be produced?
- Worker profile – what kind of workers are likely to be employed? Where will they come from?
- Population – what additional public services might be required to support a larger population?
- Economic growth – which businesses will benefit from the factory's presence? For how long?

During the presentation of each group's TORs, you may want to list the contributions to help everyone reflect on the task. An important message from the activity is that HIAs look at health risks and benefits from many direct and indirect paths. This means that a HIA takes time and can be expensive. However, conducting the assessment at the proposal stage allows for changes to mitigate risks and maximize benefits. To make this point, you may want to ask the participants a follow-on question about how health could be protected by putting certain conditions on the project. Finally, it is important to emphasize that a HIA can be far less costly than the potential long-term health impacts and other socioeconomic consequences of poorly considered policies and projects.

OPTIONAL GROUP DISCUSSION: DATA SOURCES FOR HiAP

15 MINS

To support the participants in HiAP development and implementation, it is suggested that you dedicate some time to discuss publicly available sources of data and policy advice. You may want to use the opportunity to reinforce some of the messages from Module 6 on the importance of targeting policy advice and translating evidence for decision-making.

It is suggested that you list a range of sources and possibly show a few examples. If resources permit and you think it would be useful, you might want to make some of these sources available for the participants to explore in their own time between modules and during breaks. For example, you might set up a computer with pages open to sources of statistics, policy advice and videos.

Given some of the participants, especially those from a health background, will likely have a good awareness of information resources, it is recommended that you conduct the lecture in an interactive way and invite the participants to share and discuss the sources they find most valuable. Some sources that you might want to suggest could include:

Statistical databases

WHO Global Health Observatory

The WHO Global Health Observatory (GHO) is a data repository providing access to over 50 datasets on priority health topics including mortality and burden of diseases, the Millennium Development Goals (child nutrition, child health, maternal and reproductive health, immunization, HIV/AIDS, tuberculosis, malaria, neglected diseases, water and sanitation), NCDs and risk factors, epidemic-prone diseases, health systems, environmental health, violence and injuries, equity among others. Country profiles are also included.

WHO World Health Statistics Reports

These reports – WHO Health Statistics Reports – present the most recent health statistics for the WHO Member States.

National Health Accounts

Global Health Expenditure Database – the National Health Accounts (NHA) database provides evidence to monitor trends in health spending for all sectors – public and private, different health care activities, providers, diseases, population groups and regions in a country. It helps in

developing national strategies for effective health financing and in raising additional funds for health. Information can be used to make financial projections of a country's health system requirements and compare their own experiences with the past or with those of other countries.

WHO Indicator and Measurement Registry

WHO indicator registry – the WHO Indicator and Measurement Registry (IMR) is a central source of metadata of health-related indicators used by WHO and other organizations. It includes indicator definitions, data sources, methods of estimation and other information that allow users to get better understanding of their indicators of interest.

UN Data

UN Data – "UNdata" is an internet-based data service managed by the United Nations Statistical Division (UNSD) of the Department of Economic and Social Affairs (DESA). It brings UN statistical databases within easy reach through a single entry point. Users can search and download a variety of statistical resources from the UN system, including country profiles.

World Bank

World Bank – the World Bank's development indicators database contains time series data for a large range of economic and social issues for countries around the globe.

Index Mundi

Index Mundi – is a user-friendly web site that compiles country level statistics from global sources.

Concise policy advice

WHO factsheets – WHO's web site contains nearly 200 fact sheets on different health issues that detail key facts and concise policy advice.

NCD Alliance policy briefs – the NCD Alliance, an international NGO has a number of factsheets focusing on the four main NCDs: cardiovascular disease, diabetes, cancer and chronic respiratory disease.

WHO monitoring and evaluation systems' information – One Monitoring and Evaluation Platform – this platform is supported by International Health Partnership (IHP+) which is a group of partners committed to improving the health of citizens in developing countries. International organizations, bilateral agencies and country governments all sign the IHP+ global compact committing to putting internationally agreed principles for effective aid and development cooperation into practice in the health sector. IHP+ mobilizes support for a single, country-led national health strategy and through its evaluation, following a standard set of guidance, partners also aim to hold each other to account. The guidance published by WHO (*Monitoring, evaluation and review of national health strategies. A country-led platform for information and accountability*) refers to the "result chain" describing the Health Systems Performance Assessment Framework and includes core indicators related to intersectoral influences on universal health coverage from the fields of social epidemiology, gender equality and human rights.

WHO country monitoring and evaluation reports assessing monitoring and evaluation information systems are also analysed in this work.

Infographics, video clips and films

WHO YouTube Channel – WHO's video clips communicate key facts about health issues in a brief and accessible way.

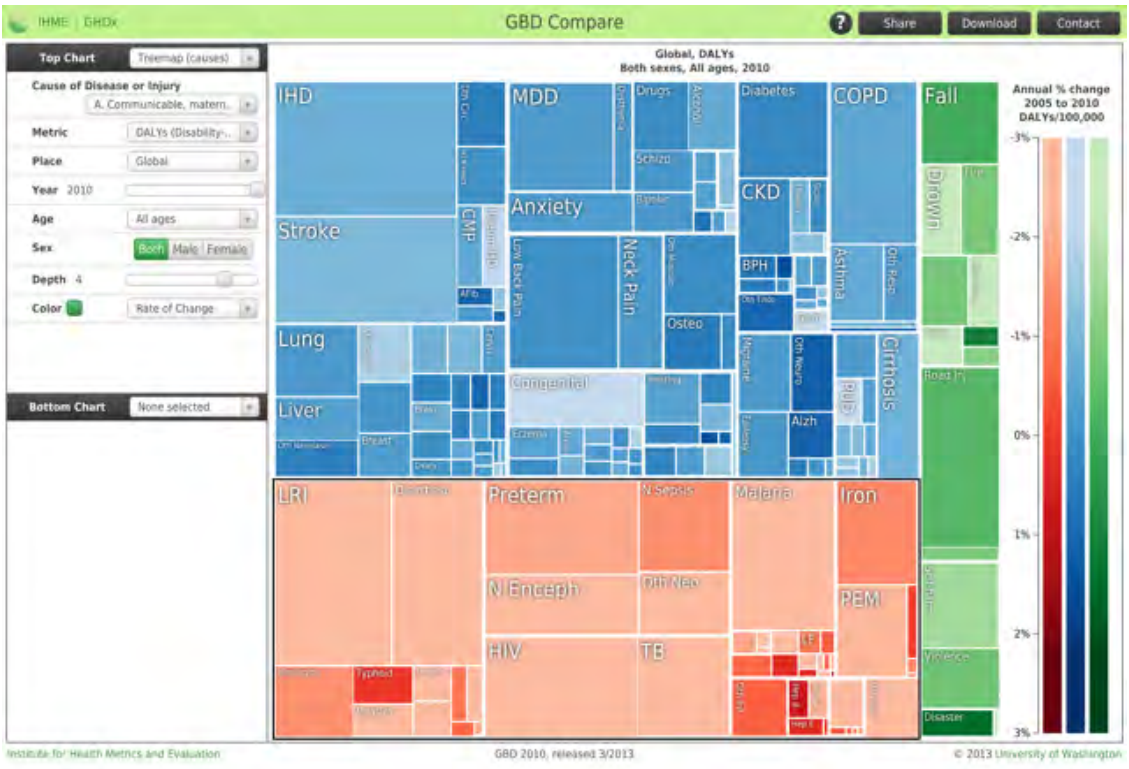
GapMinder – GapMinder is a non-profit venture promoting sustainable global development and the achievement of the UN Millennium Development Goals. Its web site and downloadable programme allow users to produce animated infographics on a range of social and economic issues including health and health inequity.

Figure 10.4: GapMinder World shows important global trends

Source: http://www.gapminder.org/

IHME – the Institute for Health Metrics and Evaluation – is an independent global health research centre at the University of Washington that provides rigorous and comparable measurement of the world's most important health problems. Their web site contains many useful data visualization tools such as GDB Compare and GDB Insight (GDB – global burden of disease).

Figure 10.5: GBD Compare (IHME)



Source: Institute for Health Metrics and Evaluation (IHME)/GBD Compare (2013) Seattle, WA, IHME, University of Washington. Available from http://www.healthdata.org/data-visualization/gbd-compare (accessed 14 July 2014).

Blogs and newsletters

International Health Policies (IHP) blog – the IHP blog is an initiative of the Health Policy Unit at the Institute of Tropical Medicine in Antwerp, Belgium (ITM), and fits in the wider project of "Strategic Network on International Health Policies." It is in line with the ITM objective of "Switching the Poles," aiming to increase the influence of the Global South on the global health debate.

Academic journals

In the event the participants are not aware of WHO's Health InterNetwork Access to Research Initiative (HINARI), you should inform them of how it can enable local and not-for-profit institutions in low- and middle-income countries to gain free or low-cost access to one of the world's largest collections of biomedical and health literature.

Publicly accessible

- *Bulletin* of the WHO
- Public Library of Science Medicine (PLOS Med)

By subscription

- *New England Journal of Medicine* (NEJM)
- *The Lancet*
- *Journal of American Medical Association* (JAMA)
- *British Medical Journal* (BMJ)
- *JAMA Internal Medicine* (formerly *Archives of Internal Medicine*)
- *Cochrane Database of Systematic Reviews* (Cochrane DB Syst Rev)

QUESTIONS AND FEEDBACK

5 MINS

It is recommended that you encourage contributions and questions throughout the workshop and dedicate a small amount of time at the end of each module for feedback and clarifications. This unallocated time can be used as necessary if part of a module takes longer than expected.

module

11

THE LEADERSHIP ROLE OF THE HEALTH SECTOR IN HiAP

module

11

THE LEADERSHIP ROLE OF THE HEALTH SECTOR IN HiAP

Recap: Developing, implementing and monitoring policy 162

Optional group activity: Health leadership qualities 163

Lecture: Leadership role of the health sector and current challenges 164

Group activity: Model contemporary health ministry 169

Questions and feedback 170

MODULE OVERVIEW

This module is about the role that the health sector must assume to effectively promote and implement HiAP, as well as the current challenges faced doing this. We refer to the term leadership liberally to reflect the ownership born by health in being concerned about the causes of ill-health and inequities, while noting that this does not mean health is in front.

	DURATION
Recap: Developing, implementing and monitoring policy	5 mins
Optional group activity: Health leadership qualities	20 mins
Lecture: Leadership role of the health sector and current challenges	20 mins
Group activity: Model contemporary health ministry	60 mins
Questions and feedback	5 mins
TOTAL TIME	**1h 30 mins**
WITH OPTION	**1h 50 mins**

Learning objectives

- Explain the leadership role of health sector in HiAP
- List challenges that the health sector faces in promoting HiAP
- Describe the role of the WHO in relation to HiAP
- Apply knowledge of HiAP by outlining a model contemporary health ministry

Key messages

- Although governments as a whole bear the ultimate responsibility for the health of their citizens, health authorities at all levels (national, regional and local) are key actors in promoting HiAP.
- Although each country has its own political structure and forms of administration, the role of the health ministry, or similar body at the national level, usually includes:
  - Supporting the growth of scientific knowledge;
  - Identifying and prioritizing health issues;
  - Monitoring the activities of other sectors that impact on health;
  - Creating structures and mechanisms for dialogue across government and with whole of society;
  - Facilitating negotiations between sectors and non-government stakeholders; and
  - Overseeing the implementation, monitoring and evaluation of policy.

- Some of the major challenges that health ministries face in effectively promoting and implementing a HiAP approach include:
  - Limited political influence;
  - Constrained resources and staff turnover;
  - Working in vertical, fragmented units;
  - Difficulty gathering and disseminating evidence;
  - Politicization of the bureaucracy, corruption and regulatory capture; and
  - Political commitment and discontinuity.
- Given the important leadership and coordination role of the health sector, the dysfunction or ineffectiveness of a health ministry can have a grave impact on a population's health. This highlights the importance of governance and politics as social determinants of health.
- For the health ministry to play a leading role in HiAP, it is crucial to:
  - Promote closer collaboration within the ministry;
  - Strengthen capacity to generate and use evidence on health impacts;
  - Look outward and work in partnership with other sectors and stakeholders;
  - Increase discussion of the social determinants of health and health inequity;
  - Manage and negotiate competing interests; and
  - Enforce the implementation of policies and monitor their results.
- The role of WHO in relation to HiAP includes:
  - Bringing health considerations into global and regional policy-making;
  - Supporting policies for global health protection and health promotion;
  - Compiling experiences of best practice as well as challenges to HiAP;
  - Providing technical assistance to countries in their efforts to apply HiAP; and
  - Training health professionals and civil servants in HiAP.

Key reading for participants

Recommended

- Leppo K and Tangcharoensathien V (2013) The Health Sector's Role in HiAP in Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies.* Finland, Ministry of Social Affairs and Health (12 pages)
- WHO (2014) HiAP Framework for Country Action. Geneva, WHO (13 pages)

Optional

- Bennett S *et al.* (2012) Approaches To Developing The Capacity of Health Policy Analysis Institutes: A Comparative Case Study. *Health Research Policy and Systems,* Vol. 10, No. 7 (8 pages)

Supporting material for instructors

- WHO (2013) Demonstrating a Health in All Policies Analytical Framework for Learning from Experiences. Geneva, WHO
- WHO (2013) Practising A Health in All Policies Approach: Lessons for Universal Health Coverage and Health Equity. Geneva, WHO
- WHO (2013) Moving Towards Health in All Policies: A Compilation of Experiences from Africa, South-East Asia and the Western Pacific. Geneva, WHO
- WHO (2013) Opportunities for scaling up and strengthening the health-in-all-policies approach in South-eastern Europe. Copenhagen, WHO
- WHO (2013) Health in All Policies. Summary of experiences from the Americas. The 8th Global Conference on Health Promotion 2013, Helsinki, Finland, 10 to 14 of June. Washington, D.C., Pan American Health Organization
- OECD (2006) *The Challenge Of Capacity Development: Working Towards Good Practice*. Paris, Organisation for Economic Co-operation and Development (DAC Guidelines and Reference Series)
- UNDP (2008) *Capacity Development*. New York, United Nations Development Programme

Teaching notes

At this point, it is suggested that you inform the participants that you are now moving on to the last two modules of the workshop, which bring together the messages and insights from the earlier modules. Having now reviewed contemporary health challenges, explored the concept of HiAP and discussed policy development, implementation and monitoring, the remaining two modules look at how participants can apply this knowledge in practice. Modules 11 and 12 are aimed at health professionals and health policy-makers but will still be useful for participants from other backgrounds.

To advance HiAP, the health sector must learn to work in partnership with other sectors. Jointly exploring policy innovation, novel mechanisms and instruments, as well as better regulatory frameworks, will be imperative. This requires a health sector that is outward oriented, open to others and equipped with the necessary knowledge, skills and mandate. This also means improving coordination and supporting new types of leaders within the health sector itself.

The module starts with examples of countries where the leadership of the health sector can be observed and explores how to move in this strategic direction and the challenges faced. Many of the messages are most relevant to the national level at which health ministries, or similar bodies, play a major role in national health policy-making. It is suggested that you begin with a recap of some of the important messages from earlier modules then conduct a group activity to discuss leadership qualities. The next part of the module is dedicated to outlining the main role of the health ministry from the perspective of HiAP and current limitations to achieving this. It is suggested that you facilitate another group activity on preparing a mission statement for a contemporary health ministry to allow the participants to consolidate their knowledge. As always, it is useful to point to the learning objectives and outline the structure of the module so that the participants know what to expect.

RECAP: DEVELOPING, IMPLEMENTING AND MONITORING POLICY

5 MINS

To begin this module on the leadership role of the health sector, it is suggested that you recap some of the key messages from previous modules, especially Modules 6–10 that focus on the development, implementation and monitoring of policy. You may want to include the following points, which summarize the conditions supportive of HiAP.

- Although governments as a whole bear the ultimate responsibility for the health of their citizens, health authorities at all level (national, regional and local) are key actors in promoting HiAP.
- The conditions that most favour effective intersectoral collaboration include:
  - Government supports and encourages intersectoral action;
  - Sectors have shared interests or all benefit from cooperation;
  - Issue has high political importance and requires urgent addressing;
  - Proposed policy has public support;
  - Strong, effective leaders in the bureaucracy (policy champions/entrepreneurs);
  - Intersectoral action is well planned with clear objectives, roles and responsibilities;
  - Laws exist or are planned to support the proposed policy;
  - Sufficient resources are available; and
  - There are plans to monitor and sustain outcomes.
- HiAP requires a cooperative or value-added approach to negotiating.
- Implementation and monitoring of HiAP is crucial but can sometimes encounter practical problems linked to low capacity, limited resources and unclear, shared roles and responsibilities across sectors.

OPTIONAL GROUP ACTIVITY: HEALTH LEADERSHIP QUALITIES

20 MINS

The purpose of this group activity is to encourage the participants to explore the leadership qualities needed in the health sector to successfully promote and implement HiAP. In addition to recalling the conditions supporting HiAP during the previous recap, you might want to share the following quote to get the participants thinking:

> "People often think of 'leadership' in terms of personality characteristics, usually as something they call charisma. Since few people have great charisma, this leads logically to the conclusion that few people can provide leadership, which gets us into increasing trouble. (…) Leadership is entirely different. It is associated with taking an organization into the future (…) And in an ever-faster-moving world, leadership is increasingly needed from more and more people, no matter where they are in a hierarchy. The notion that a few extraordinary people at the top can provide all the leadership needed today is ridiculous, and it's a recipe for failure."
>
> John P Kotter (2013) *Harvard Business Review* Blog

It is suggested that you divide the participants into small groups for this brainstorming exercise and ask each group to create a list of the leadership qualities needed in the health sector to make HiAP work. You should move around the groups and ensure that the participants adopt a broad approach to the task by considering the kinds of leadership required throughout the health sector and not simply by the health minister. To encourage this, you might want to ask questions such as:

- What kind of leadership is required given that health is influenced by many sectors outside health?
- What are the qualities needed to successfully engage non-government stakeholders?
- How should leaders in the health sector deal with the fact that health is also shaped by regional and global issues like globalization and climate change?

After the participants have had some time to prepare their lists, it is suggested that you re-convene everyone and ask each group to take turns sharing one of the leadership qualities they propose. The kinds of qualities suggested are likely to include:

- Creative;
- Passionate and determined;
- Empowers others and shares information;
- Encourages team work;
- Strategic thinking;
- Politically astute;
- Understands multiple disciplines, not just medicine and public health;

- Good listener and communicator;
- Diplomatic;
- Accountable and transparent; and
- Sincere and honest.

If time permits, you may want to extend the duration of this group activity.

LECTURE: LEADERSHIP ROLE OF THE HEALTH SECTOR AND CURRENT CHALLENGES

20 MINS

Sophisticated leadership role

You may want to begin this discussion of the sophisticated leadership role needed in the health sector in today's increasingly complex world by listing reasons why a new approach is required. Specifically:

- The global burden of disease is changing. The determinants of health and health inequalities increasingly lay beyond the direct influence of the health sector and health policies.
- Countries are also increasingly connected and interdependent. Issues such as globalization, socioeconomic inequality, environmental degradation, food insecurity, migration and urbanization directly impact a growing portion of the world's population. Social movements and new technologies are also spreading rapidly.

This means HiAP is increasingly relevant and the health sector must be more outward looking and dynamic.

Although governments, as a whole, bear the ultimate responsibility for the health of their citizens, health authorities at all levels (national, regional and local) are key actors in promoting HiAP. As indicated in the previous modules, leadership and coordination are crucial during all stages of the policy cycle: agenda setting, policy formation, implementation and review. Windows of opportunity are missed or may never emerge without astute health policy-makers supported by a functional health ministry.

Although each country has its own political structure and forms of administration, the role of the health ministry usually includes:

- Supporting the growth of scientific knowledge;

- Identifying and prioritizing health issues;
- Monitoring the activities of other sectors that impact on health;
- Creating structures and mechanisms for dialogue across government and with the whole of society;
- Facilitating negotiations between sectors and non-government stakeholders; and
- Overseeing the implementation, monitoring and evaluation of policy.

To reinforce these functions of contemporary health ministries, you may want to mention some concrete or abstract examples that have come up during the workshop such as the health sector's role in identifying health issues and setting priorities or the health sector's efforts to engage stakeholders and facilitate negotiations. The case studies in Handout 11.1 provide interesting examples of the dynamic role the health sector can play in successfully championing HiAP in specific contexts.

The role of the WHO

Depending on the backgrounds of the participants and their familiarity with the work of the WHO, you might want to outline here the assistance that WHO can provide in advancing and implementing the HiAP agenda.

The overall role of WHO in public health is to:

- Provide leadership on matters critical to health and engage in partnerships where joint action is needed;
- Shape the research agenda and stimulate the generation, translation and dissemination of valuable knowledge;
- Set norms and standards, and promote and monitor their implementation;
- Articulate ethical and evidence-based policy options;
- Provide technical support, catalyse change and build sustainable institutional capacity; and
- Monitor the health situation and assess health trends.

With respect to HiAP, WHO can:

- Bring health considerations into global and regional policy-making;
- Support policies for global health protection and health promotion;
- Compile experiences of best practice as well as challenges to HiAP;
- Provide technical assistance to countries in their efforts to apply HiAP; and
- Train health professionals and civil servants in HiAP.

If you think it is relevant and useful, you might also want to give examples of WHO's leadership on HiAP in areas such as the Framework Convention on Tobacco Control, International Code of Marketing of Breast-Milk Substitutes and the Global Code of Practice on the International Recruitment of Health Personnel.

Current challenges

It is suggested that you also outline some of the challenges faced by the health sector, especially for the health ministry, in taking on the leadership role discussed above. Ideally, you should cover the major issues that are most relevant to the country or region where the workshop is being held. Some challenges you might consider include:

1. Limited political influence

- To address the social determinants of health, the health ministry must have the political influence to convene meetings of all relevant sectors and stakeholders to discuss and address the health implications of their respective activities.
- In many countries the political influence of the health ministry is limited by its low status and scarce resources in comparison with other portfolios. Often, the health sector is viewed as a drain on government revenue rather than a contributor to socioeconomic well-being and prosperity.
- To deal with this challenge, it can help to make the arguments about prioritizing health in policy discourse, mentioned in Module 6. It is also imperative to seize the rare windows of opportunity that do come up if regular intersectoral collaboration and stakeholder engagement is not possible. As discussed in Module 4, windows of opportunity can sometimes coincide with political campaigns, changes in the government's balance of power, as well as health hazards, crises and disasters. Lastly, it is important to remember that there are many structures and mechanisms, both formal and informal, that can be used to promote intersectoral collaboration and stakeholder engagement. Although the preferred approach may not be possible, other avenues might still exist.

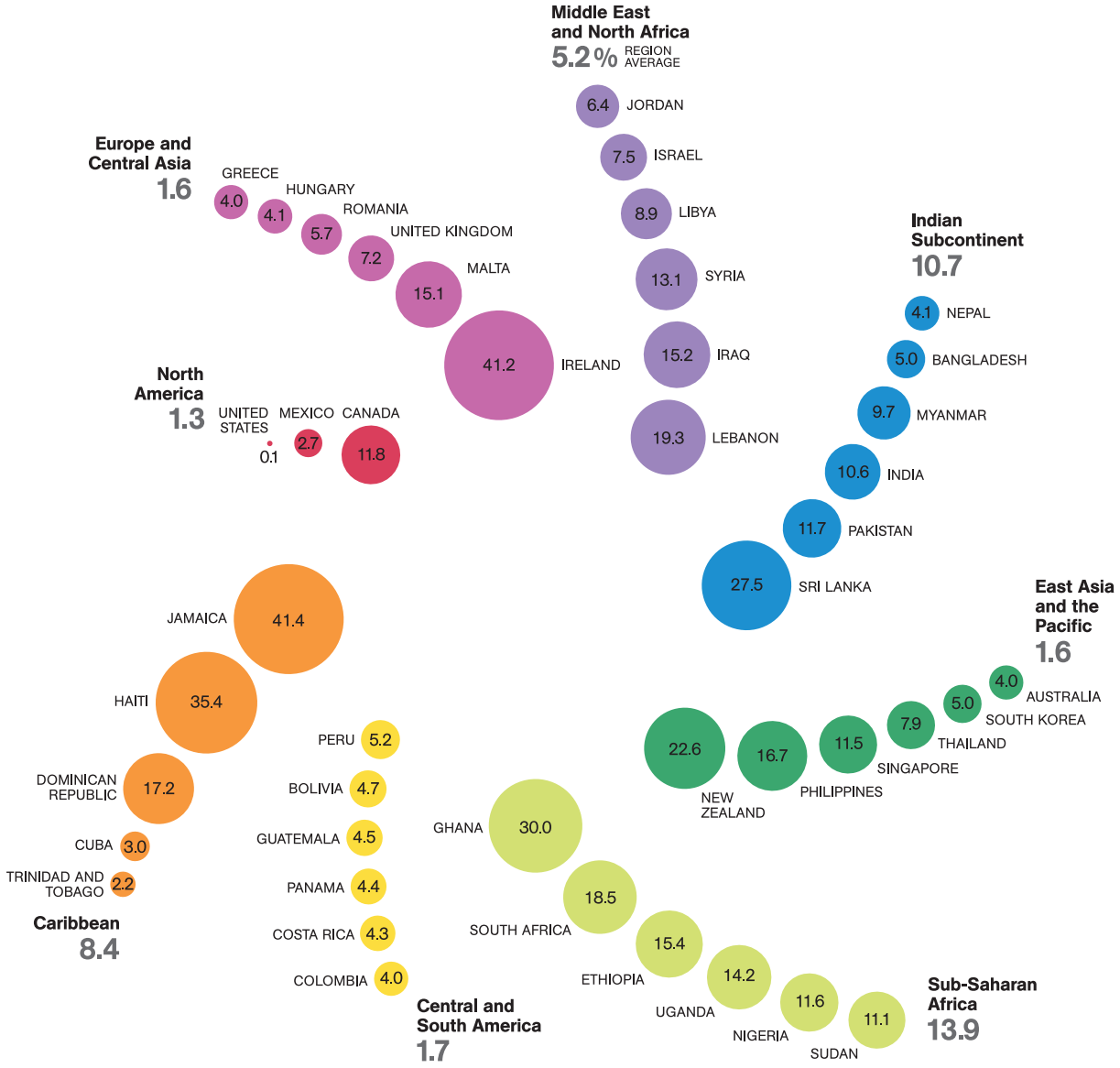
2. Constrained resources and staff turnover

- Health ministries in all countries are arguably constrained by resources but many face a scarcity that seriously impinges on their ability to provide a minimum level of health.[1] This shortage of resources also impacts on the health ministry's capacity to formulate and implement evidence-informed policy.
- High turnover of staff is also challenging as well-trained health professionals are either promoted and move up the hierarchy or quit the ministry due to low incentives, poor motivation, low morale, bureaucratic inertia and lack of social recognition.[2] The long-term sustainability of institutional capacities is then at risk (see Figure 11.1 on the international migration of doctors).
- Addressing this challenge is as difficult as the problem is serious. However, a focus on universal health coverage, a commitment to develop national public health institutes and the gradual systemic development of capacity can make a difference.

1 WHO (2010) *World Health Report: Health Systems Financing. The Path to Universal Health Coverage.* Geneva, WHO.

2 Ahmad O (2005) Managing Medical Migration from Poor Countries. *BMJ*, Vol. 331, pp. 43–45.

Figure 11.1: International migration of doctors



Source: Bates M (2008) Medical Migration. ***National Geographic.***

3. Working in vertical, fragmented units

- Too often, health sectors are highly compartmentalized based either on levels of medical care or different categories of disease. Health ministry policy-makers are also often overwhelmed by day-to-day crisis management. Expertise is frequently too narrow, comprising the medical and nursing staff, lawyers, finance professionals and statisticians necessary for administration of health.
- The HiAP approach requires a wider professional mix: people with broad understanding and knowledge of modern public health and staff trained in economics and policy sciences.[1]

1 Leppo K and Tangcharoensathien V (2013) The Health Sector's Role in HiAP in Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health

4. Difficulty gathering and disseminating evidence

- Health ministries, especially in developing countries, can have difficulties gathering and disseminating evidence in support of taking action on health issues. However, this is an essential capacity, linked to evidence-informed policy-making and especially critical when it comes to monitoring the health and health inequity impacts of other sectors and stakeholders.
- Evidence gathering for informed policy decisions can often be carried out by research institutes at arm's length of the ministry of health or by academic bodies specializing in policy research. It is important to maintain scientific independence: not too close to be dominated by the ministry; not too distant to be policy irrelevant.
- Effective publicizing and dissemination of evidence are essential for bringing together all stakeholders and gradually forming public opinion. Good examples include global efforts to raise awareness of road safety and the dangers of tobacco and excise drinking.

Figure 11.2: See public awareness campaigns from countries around the world on the WHO YouTube channel

http://www.youtube.com/watch?v=4QTxaQprZPw

5. Politicization of the bureaucracy, corruption and regulatory capture

- Given health is distributed along a gradient, which reflects the unfair distribution of wealth and power in society, targeting health inequities is a deeply political issue and not simply a technical matter. Without positive discrimination measures that prioritize the needs of the underprivileged, health services are likely to be disproportionately used by better educated and wealthier sections of society, and health inequalities may rise.
- In principle, the politicization of the bureaucracy can bring about pro-poor policies as sometimes occurs after political upheavals and the formation of populist governments. Politicization more often means health policy is subjugated to private interests. This can lead to appropriation of health funds and the appointment of officials based on their political affiliations.
- Regulatory capture is common in settings with poor governance and leads to regulatory agencies becoming indirectly dominated and controlled by those they are supposed to regulate. This results in the regulator acting in the interests of the regulated partner, which is often a commercial entity, and the regulator failing to protect the public interest.
- Public services, including health, often benefit the better educated and wealthier sections of society because they have the greater means to access these services than those who are poor or less educated. Positive discrimination measures that prioritize the needs of underprivileged and thereby address inequities should be an essential part of public health policy.

6. Political commitment and discontinuity

- Improving population health and health equity normally takes much longer than most government tenures. Therefore, time frames and sustainability may pose particular difficulties for HiAP.
- Some of the ways that the health ministry can mitigate this challenge is through effective publicizing and dissemination of evidence for action, building alliances and using multiple structures and mechanisms of intersectoral collaboration and stakeholder engagement.

GROUP ACTIVITY: MODEL CONTEMPORARY HEALTH MINISTRY

60 MINS

The purpose of this group activity is for the participants to consolidate their understanding of the course and the kind of health sector leadership required to promote and implement HiAP.

The task involves drafting a mission statement for a contemporary health ministry focused on adopting a HiAP approach to improve population health and well-being as well as reduce health inequalities. It is suggested that this mission statement should have the following structure:

1. **Vision statement** explaining the purpose or reason *why* the health ministry exists (one sentence);
2. **Goals** that summarize specifically *what* the health ministry aims to achieve (5–10 sentences); and
3. **Principles** that explain *how* the ministry will conduct its work (5–10 sentences).

You may want to show examples of mission statements to illustrate the specific way they are worded, usually with sentences in the active voice and beginning with a verb.

You should divide the participants into small groups and ask them to write down their mission statements to share with the group at the end of the activity. Remember to remind the participants of the time and ask each group to nominate a speaker.

When each group shares their mission statement, it is suggested that you highlight some of the valuable contributions and reiterate any of the key messages on health leadership that may have been missed or not understood.

If time permits, you may want to extend the duration of this group activity.

QUESTIONS AND FEEDBACK

5 MINS

It is recommended that you encourage contributions and questions throughout the workshop and dedicate a small amount of time at the end of each module for feedback and clarifications. This unallocated time can be used as necessary if part of a module takes longer than expected.

module 12

NEXT STEPS AND ROUND UP

module

12

NEXT STEPS AND ROUND UP

Recap: Key messages of the workshop 175

Group discussion: Applying HiAP in practice 175

Group activity: Next steps 177

Evaluation and round up 178

MODULE OVERVIEW

This final module summarizes the key messages of the workshop, explores ways HiAP can be applied in practice and allows time for an evaluation of the course.

	DURATION
Recap: Key messages of the workshop	20 mins
Group discussion: Applying HiAP in practice	20 mins
Group activity: Next steps	20 mins
Evaluation and round up	30 mins
TOTAL TIME	**1h 30 mins**

Learning objectives

- List key messages of HiAP workshop
- Identify ways to apply HiAP in practice

Key messages

- The overall purpose of the workshop was to:
  - Build capacity to promote, implement and evaluate HiAP;
  - Encourage engagement and collaboration across sectors;
  - Facilitate the exchange of experiences and lessons learned; and
  - Promote regional and global collaboration on HiAP.
- The most important key messages of the workshop were:
  - Many of the determinants of health and health inequities in populations have social, environmental and economic origins that extend beyond the direct influence of the health sector and health policies. Thus, public policies and decisions made in all sectors and at different levels of governance can have a significant impact on population health and health equity (Module 1).
  - Health inequity is the presence of unfair, avoidable or remediable differences in health services and outcomes among groups of people. In all countries – whether low-, middle- or high-income – there are wide disparities in the health status of different social groups. The lower an individual's socioeconomic position, the higher their risk of poor health (Module 2).
  - Health in All Policies (HiAP) 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. It improves the accountability of policy-makers for health impacts at all levels of

policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being (Module 3).

› Policy-making is complex, highly political and a continual process. It can stretch over long periods of time and usually involves many actors and interests, which may vary over the course of time. Given the complex, political nature of policy-making, it is essential to seize "windows of opportunity" that arise from changing economic, social and political realities (Module 4).

› Policy champions and policy entrepreneurs are crucial to the HiAP approach. A policy champion is a person or team willing and able to lead and manage the policy process. Entrepreneurial policy-makers are able to break with habits and initiate new policies. Their creative acts have transformative effects on politics, policies or institutions (Module 4).

› Intersectoral action refers to the coordinated efforts of two or more sectors within government to improve health outcomes. This can include working across different levels of government such as district, provincial and national jurisdictions. The term intergovernment is sometimes used to refer to these horizontal and vertical linkages between levels of government within a country. Whole-of-government, joined-up government and healthy public policies are similar terms (Module 5).

› A stakeholder is a person or group of persons who have an interest or concern in a particular process or issue due to direct or indirect involvement (Module 7).

› A whole-of-society approach refers to coordinated efforts to improve health by multiple stakeholders from several sectors within and outside government (Module 7).

› HiAP is best served by a cooperative or value-added approach to negotiating (Module 8).

› There are many opportunities to formally and informally implement HiAP (Module 9).

› Although governments as a whole bear the ultimate responsibility for the health of their citizens, health authorities at all levels (national, regional and local) are key actors in promoting HiAP (Module 11).

› Given the important leadership and coordination role of the health sector, the dysfunction or ineffectiveness of a health ministry can have a grave impact on population health. This highlights the importance of governance and politics as determinants of health (Module 11).

Supporting material for instructors

- WHO (2010) WHO Training Evaluation Guide. Geneva, WHO

Teaching notes

This final module aims to reinforce the most important key messages of the course and to give participants the confidence to apply HiAP in practice. It is recommended that you recap the key messages and revisit the participants' expectations if you discussed them in Module 1. It is suggested

that you then facilitate a group discussion about how the participants can apply HiAP in practice having completed the course. You may also want to conduct a group activity based on next steps for the participants. Finally, conduct a course evaluation to gain feedback and improve the training.

RECAP: KEY MESSAGES OF THE WORKSHOP

20 MINS

To begin the module, it is suggested that you recap the purpose of the workshop, the modules that the course participants have covered and most importantly, the key messages as suggested above. In outlining what the course has involved, you might want to make reference to what the participants hoped to learn at the beginning of the course if you conducted the Module 1 group activity to share expectations. Hopefully, you have been able to address all of the issues participants wanted to cover and more. However, if this was not possible, it is suggested that you try to refer them to where they might get certain answers or gain further knowledge or expertise.

GROUP DISCUSSION: APPLYING HiAP IN PRACTICE

20 MINS

A key objective of this module and the training as a whole is to build the participants' knowledge and confidence to apply HiAP in practice.

It strongly recommended that you emphasize that HiAP is still work in progress to which many actors in many countries and at many levels are contributing every day. HiAP is both aspirational and deeply pragmatic: it simultaneously guides everyday practice while reminding decision-makers of what health, in its broadest sense of "complete physical, mental and social well-being" is all about.

As such, it is important to emphasize that the participants are most probably already applying aspects of a HiAP approach in their everyday work. The task now is to do this more consciously and where possible increase efforts.

To get the participants thinking about how they will apply their knowledge from the course, it is suggested that you conduct a group discussion about what the participants intend to do differently in their work having completed this HiAP training. You should encourage as many ideas, big and small, aspirational and pragmatic. If possible, it is suggested that you group the suggestions to help the participants take away some key ideas.

Some possible suggestions for applying HiAP in day-to-day practice might include:

1. **Shape the agenda**
   - Identify and prioritize issues suitable for a HiAP approach (Module 3);
   - Look for windows of opportunity (Module 4);
   - Prepare targeted and effective policy briefs supported by evidence (Modules 6 and 10); and
   - Publicize widely and creatively evidence for health interventions.

2. **Promote intersectoral collaboration within government and engage external stakeholders** (Modules 5 and 7)
   - Implement small bottom-up efforts:
     - › Identify key gate-keepers and influential decision-makers;
     - › Liaise more with colleagues in other departments;
     - › Share information; and
     - › Learn the "language" of other sectors.
   - Initiate top-down efforts:
     - › Establish formal mechanisms and structures for intersectoral collaboration;
     - › Create platforms for dialogue;
     - › Assign focal points for intersectoral collaboration; and
     - › Search for high-level political support.
   - Identify and analyse external stakeholders to engage; and
   - Build a supportive network for policy change (Module 8).

3. **Build institutional capacity**
   - Develop a workforce with diverse skills and expertise;
   - Facilitate staff secondments;
   - Add HiAP-related activities to job descriptions and performance requirements;
   - Promote public health training into education of future health and other professionals, especially journalists and other civil servants; and
   - Seek WHO support.

4. **Reinforce research activities**
   - Support public health institutions (Module 10); and
   - Strengthen ties between academia and policy circles while retaining separation (Modules 10 and 11).

5. Monitor and evaluate progress

- Share and publish case studies; and
- Follow regional and international developments for HiAP.

GROUP ACTIVITY: NEXT STEPS

20 MINS

The purpose of this suggested group activity is to consolidate the above discussion and encourage participants to share their personal thoughts on next steps and impressions of the course. This can also be a useful exercise to gain general feedback on the course that you might not obtain from the written course evaluation.

Depending on the number of participants you might want to divide them into a few small groups. However, it is preferable to be in one group to hear each person's contribution. To facilitate this discussion on the next steps, it is suggested that you place several pictures on the ground that metaphorically represent different levels of comfort with the idea of HiAP and applying it in practice. You might want to choose pictures of different kinds of houses – one large and grandiose, another a small house and another in construction. You could equally choose pictures of modes of transport such as boats – one a sailing ship, another a wreck and another a fast vessel (see Handout 12.1). You should choose pictures that the participants will recognize and will be able to interpret.

After placing the pictures on the ground, you should ask the participants to stand next to the picture that best represents their understanding of HiAP and apply it to their work. It is suggested that you then go around the group with each participant giving a brief explanation of how they have interpreted the image and share how they feel.

Again, it is strongly recommended that you emphasize that HiAP is still work in progress to which many actors in many countries and at many levels are contributing every day. HiAP is both aspirational and deeply pragmatic. Participants should ideally feel confident they understand the concepts covered in the training and have some ideas about how they will apply HiAP to their daily work. It is suggested that you informally take note of the comments and reflect on whether they suggest ways of improving the course.

EVALUATION AND ROUND UP

30 MINS

To conclude the training, it is suggested that you thank the participants for their time and contributions and encourage them to follow up any remaining questions or further interests. You may want to repeat where the participants can get more information and continue to be engaged in HiAP at a country, regional or international level.

Before wrapping up the workshop, it is strongly recommended that you conduct a formal written evaluation, such as those provided as examples in Appendix F).

Depending on resources and the likelihood of repeating the training, you should also give thought to conducting more detailed evaluation with follow-up interviews or longer questionnaires with selected participants and the supervisor responsible for the workshop.[1]

1 For example, see WHO (2010) WHO Training Evaluation Guide. Geneva, WHO.

APPENDICES

A: LEARNING OBJECTIVES

Module 1: Introduction and the determinants of health

- Note the objectives and arrangements for the workshop
- Explain the concepts of health and well-being
- Recognize the responsibility of states to uphold the health of their population
- Identify socioeconomic, biological and behavioural factors that influence health
- Explain the social determinants of health

Module 2: 21st-century health dynamics and inequality

- Explain the measurement unit "DALY" (disability-adjusted life year)
- Summarize stylized facts about the contemporary burden of disease
- Describe some of the major global challenges impacting health
- Distinguish health inequality and health inequity
- Explain how inequality influences health outcomes

Module 3: Health in All Policies (HiAP)

- Define public health and HiAP
- Explain the origins and development of HiAP
- Recognize when to use a HiAP approach
- Distinguish the HiAP approach from other public policies

Module 4: The policy-making process

- Define policy and describe the stages of the policy-making cycle
- Recognize the complex and political nature of the policy-making process
- Identify the characteristics of a "window of opportunity" for policy change
- Define a policy champion/policy entrepreneur
- Frame a complex health issue and identify its policy challenges and opportunities

Module 5: The role of government in HiAP/whole-of-government approaches

- Describe the role of government in the HiAP approach
- Recognize a range of terms that refer to intersectoral action
- Explain some of the barriers to closer intersectoral collaboration
- Describe conditions conducive to the HiAP approach
- List and appraise different structures and mechanisms for intersectoral action
- Discuss examples of HiAP in practice

Module 6: Preparing policy briefs

- Explain the purpose of a policy brief in the context of policy-making
- Summarize characteristics of effective writing and influential policy briefs

- Describe three common approaches to prioritizing health in policy discourses
- Develop and present a policy brief

Module 7: The role of non-government stakeholders in HiAP/whole-of-society approaches

- Define a stakeholder and provide examples
- Explain the benefits and challenges of non-government stakeholder engagement
- List principles for effective and accountable stakeholder consultation
- Identify formal and informal mechanisms for non-government stakeholder involvement in HiAP
- Recognize strategies used by actors to counteract efforts to improve health and inequity
- Prepare a stakeholder analysis

Module 8: Negotiating for health

- List the major stages of the negotiation process
- Describe several approaches to policy negotiation
- Explain the characteristics of cooperative or value-added negotiating
- Apply knowledge of negotiation to a role play

Module 9: HiAP implementation at local, regional and global levels

- Discuss examples of HiAP implementation at the local, regional and/or global level
- Identify some of the challenges of implementation

Module 10: Measuring progress in health

- List reasons for monitoring and evaluation
- Recognize different types of monitoring and evaluation related to health
- Distinguish between inputs, outputs, outcomes and impact
- Explain the purpose and key steps involved in health impact assessment and health lens analysis
- Conduct a mock health impact assessment or health lens analysis
- Identify sources of health data and policy advice

Module 11: The leadership role of the health sector in HiAP

- Explain the leadership role of health sector in HiAP
- List challenges that the health sector faces in promoting HiAP
- Describe the role of the WHO in relation to HiAP
- Apply knowledge of HiAP by outlining a model contemporary health ministry

Module 12: Next steps and round up

- List key messages of HiAP workshop
- Identify ways to apply HiAP in practice

B: MODULE OUTLINES

Module 1: Introduction and the determinants of health

Welcome and introductions	30 mins
Lecture: Outline of course structure and learning objectives	30 mins
Optional group activity: Expectations	15 mins
Group discussion: What is health and well-being?	20 mins
Optional group activity: Factors determining health	20 mins
Video: Social determinants of health	15 mins
Questions and feedback	5 mins
TOTAL TIME	**1h 40 mins**
WITH OPTIONS	**2h 15 mins**

Module 2: 21st-century health dynamics and inequality

Video: Life expectancy "200 Countries, 200 Years, 4 Minutes"	5 mins
Group activity: Contemporary burden of disease	30 mins
Lecture: Global challenges and health dynamics	20 mins
Group activity: Health inequalities	30 mins
Questions and feedback	5 mins
TOTAL TIME	**1h 30 mins**

Module 3: Health in All Policies (HiAP)

PART ONE	
Recap: Key messages of Modules 1–2	10 mins
Group activity: Health linkages with other sectors	20 mins
Lecture: Public health, HiAP and its development including Q&A	45 mins
PART TWO	
Group activity: Identifying the HiAP approach	25 mins
Group activity: WHO HiAP Framework for Country Action	40 mins
Questions and feedback	10 mins
PART ONE	**1h 15 mins**
PART TWO	**1h 15 mins**
TOTAL TIME	**2h 30 mins**

Module 4: The policy-making process

PART ONE	
Group discussion: What is policy?	10 mins
Lecture: Complex social issues	20 mins
Group activity: Complex social problems	45 mins
PART TWO	
Lecture: Policy-making and HiAP	20 mins
Group activity: Framing and windows of opportunity	45 mins
Questions and feedback	10 mins
PART ONE	**1h 15 mins**
PART TWO	**1h 15 mins**
TOTAL TIME	**2h 30 mins**

Module 5: The role of government in HiAP/whole-of-government approaches

Lecture: The role of government in the HiAP approach	10 mins
Group activity: Conditions that promote or hinder intersectoral collaboration	20 mins
Lecture: Structures and mechanisms for intersectoral collaboration	15 mins
Group activity: Case studies of HiAP intersectoral action	35 mins
Questions and feedback	10 mins
TOTAL TIME	**1h 30 mins**

Module 6: Preparing policy briefs

Lecture: Effective writing and policy briefs	15 mins
Optional group activity: Appraise examples of policy briefs	15 mins
Group activity: Policy brief writing	60 mins
Group activity: Class presentations	30 mins
TOTAL TIME	**1h 45 mins**
WITH OPTION	**2h 00 mins**

Module 7: The role of non-government stakeholders in HiAP/whole-of-society approaches

ALTERNATIVE ONE	
Recap: Whole-of-government vs whole-of-society approaches	5 mins
Lecture: Stakeholder engagement	15 mins
Optional: Civil society and private sector panel discussion and Q&A	1h 10 mins
ALTERNATIVE TWO	
Recap: Whole-of-government vs whole-of-society approaches	5 mins
Lecture: Stakeholder engagement	15 mins
Group activity: Stakeholder engagement case studies	20 mins
Group activity: Stakeholder analysis	60 mins
Questions and feedback	5 mins
ALTERNATIVE ONE	**1h 30 mins**
ALTERNATIVE TWO	**1h 45 mins**

Module 8: Negotiating for health

Lecture: Policy negotiations	15 mins
Group activity: Negotiation role play – megacities and cardiovascular disease	60 mins
Group discussion: Debrief	30 mins
TOTAL TIME	**1h 45 mins**

Module 9: HiAP implementation at local, regional and global levels

ALTERNATIVE ONE	
Participant presentations of local and regional HiAP case studies	1h 30 mins
ALTERNATIVE TWO	
Recap: Modules 5–8	10 mins
Lecture: HiAP implementation at global, regional and local levels	60 mins
Lecture: Challenges of HiAP implementation	15 mins
Questions and feedback	5 mins
ALTERNATIVE ONE	**1h 30 mins**
ALTERNATIVE TWO	**1h 30 mins**

Module 10: Measuring progress in health

Group discussion: Reasons for M&E and health indicators	10 mins
Lecture: M&E, HiAP, HIA and HLA	15 mins
Group activity: HIA	60 mins
Optional group discussion: Data sources for HiAP	15 mins
Questions and feedback	5 mins
TOTAL TIME	**1h 30 mins**
WITH OPTION	**1h 45 mins**

Module 11: The leadership role of the health sector

Recap: Developing, implementing and monitoring policy	5 mins
Optional group activity: Health leadership qualities	20 mins
Lecture: Leadership role of the health sector and current challenges	20 mins
Group activity: Model contemporary health ministry	60 mins
Questions and feedback	5 mins
TOTAL TIME	**1h 30 mins**
WITH OPTION	**1h 50 mins**

Module 12: Next steps and round up

Recap: Key messages of the workshop	20 mins
Group discussion: Applying HiAP in practice	20 mins
Group activity: Next steps	20 mins
Evaluation and round up	30 mins
TOTAL TIME	**1h 30 mins**

C: KEY READING FOR PARTICIPANTS

Essential reading

- WHO (2013) Helsinki Statement on Health in All Policies. WHO 8th Global Conference on Health Promotion (2 pages)
- WHO (2014) HiAP Framework for Country Action. WHO, Geneva (13 pages)
- Leppo K *et al.* (2013) Lessons for Policy-Makers in Leppo K *et al.* (2013) *Health in All Policies*: *Seizing Opportunities, Implementing Policies*. Finland Ministry of Social Affairs and Health (12 pages)
- CSDH (2008) *Closing the Gap: Health Equity Through Action on the Social Determinants of Health*, Final Report of the Commission on Social Determinants of Health. Geneva, WHO (AR) (CN) (ES) (FR) (PT) (RU) (Executive Summary – 24 pages)
- Audio: WHO Podcast (2008) Commission on Social Determinants of Health (4 mins)
- Video: WHO (2011) 25 Years of the Ottawa Charter (11 mins)

Desirable reading

Module 1: Introductions and the determinants of health

Recommended

- WHO (1946) WHO Constitution (AR) (CN) (ES) (FR) (RU) (Preamble, Chapters 1–2) (3 pages)
- Video: WHO (2013) Bringing Health to Life (AR) (CN) (ES) (FR) (PT) (RU) (3 mins)
- CSDH (2008) Closing the Gap: Health Equity Through Action on the Social Determinants of Health, *Final Report of the Commission on Social Determinants of Health*. Geneva, WHO (AR) (CN) (ES) (FR) (PT) (RU) (Executive Summary – 24 pages)
- Audio: WHO Podcast (2008) Commission on Social Determinants of Health (4 mins)
- Video: WHO (2011) 25 Years of the Ottawa Charter (11 mins)

Optional

- WHO (2013) *Communicating the Economics of Social Determinants of Health and Health Inequalities*. Geneva, WHO

Module 2: 21st-century health dynamics and inequality

Recommended

- Video: Institute for Health Metrics and Evaluation, Global Burden of Disease Tool Tutorial (11 mins)
- Marmot M (2005) Social Determinants of Health Inequalities. *The Lancet*, Vol. 365, pp. 1099–1104 (6 pages)
- WHO (2011) 10 Facts on Health inequities and their causes. Geneva, WHO (2 pages)
- Rockström J *et al.* (2009) A safe operating space for humanity. *Nature*, Vol. 461, No. 24, pp. 472–475 (4 pages)
- Infographic: Gapminder (2003) Income Distribution 1970–2000

Optional

- Buxton N (2014) *State of Power*, Transnational Institute, including infographics Planet Earth: A Corporate World and The Global 0.001%
- Fuentes-Nieva R and Galasso N (2014) *Working for the Few: Political Capture and Economic Inequality*. Oxford, UK, Oxfam
- Lim *et al.* (2012) Comparative Risk Assessment of Burden of Disease and Injury Attributable to 67 Risk Factors and Risk Factor Clusters in 21 Regions, 1990–2010. *The Lancet*, Vol. 380, pp. 2224–60 (Summary)

Module 3: Health in All Policies (HiAP)

Recommended

- Baum F, Ollila E and Peña S (2013) History of HiAP in Leppo K *et al*. (eds) (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health (14 pages)
- WHO (2013) Helsinki Statement on Health in All Policies. WHO 8th Global Conference on Health Promotion (2 pages)
- WHO (2014) HiAP Framework for Country Action. Geneva, WHO (13 pages)

Optional

- Cook S, Zhang S and Yi I (2013) Health and Development: Challenges and Pathways to HiAP in Low-Income Countries in Leppo K *et al.* (eds) (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health (13 pages)

Module 4: The policy-making process

Recommended

- Mannheimer L, Lentho J and Östlin P (2007) Windows of Opportunity for Intersectoral Health Policy in Sweden: Open, Half-Open or Half-Shut? *Health Promotion International,* Vol. 22, No. 4, pp. 307–315 (7 pages)

Optional

- Korn D, Gibbens R and Azmier J (2003) Framing Public Policy Towards a Public Health Paradigm for Gambling. *Journal of Gambling Studies*, Vol. 19, No. 2, pp. 235–256
- WHO's Violence Against Women Factsheet. Geneva, WHO

Module 5: The role of government in HiAP/whole-of-government approaches

Recommended

- Lin V *et al*. (2012) Synthesizing the Evidence: How Governance Structures can Trigger Governance Actions to Support Health in All Policies in McQueen DV *et al.* (2012) *Intersectoral Governance for Health in All Policies*. WHO (30 pages)
- Leppo K *et al.* (2013) Lessons for Policy-Makers in Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies.* Finland, Ministry of Social Affairs and Health (12 pages)

Optional

- WHO Social Determinants of Health Sectoral Briefings:
  - WHO (2011) *Housing: Shared Interests in Health and Development – Social Determinants of Health Sectoral Briefing Series One.* Geneva, WHO
  - WHO (2011) *Education: Shared Interests in Well-Being and Development – Social Determinants of Health Sectoral Briefing Series Two.* Geneva, WHO
  - WHO (2011) *Transport (Road Transport): Shared Interests in Sustainable Outcomes – Social Determinants of Health Sectoral Briefing Series Three.* Geneva, WHO
  - WHO (2012) *Social Protection: Shared Interests in Vulnerability Reduction and Development – Social Determinants of Health Sectoral Briefing Series Four.* Geneva, WHO
  - WHO (2013) *Energy: Shared Interests in Sustainable Development and Energy Services – Social Determinants of Health Sectoral Briefing Series Four*. Geneva, WHO

Module 6: Preparing policy briefs

Optional

- WHO (2013) *Communicating the Economics of Social Determinants of Health and Health Inequalities.* Geneva, WHO

Module 7: The role of non-government stakeholders in HiAP/whole-of-society approaches

Recommended

- WHO (2005) Bangkok Charter for Health Promotion in a Globalized World (6 pages)
- CommGap (2009) Multi-Stakeholder Dialogue. World Bank (5 pages)
- Reich M. (2002) Introduction: Public-Private Partnerships for Public Health in Reich M (ed.) *Public-Private Partnerships for Public Health*, Harvard Series on Population and International Health. Cambridge, MA, Harvard University Press, pp. 1–18 (15 pages)
- NCD Alliance (2012) Key Points of UN Political Declaration on the Prevention and Control of Non-Communicable Diseases (2 pages)

Optional

- Gauvin F (2012) Involving the Public to Facilitate or Trigger Governance Actions Contributing to HiAP in McQueen DV *et al.* (2012) *Intersectoral Governance for Health in All Policies*. WHO, pp. 147–164 (12 pages)
- CommGap (2009) Coalition Building. World Bank, (9 pages)
- CommGap (2009) Changing Public Opinion. World Bank (5 pages)
- CommGap (2009) Media Effects. World Bank (6 pages)
- Video: CommGap Media Effects. World Bank (3 mins)

Module 8: Negotiating for health

Recommended

- Smith S *et al.* (2012) *Urbanization and Cardiovascular Disease: Raising Heart-Healthy Children in Today's Cities*. Geneva, The World Health Foundation, Chapters 1, 2 and 3 (13 pages)
- Umiker W (2007) Negotiating Skill for Health Care Professionals in Kongstvedt P (2007) *Essentials of Managed Health Care Handbook,* Fourth Edition. Aspen Publishers (6 pages)
- Video: CommGap, Negotiation (5 mins)
- Video: WHO (2011) Unite in the Fight Against NCDs (2 mins)

Optional

- CommGap (2009) Intercultural Communication. World Bank (6 pages)
- CommGap (2009) Non-Verbal Communication. World Bank (5 pages)

Module 9: HiAP Implementation at local, regional and global levels

Recommended

- Koivusalo M *et al.* (2013) Globalization and National Policy Space for Health and a HiAP approach in Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health (16 pages)

Optional

- WHO (2013) *Health in All Policies: Report on Perspectives and Intersectoral Actions in the African Region*. Brazzaville, WHO
- WHO (2013) *Health in All Policies: Report on Perspectives and Intersectoral Actions in the South-East Asia Region*. New Delhi, WHO
- WHO (2013) *Health in All Policies: Report on Perspectives and Intersectoral Actions in the Western Pacific Region*. Manila, WHO
- British Academy (2014) *If You Could Do One Thing: Nine Local Action to Reduce Health Inequalities*. London, The British Academy (Executive Summary) (4 pages)

Module 10: Measuring progress in health

Recommended

- WHO (2013) *Handbook on Health Inequality Monitoring with a Special Focus on Low- and Middle-Income Countries*. Geneva, WHO (Introduction) (15 pages)
- Quigley R *et al.* (2006) *Health Impact Assessment International Best Practice Principles* Special Publication Series No. 5. International Association for Impact Assessment (4 pages)
- WHO (2014) HiAP Framework for Country Action. Geneva, WHO (Annex 1) (1 page)
- WHO (2011) Health in All Policies. South Australia's country case study on action on the social determinants of health. Produced for the World Conference on Social Determinants of Health, Rio de Janeiro, Brazil.
- International Health Partnership and WHO (2011). Monitoring, evaluation and review of national health strategies. A country-led platform for information and accountability. Geneva, WHO

Module 11: The leadership role of the health sector in HiAP

Recommended

- Leppo K and Tangcharoensathien V (2013) The Health Sector's Role in HiAP in Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health (12 pages)
- WHO (2014) HiAP Framework for Country Action. Geneva, WHO (13 pages)

Optional

- Bennett S *et al.* (2012) Approaches To Developing The Capacity of Health Policy Analysis Institutes: A Comparative Case Study. *Health Research Policy and Systems,* Vol. 10, No. 7 (8 pages)

D: SUPPORTING MATERIAL FOR INSTRUCTORS

Module 1: Introductions and the determinants of health

- Video: WHO (2013) The Social Determinants of Health (15 mins)
- Kickbusch I (2012) Addressing the interface of the political and commercial determinants of health, *Health Promotion International*, Vol. 27, No. 4
- CSDH (2008) Closing the Gap: Health Equity Through Action on the Social Determinants of Health, *Final Report of the Commission on Social Determinants of Health*. Geneva, WHO (AR) (CN) (ES) (FR) (PT) (RU)
- Booske B *et al.* (2010) Different Perspectives For Assigning Weights to Determinants of Health, *County Health Rankings Working Paper*. University of Wisconsin
- WHO Social Determinants of Health Sectoral Briefings:
  - WHO (2011) *Housing: Shared Interests in Health and Development – Social Determinants of Health Sectoral Briefing Series One*. Geneva, WHO
  - WHO (2011) *Education: Shared Interests in Well-Being and Development – Social Determinants of Health Sectoral Briefing Series Two.* Geneva, WHO
  - WHO (2011) *Transport (Road Transport): Shared Interests in Sustainable Outcomes – Social Determinants of Health Sectoral Briefing Series Three.* Geneva, WHO
  - WHO (2012) *Social Protection: Shared Interests in Vulnerability Reduction and Development – Social Determinants of Health Sectoral Briefing Series Four*. Geneva, WHO
  - WHO (2013) *Energy: Shared Interests in Sustainable Development and Energy Services –Social Determinants of Health Sectoral Briefing Series Four.* Geneva, WHO

Module 2: 21st-century health dynamics and inequality

- Lim *et al.* (2012) Comparative Risk Assessment of Burden of Disease and Injury Attributable to 67 Risk Factors and Risk Factor Clusters in 21 Regions, 1990–2010. *The Lancet*, Vol. 380, pp. 2224–60
- Ezzati M, Lopez AD, Rodgers A and Murray CJL (eds) (2004) *Comparative Quantification of Health Risks: Global and Regional Burden of Disease Attributable to Selected Major Risk Factors*, Volumes 1 and 2. Geneva, WHO
- Institute for Health Metrics and Evaluation:
  - Global Burden of Disease Visualizations: http://www.healthmetricsandevaluation.org/gbd/visualizations/country
  - Global Burden of Disease Insight: http://www.healthmetricsandevaluation.org/gbd/visualizations/gbd-insight
- Bloom DE *et al*. (2011) *The Global Economic Burden of Non-communicable Diseases.* Geneva, World Economic Forum
- WHO (2013) Handbook on Health Inequality Monitoring with a Special Focus on Low- and Middle-Income Countries. Geneva, WHO
- WHO (2010) *Global Status Report on Noncommunicable Diseases 2010*. Geneva, WHO

- WHO (2011) *Noncommunicable Diseases Country Profiles 2011*. Geneva, WHO
- WHO (2011) *From Burden To "Best Buys": Reducing The Economic Impact of NCDs in Low- and Middle-Income Countries.* Geneva. WHO
- WHO (2011) *Scaling Up Action against Noncommunicable Diseases: How Much Will It Cost?* Geneva, WHO
- WHO (2009) *Setting the Political Agenda to Tackle Health Inequity in Norway.* Copenhagen, WHO
- Baker A *et al*. (2005) Addressing Social Determinants of Health Inequities: Learning From Doing. *American Journal of Public Health*, Vol. 95, No. 5, pp. 553–555
- WHO Health Equity Country Profiles, http://www.who.int/gho/health_equity/countries/en/index.html
- Buxton N (2014) *State of Power*. Transnational Institute, Washington, D.C.
- Wilkinson, R (1996) *Unhealthy Societies: The Afflictions of Inequality.* London, Routledge

Module 3: Health in All Policies (HiAP)

- Leppo K *et al.* (eds) (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies.* Finland, Ministry of Social Affairs and Health
- Rosen G (1993) *A History of Public Health.* Baltimore, Johns Hopkins University Press
- ASTHO (2013) *Health in All Policies: Strategies to Promote Innovative Leadership*. Arlington, VA, Association of State and Territorial Health Offices
- Kickbusch I and Behrendt T (2013) *Implementing a Health 2020 Vision: Governance for Health in the 21st Century – Making it Happen.* Copenhagen, WHO
- CDC (2011) Ten Great Public Health Achievements in America in *Morbidity and Mortality Weekly Report (MMWR)*, Vol. 60. No. 19. Atlanta, Centers for Disease Control and Prevention
- CDC (2011) Ten Great Public Health Achievements Worldwide in *Morbidity and Mortality Weekly Report (MMWR),* Vol. 60. No. 24. Atlanta, Centers for Disease Control and Prevention

Module 4: The policy-making process

- Walt G (1994) *Health Policy: An Introduction to Process and Power.* London, Zed Press
- Ritchey T (2011) *Wicked problems: Social messes.* Berlin, Springer
- Butland B *et al.* (2007) *Tackling Obesities: Future Choices.* London, Government Office for Science,
- WHO (2009) *Setting the Political Agenda to Tackle Health Inequity in Norway.* Copenhagen, WHO

Module 5: The role of government in HiAP/whole-of-government approaches

- McQueen DV *et al.* (2012) *Intersectoral Governance for Health in All Policies.* WHO
- Leppo K *et al.* (2013*) Health in All Policies: Seizing Opportunities, Implementing Policies.* Finland, Ministry of Social Affairs and Health
- Kickbusch I and Behrendt T (2013) *Implementing a Health 2020 Vision: Governance for Health in the 21st Century.* Copenhagen, WHO
- Gray, B (1985) Conditions Facilitating Interorganizational Collaboration. *Human Relations,* Vol. 38, No. 10, pp. 911–936

Module 6: Preparing policy briefs

- Young E and Quinn L (undated) The Policy Brief described
- IDRC (undated) How to Write a Policy Brief. International Development Research Centre
- Writing effectively for WHO: Course guide:
  - Course Outline
  - Module 1: Effective Writing
  - Module 2: Correspondence, Records and Notes
  - Module 3: Reports and Proposals
- WHO Capacity Building Workshop Material for Evidence-Informed Policy-Making
- Sample policy briefs:
  - ODI policy brief – food insecurity
  - RWJF policy brief – transport
  - NCD Alliance policy brief – human rights and NCDs

Module 7: The role of non-government stakeholders in HiAP/whole-of-society approaches

- WEF (2013) Multi-Stakeholder Collaboration for Healthy Living. Geneva, World Economic Forum
- Buse K and Waxman A (2001) Public-Private Health Partnerships: A Strategy for WHO. *Bulletin of the World Health Organization,* Vol. 79, No. 8, pp. 748–754
- OECD (2005) *Evaluating Public Participation in Policy Making.* Paris, Organisation for Economic Co-operation and Development, pp. 85–108
- WHO (2011) *Noncommunicable Diseases Country Profiles 2011*. Geneva, WHO
- UN Political Declaration on the Prevention and Control of Non-Communicable Diseases, A/RES/66/2
- NCD Alliance (2012) Key Points of UN Political Declaration on the Prevention and Control of Non-Communicable Diseases

Module 8: Negotiating for health

- Drager N *et al.* (2000) *Negotiating Health Development: A Guide for Practitioners.* Geneva, Conflict Management Group and WHO
- Saner R (2000) *The Expert Negotiator: Strategy, Tactics, Motivation, Behaviour, Leadership.* Kluwer Law International
- Bhattacharya D (2005) Least Developed Countries in Trade Negotiations: Planning Process and Information Needs in *Asia-Pacific Trade and Investment Review,* Vol. 1, No. 1
- Gilson L and Erasmus E (2007) Health Policy and Policy Analysis Training, Sessions 10 and 11. Centre for Health Policy, Johannesburg, University of the Witwatersrand
- CommGap Publications. World Bank

Module 9: HiAP Implementation at local, regional and global levels

- WHO regional HiAP reports
- WHO country HiAP case studies:
  - WHO (2013) Moving Towards Health in All Policies: A Compilation of Experiences from Africa, South-East Asia and the Western Pacific. Geneva, WHO
  - WHO (2013) Opportunities for scaling up and strengthening the health-in-all-policies approach in South-eastern Europe. Copenhagen, WHO
  - WHO (2013) Health in All Policies. Summary of experiences from the Americas. The 8th Global Conference on Health Promotion 2013, Helsinki, Finland, 10 to 14 of June. Washington, D.C., Pan American Health Organization
- WHO (2003) Framework Convention on Tobacco Control (AR) (CN) (ES) (FR) (RU)
- WHO (2005) International Health Regulations (AR) (CN) (ES) (FR) (RU)
- Video: WHO (2012) World No Tobacco Day – Sponsorship (1 min) (AR) (CN) (ES) (FR) (PT) (RU)
- Video: WHO (2012) World No Tobacco Day – Advertising (1 min) (ES) (FR)
- Video: WHO (2008) World No Tobacco Day – Fashion (1 min)
- Video: WHO (2008) World No Tobacco Day – Film (1 min)
- Video: WHO (2013) Tobacco Control Measures (3 mins)
- Video: WHO (2012) International Health Regulations (4 mins)
- Video: WHO (2014) Responding to International Health Threats (7 mins)
- Video: WHO (2013) Towards Making Every City a Healthy City (6 mins)

Module 10: Measuring progress in health

- Quigley R (2010) Role of Health Impact Assessment in HiAP in Kickbusch I and Buckett K (2010) *Implementing Health in All Policies.* Department of Health, Government of South Australia
- WHO (2003) *Bulletin of the World Health Organization*. Geneva, WHO, Vol. 81, No. 6, pp. 387–472
- WHO (2005) Health Impact Assessment Toolkit for Cities, Training Module. Copenhagen, WHO
- Lee J, Röbbel N and Dora C (2013) Cross-Country Analysis of the Institutionalization of Health Impact Assessment. Social Determinants of Health Discussion Paper Series 8. Geneva, WHO
- IFC (2009) Introduction to Health Impact Assessment (HIA). International Finance Corporation, World Bank Group
- UNDP (2011) *Handbook on Planning, Monitoring and Evaluating for Results*. New York, UNDP (AR) (FR) (ES) (RU)
- WHO (2011). Health in the green economy: health co-benefits of climate change mitigation - housing sector. Geneva, WHO
- WHO (2011). Social Determinants of Health Sectoral Briefing Series. Housing: shared interests in health and development. Geneva, WHO

- Loewenson R (2013) Evaluating intersectoral processes for action on the social determinants of health: learning from key informants (Social Determinants of Health Discussion Paper 5: Policy & Practice). Geneva, WHO
- Technical Paper for World Health Organization, written for the 8th Global Conference on Health Promotion, June 2013, Helsinki
- Baum F, Lawless A, Delany T, MacDougall C, Williams C, Broderick D, Wildgoose D, Harris E, McDermott D, Kickbusch I, Popay J and Marmot M (2014) Evaluation of Health in All Policies: concept, theory and application. *Health Promotion International*, Vol. 29

Module 11: The leadership role of the health sector in HiAP

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Module 12: Next steps and round up

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E: TEACHING RESOURCES/HANDOUTS

Handout 2.1: Contemporary burden of disease

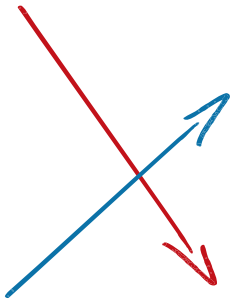
Activity template – South-East Asia, Top Diseases, 1990–2010, both genders, all ages

Instructions: Based on the 2010 Global Burden of Disease Study, the 14 diseases listed below in alphabetical order were the most burdensome as measured by disability-adjusted life years. Communicable diseases are in red, noncommunicable diseases are in blue and physical injuries are in green. The burden of disease has changed over time. As a group, put the diseases in order from most burdensome to least burdensome for the two dates.

Diseases (alphabetical order)

A. Lower respiratory infections – a category of diseases including bronchitis and pneumonia
B. Diarrheal diseases – usually symptomatic of infection of the intestinal tract by bacteria, viruses or parasites
C. Tuberculosis – an infectious disease affecting the lungs
D. Stroke – damage to the brain caused by bleeding or blood clot
E. Preterm birth complications – problems like infections and pneumonia can result in infant death or disability
F. Ischemic heart disease – damage to heart caused by accumulation of plaque in arteries
G. Malaria – mosquito-borne infectious disease
H. Road injury – disabilities caused by vehicle accidents
I. Congenital abnormalities – disabilities at birth
J. Iron-deficiency anaemia – shortage of iron in blood often caused by malnutrition and parasitic worms
K. Depression – a mental disorder characterized by sadness, fatigue and loss of interest or pleasure
L. COPD – chronic obstructive pulmonary disease is characterized by persistent blockage of lung airflow
M. Low back pain – common disorder involving muscles and bones of the back
N. Diabetes – a lifestyle illness due to malfunction of the pancreas

Rank	Disease (1990)
1	
2	
3	
4	
5	
6	
7	G. Malaria
8	
9	
10	
11	
12	
13	
14	N. Diabetes

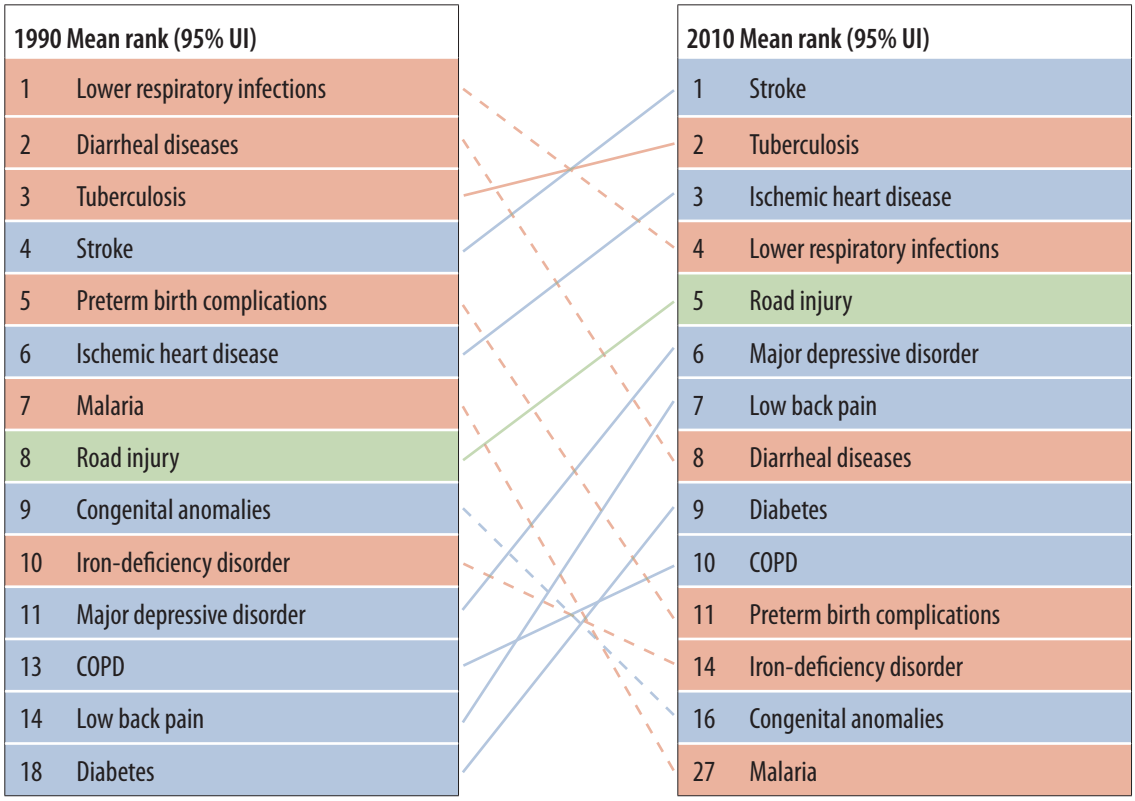


Rank	Disease (2010)
1	D. Stroke
2	
3	
4	
5	
6	
7	
8	
9	N. Diabetes
10	
11	
12	
13	
14	G. Malaria

Source: IHME Global Burden of Disease Arrow Tool: http://www.healthmetricsandevaluation.org/gbd/visualizations/gbd-arrow-diagram

Answer sheet

The diagram below correctly lists the 14 diseases in order, from most burdensome to least burdensome for the two dates. The number beside each disease indicates its actual rank. For example, in 1990 malaria was the 7th most burdensome disease but in 2010 it had fallen dramatically to become just the 27th most burdensome disease.



Handout 3.1: International milestones in HiAP development[1]

Year	International milestone	Relevance
1978	WHO Conference on Primary Health Care (Alma-Ata)	Produced Alma-Ata Declaration on Primary Health Care promoting a social view of health and advocating importance of intersectoral action for achieving health for all.
1986	Intersectoral Action for Health, 39th World Health Assembly	*Intersectoral Action for Health: The Role of Intersectoral Cooperation in National Strategies for Health for All* – gave a detailed analysis of the technical linkages between health, actions in other sectors and within development plans. It proposed that health needed to make more of an effort in the development and use of its planning instruments to recognize cooperation with other sectors and where some responsibilities for health promotion and disease prevention needed to be devolved. It also led to World Health Assembly resolution WHA39.22, Intersectoral cooperation in national strategies for health for all.
1986	WHO First International Conference on Health Promotion (Ottawa)	Produced Ottawa Charter for Health Promotion: among the five strategies for health promotion were "promoting healthy public policy" and "creating supportive environments for health".
1988	WHO Second International Conference on Health Promotion (Adelaide)	Produced Adelaide Recommendations on Healthy Public Policy defined as "an explicit concern for health and equity in all areas of policy and by an accountability for health impact".
1991	WHO Third International Conference on Health Promotion (Sundsvall)	Produced Sundsvall Statement on Supportive Environments for Health which "recognized that everyone has a role in creating supportive environments for health" and stressed the importance of community empowerment.
1995	WHO Healthy Cities project	Healthy Cities is a long-term international development initiative that aims to place health high on the agendas of decision-makers and to promote comprehensive local strategies for health protection and sustainable development. Basic features include community participation and empowerment, intersectoral partnerships and participant equity.
1997	WHO Fourth International Conference on Health Promotion (Jakarta)	Produced Jakarta Declaration on Leading Health Promotion into the 21st century. More than previous declarations focused on low- and middle-income countries and advocated that public and private sectors should promote health and that health development required a multisectoral approach; and emphasized the importance of health promotion partnerships.
2000	WHO Fifth Global Conference on Health Promotion (Mexico City)	Produced Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action. Identified key action "to position the promotion of health as a fundamental priority in local regional, national and international policies and programmes" and also "to advocate that UN agencies be accountable for the health impact of their development agenda".
2005	WHO Sixth Global Conference on Health Promotion (Bangkok)	Produced Bangkok Charter for Health Promotion in a Globalized World. Reinforced the basic strategies of the Ottawa Charter, extended their relevance for a globalized world and made health promotion central to the global development agenda, a core responsibility of all governments and a requirement for good corporate practice. Called for global governance to address harmful impact of "trade, products, services and marketing strategies".

1 A more in-depth historical account is provided by Anne-Emanuelle Birn in: WHO (forthcoming) All for health? WHO's intersectoral approaches to health: historical perspectives. *Social Determinants of Health Discussion Paper No. 10.* Geneva, WHO.

Year	International milestone	Relevance
2008	Final Report of the Commission on Social Determinants of Health (CSDH)	Provided extensive evidence on the impact of the social determinants of health and so the health impacts of activities in multiple sectors. Recommended the use of health equity impact assessments and endorsed the HiAP approach.
2009	WHO Seventh Global Conference on Health Promotion (Nairobi)	Produced Nairobi Call to Action for Closing the Implementation Gap in Health Promotion. Calls for governments to make health promotion integral to the policy and developmental agenda. This includes implementing the recommendations of the CSDH.
2010	Health in All Policies International Meeting (Adelaide)	Produced Adelaide Statement on Health in All Policies which "emphasizes that government objectives are best achieved when all sectors include health and well-being as a key component of policy development".
2011	UN Political Declaration on the Prevention and Control of Non-Communicable Diseases	The UN Political Declaration on the Prevention and Control of Non-communicable Diseases focuses on the four most prominent NCDs, namely: cancers, cardiovascular disease, chronic respiratory diseases and diabetes. The Declaration identifies five broad areas of action: 1) Implementing multisectoral, cost-effective, population-wide interventions; 2) Accelerating the implementation of the Framework Convention on Tobacco Control (FCTC); 3) Advancing the implementation of the WHO's Strategy on Diet, Physical Activity and Health, and Strategy to Reduce Harmful Use of Alcohol; 4) Promoting interventions to reduce salt, sugar and saturated fats; and 5) Promoting vaccinations to prevent infections associated with cancers.
2011	World Conference on Social Determinants of Health (Rio de Janeiro)	Produced Rio Political Declaration on Social Determinants of Health which states, "Health in All Policies, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies".
2014	WHO Eighth Global Conference on Health Promotion (Helsinki), 67th World Health Assembly	The main theme of the conference was HiAP and its implementation. It was structured around six themes: 1) Facilitating the exchange of experiences; 2) Reviewing approaches to address barriers and build capacity for implementing HiAP; 3) Identifying opportunities to implement the recommendations of the CSDH; 4) Establish and review economic and developmental cases for investing in HiAP; 5) Addressing the contribution of health promotion in the renewal and reform of primary health care; and 6) Reviewing progress, impact and achievements of health promotion since the Ottawa Conference. It led to World Health Assembly resolution WHA67.12, Contributing to social and economic development: sustainable action across sectors to improve health and health equity.

Handout 3.2: HiAP and related terms

Cross-sectoral action

See intersectoral action.

Health for all

The attainment by all the people in the world of a level of health that will permit them to live a socially and economically productive life. Health for all has served as an important focal point for health strategy for WHO and its Member States for almost 20 years.

Health in All Policies (HiAP)

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. It improves accountability of policy-makers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being.

Health policy

A formal statement or procedure within institutions (notably government) which defines priorities and the parameters for action in response to health needs, available resources and other political pressures.

Health promotion

The process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. An evolving concept that encompasses fostering lifestyles and other social, economic, environmental and personal factors conducive to health. Reference: Ottawa Charter for Health Promotion, WHO, Geneva, 1986.

Healthy public policy

Healthy public policy is characterized by "an explicit concern for health and equity in all areas of policy, and by accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens. It makes social and physical environments health enhancing". The term "healthy public policy" is a synonym for HiAP and an early term used in the health promotion movement. See also whole-of-government. Reference: Adelaide Recommendations on Healthy Public Policy, WHO, Geneva, 1988.

Intersectoral action

Intersectoral action refers to the process in which the objectives, strategies, activities and resources of a sector are considered in terms of their implications and impact on objectives, strategies, activities and resources of two or more other sectors. This can include working across different levels of government such as district, provincial and national jurisdictions. The term intergovernment is sometimes used to refer to these horizontal and vertical linkages between levels of government within a country. Whole-of-government, joined-up government and healthy public policies are similar terms used in the HiAP literature.

Joined-up government

See whole-of-government.

Public health

Public health refers to all organized efforts of society to prevent disease, promote health and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases.

Whole-of-government

A whole-of-government approach refers to the coordinated efforts of two or more sectors within government to improve health outcomes. This can include working across different levels of government such as district, provincial and national jurisdictions. Joined-up government and healthy public policies are similar terms used in the HiAP literature.

Whole-of-society

A whole-of-society approach refers to coordinated efforts to improve health by multiple stakeholders within and outside government that may also be from several sectors.

Handout 3.3: Identifying the HiAP approach

Examples of health-related initiatives for discussion

✂ . . . . . .

National Breast and Cervical Cancer Early Detection Program[1]

…Created in 1991, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) now functions in all states of the country. Services include clinical breast exams, mammograms, Pap tests, pelvic exams, diagnostic testing for women whose screening outcome is abnormal, and referrals to treatment. NBCCEDP has served more than 4.2 million women, provided more than 10.4 million breast and cervical cancer screening tests, and diagnosed more than 54 276 breast cancers. NBCCEDP is based on a referral system from general practitioners but also conducts public awareness raising and outreach to women who may not be aware of the services available…

✂ . . . . . .

Cook Islands Tobacco Control Action Plan[2]

… The Framework Convention on Tobacco Control was ratified by the Cook Islands in 2004. Following a needs assessment exercise in early 2012, the Cook Islands have adopted a Tobacco Control Action Plan for the period 2012 to 2016. The Action Plan was developed in consultation with other government agencies, non-government organizations and civil society. It identifies seven objectives and initiatives: 1) Improving infrastructure and setting up a multisectoral coordination mechanism; 2) Increasing awareness among and empowering the community to discourage tobacco use and encourage protection from exposure to tobacco use; 3) Promoting cessation services; 4) Reducing the accessibility of tobacco products by increasing the levy on imported tobacco and through supply reduction measures; 5) Further reducing tobacco promotion and regulating tobacco product contents and disclosures; 6) Reducing exposure to second-hand smoke; and 7) Strengthening tobacco monitoring, evaluation and surveillance programmes…

✂ . . . . . .

Immunization Campaign Across the Middle East[3]

…The largest-ever immunization response in the Middle East is under way this week, aiming to vaccinate more than 23 million children against polio in Syria and neighbouring countries over the coming weeks. The campaign is a crucial part of the response to an outbreak of the virus-borne disease in Syria, where 17 cases have so far been confirmed, and to the detection of the virus in environmental samples in other parts of the Middle East. In order to stop the outbreak and prevent further spread, organizers aim to vaccinate, repeatedly over the next few months, all children under the age of 5, whether they are living at home or displaced by conflict…

1 Based on "National Breast and Cervical Cancer Early Detection Program Factsheet". Atlanta, Centers for Disease Control and Promotion.

2 Based on press release "Cook Islands – Tobacco Control Action Plan Adopted". WHO.

3 Based on press release "Over 23 Million Children to be Vaccinated in Mass Polio Immunization Campaign". WHO.

Healthy Mobility Week Kuala Lumpur[1]

…Armed with flyers and stickers, RapidKL staff hit the streets of Kuala Lumpur to promote the upcoming Healthy Mobility Week to encourage the usage of public transport. In this global campaign to promote healthy living, environmental sustainability and the use of public transport, supporters of the campaign would move around the city using public transport, cycling or walking for one week between 3–9 March 2013 and share their experience in an online survey. The programme is facilitated by Youth For Public Transport (Y4PT) – an NGO promoting integrated use of public transport to achieve greater well-being and better quality of life around the world…

✂ . . . . . .

Gene Therapy for Treating Heart Attack Victims[2]

…Among survivors (of heart attacks), the recovery itself fuels more permanent damage to the heart. Scar tissue can harden once-flexible heart muscle, making it less elastic…Heart transplants are one way to circumvent these scar tissue issues, but donor hearts are always in short supply… It turns out that a normally silent gene called Cyclin A2 (or CCNA2) can be coaxed into action to combat the formation of scar tissue in pigs that suffer a heart attack. Gene therapy, the authors (of the research) hope, may one day join stem cell treatments as a contender for transforming the way doctors treat heart failure. Stem cell-based therapies have already resulted in more healthy tissue and decreased scar mass in human clinical trials as well as small improvements in how much blood the heart can pump from one chamber to another…

✂ . . . . . .

Improving the Quality of Life of Older People in Vienna[3]

…The pilot project sALTo, which ran from November 2006 to May 2008, was initiated by the Vienna City Department for Urban Planning to improve and sustain the quality of life, mobility and health of older people in two areas of the city. A budget of €260 000 was jointly financed by the local authority and health sectors… Measures for specific target groups focused on empowerment to support active ageing, for example through better public spaces (pavements, green areas, meeting points), intergenerational cooperation and the more active involvement of old people in the planning of their environment…

1 Based on news article "Use Public Transport During Healthy Mobility Week". *The Star Online.*

2 Based on news article "Gene Therapy Shows Promise for treating Heart Attack Victims". *Scientific American.*

3 Based on case study "Joint Financing in Vienna: sALTo – Improving the Quality of Life of Older People" in McQueen DV *et al.* (2012) *Intersectoral Governance for Health in All Policies.* WHO.

Child Nutrition Rwanda[1]

…In a bid to promote good nutrition among families and thus improve children's health, the Ministry of Health (in Rwanda) has launched a campaign called "1 000 Days Nutrition Campaign" which will run for three years. The campaign involves social clusters ministries namely health (Minisante), agriculture (Minagri), education (Mineduc), local government (Minaloc) and gender and family promotion (Migeprof) as well as other partners. Officials from the ministry of health say that the campaign is called "1 000 Days" as these are crucial for a child's health. Nathan Mugume, the head of the Health Communication Centre, said that the campaign intends to raise awareness among the population on how to improve nutrition…

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Health Worker Training[2]

…UNICEF said on Tuesday that more than 30 Liberian health workers, health directors, ministry officials and programme staff attended a three-day workshop to test the new World Health Organization/UNICEF handbook on newborn and child care. The workshop taught health care workers to practise effective health practices, such as "kangaroo mother care" and umbilical cord care that they can integrate in their communities in Liberia. UNICEF Representative Sheldon Yett said skilled and empowered frontline health workers are key to lowering the child mortality rate in Liberia. "Thirty two children die every day from preventable diseases," Yett said. "These children might have been with us today if they received basic and timely health interventions"…

✂ . . . . . .

Risk of Imported Chikungunya in Caribbean and South America[3]

…More than 5 900 suspected cases of chikungunya have been reported in the Caribbean region and South America since 6 December, the European Centre for Disease Prevention and Control (ECDC) said on Friday. The ECDC published a risk assessment of the outbreak of autochthonous cases of chikungunya fever…on 12 December. The ECDC said the risk of the disease spreading to other islands in the Caribbean region was high. The ECDC said clinicians and travel medicine clinics should remain vigilant regarding imported chikungunya and dengue cases…Chikungunya is a mosquito-borne viral disease that causes fever and arthralgia. Other complications include hepatitis, myocarditis and ocular and neurological disorders…

1 Based on news article "New Campaign Highlights Healthy Nutrition". *Rwanda Focus*.

2 Based on news article "UNICEF gives Liberian Health Workers NewBorn and Child Care Training". *Vaccine News Daily*.

3 Based on news article "More than 5 900 cases of Chikungunya in Caribbean, South America". *Vaccine News Daily*.

Caesar Salad Recalled Over Possible Listeria Contamination[1]

The Canadian Food Inspection Agency has put a recall notice on three brands of caesar salad products because of possible Listeria contamination. These products have been sold in Buy-Low Foods and Nesters Market stores in British Columbia and Alberta…Food contaminated with Listeria may not look or smell spoiled, but it can make people sick. Symptoms include vomiting, nausea, persistent fever, muscle aches, severe headache and neck stiffness. Pregnant women, elderly people and those with compromised immune systems are particularly at risk…

✂ . . . . . .

British Alcohol Strategy[2]

…In March 2012, the British Government launched a new strategy on alcohol focused on reducing the health and social impacts of binge drinking. The strategy focuses on alcohol as the cause of problems, rather than the "harmful use" of alcohol; promotes joined-up action across different government sectors…The strategy recognizes that the alcohol industry has a direct and powerful influence on consumer behaviours – people consume more when prices are lower; marketing and advertising affect drinking behaviour; and store layout and product location affect the type and volume of sales. The proposal to introduce a new minimum price per gram of alcohol will make it illegal for shops and pubs to sell alcohol for less than this set price…

✂ . . . . . .

Handout 3.4: WHO's HiAP Framework for Country Action

Available at: WHO's HiAP Framework for Country Action

1 Based on news article "Caesar Salad Recalled Over Possible Listeria Contamination". CBC News.

2 Based on "Lessons from British Government's Strategy on Alcohol" in Leppo K *et al*. (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies*. Finland, Ministry of Social Affairs and Health, pp. 240–241.

Handout 4.1: Violence against women

WHO Fact Sheet No. 239, updated October 2013; available at: www.who.int/mediacentre/factsheets/fs239/en/

Key facts

- Violence against women – particularly intimate partner violence and sexual violence against women – are major public health problems and violations of women's human rights.
- Recent global prevalence figures indicate that 35% of women worldwide have experienced either intimate partner violence or non-partner sexual violence in their lifetime.
- On average, 30% of women who have been in a relationship report that they have experienced some form of physical or sexual violence by their partner.
- Globally, as many as 38% of murders of women are committed by an intimate partner.
- Violence can result in physical, mental, sexual, reproductive health and other health problems, and may increase vulnerability to HIV.
- Risk factors for being a perpetrator include low education, exposure to child maltreatment or witnessing violence in the family, harmful use of alcohol, attitudes accepting of violence and gender inequality.
- Risk factors for being a victim of intimate partner and sexual violence include low education, witnessing violence between parents, exposure to abuse during childhood and attitudes accepting of violence and gender inequality.
- In high-income settings, school-based programmes to prevent relationship violence among young people (or dating violence) are supported by some evidence of effectiveness.
- In low-income settings, other primary prevention strategies, such as microfinance combined with gender equality training and community-based initiatives that address gender inequality and communication and relationship skills, hold promise.
- Situations of conflict, post conflict and displacement may exacerbate existing violence and present new forms of violence against women.

Introduction

The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."

Intimate partner violence refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviours.

Sexual violence is any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object.

Scope of the problem

Population-level surveys based on reports from victims provide the most accurate estimates of the prevalence of intimate partner violence and sexual violence in non-conflict settings. The first report of the "WHO multi-country study on women's health and domestic violence against women" (2005) in 10 mainly developing countries found that, among women aged 15–49:

- Between 15% of women in Japan and 71% of women in Ethiopia reported physical and/or sexual violence by an intimate partner in their lifetime;
- Between 0.3–11.5% of women reported experiencing sexual violence by a non-partner since the age of 15 years;
- The first sexual experience for many women was reported as forced – 17% in rural United Republic of Tanzania, 24% in rural Peru and 30% in rural Bangladesh.
- A more recent analysis of WHO together with the London School of Hygiene and Tropical Medicine and the Medical Research Council, based on existing data from over 80 countries, found that globally 35% of women have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence. Most of this violence is intimate partner violence. Worldwide, almost one third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner, in some regions this is much higher. Globally as many as 38% of all murders of women are committed by intimate partners.
- Intimate partner and sexual violence are mostly perpetrated by men against women and child sexual abuse affects both boys and girls. International studies reveal that approximately 20% of women and 5–10% of men report being victims of sexual violence as children. Violence among young people, including dating violence, is also a major problem.

Risk factors

Factors found to be associated with intimate partner and sexual violence occur within individuals, families and communities and wider society. Some factors are associated with being a perpetrator of violence, some are associated with experiencing violence and some are associated with both.

Risk factors for both intimate partner and sexual violence include:

- Lower levels of education (perpetration of sexual violence and experience of sexual violence);
- Exposure to child maltreatment (perpetration and experience);
- Witnessing family violence (perpetration and experience);
- Antisocial personality disorder (perpetration);
- Harmful use of alcohol (perpetration and experience);
- Having multiple partners or suspected by their partners of infidelity (perpetration); and
- Attitudes that are accepting of violence and gender inequality (perpetration and experience).

Factors specifically associated with intimate partner violence include:

- Past history of violence;
- Marital discord and dissatisfaction;
- Difficulties in communicating between partners.

Factors specifically associated with sexual violence perpetration include:

- Beliefs in family honour and sexual purity;
- Ideologies of male sexual entitlement; and
- Weak legal sanctions for sexual violence.

The unequal position of women relative to men and the normative use of violence to resolve conflict are strongly associated with both intimate partner violence and non-partner sexual violence.

Health consequences

Intimate partner and sexual violence have serious short- and long-term physical, mental, sexual and reproductive health problems for survivors and for their children, and lead to high social and economic costs.

- Violence against women can have fatal results like homicide or suicide.
- It can lead to injuries, with 42% of women who experience intimate partner reporting an injury as a consequence of this violence.
- Intimate partner violence and sexual violence can lead to unintended pregnancies, induced abortions, gynaecological problems, and sexually transmitted infections, including HIV. The 2013 analysis found that women who had been physically or sexually abused were 1.5 times more likely to have a sexually transmitted infection and, in some regions, HIV, compared to women who have not experienced partner violence. They are also twice as likely to have an abortion.
- Intimate partner violence in pregnancy also increases the likelihood of miscarriage, stillbirth, pre-term delivery and low birth weight babies.
- These forms of violence can lead to depression, post-traumatic stress disorder, sleep difficulties, eating disorders, emotional distress and suicide attempts. The same study found that women who have experienced intimate partner violence were almost twice as likely to experience depression and problem drinking. The rate was even higher for women who had experienced non-partner sexual violence.
- Health effects can also include headaches, back pain, abdominal pain, fibromyalgia, gastrointestinal disorders, limited mobility and poor overall health.
- Sexual violence, particularly during childhood, can lead to increased smoking, drug and alcohol misuse, and risky sexual behaviours in later life. It is also associated with perpetration of violence (for males) and being a victim of violence (for females).

Impact on children

Children who grow up in families where there is violence may suffer a range of behavioural and emotional disturbances. These can also be associated with perpetrating or experiencing violence later in life.

Intimate partner violence has also been associated with higher rates of infant and child mortality and morbidity (e.g. diarrhoeal disease, malnutrition).

Social and economic costs

The social and economic costs of intimate partner and sexual violence are enormous and have ripple effects throughout society. Women may suffer isolation, inability to work, loss of wages, lack of participation in regular activities and limited ability to care for themselves and their children.

Prevention and response

Currently, there are few interventions whose effectiveness has been proven through well-designed studies. More resources are needed to strengthen the prevention of intimate partner and sexual violence, including primary prevention (i.e. stopping it from happening in the first place).

Regarding primary prevention, there is some evidence from high-income countries that school-based programmes to prevent violence within dating relationships have shown effectiveness. However, these have yet to be assessed for use in resource-poor settings. Several other primary prevention strategies: those that combine microfinance with gender equality training; that promote communication and relationship skills within couples and communities; that reduce access to, and harmful use of alcohol; and that change cultural gender norms, have shown some promise but need to be evaluated further.

To achieve lasting change, it is important to enact legislation and develop policies that:

- Address discrimination against women;
- Promote gender equality;
- Support women; and
- Help to move towards more peaceful cultural norms.

An appropriate response from the health sector can play an important role in the prevention of violence. Sensitization and education of health and other service providers is therefore another important strategy. To address fully the consequences of violence and the needs of victims/survivors requires a multisectoral response.

WHO actions

WHO, in collaboration with a number of partners, is:

- Building the evidence base on the size and nature of violence against women in different settings and supporting countries' efforts to document and measure this violence and its consequences. This is central to understanding the magnitude and nature of the problem at a global level and to initiating action in countries;
- Strengthening research and research capacity to assess interventions to address partner violence;
- Developing technical guidance for evidence-based intimate partner and sexual violence prevention and for strengthening the health sector responses to such violence;
- Disseminating information and supporting national efforts to advance women's rights and the prevention of and response to violence against women; and
- Collaborating with international agencies and organizations to reduce/eliminate violence globally.

Handout 5.1: Case studies of intersectoral action

AUSTRALIA

This example focuses on the Health Lens Analysis (HLA) Project for improving the mobility, safety and well-being of Aboriginal people in South Australia. The Aboriginal Road Safety project is intended to collaboratively identify ways of increasing Aboriginal healthy life expectancy by improving road safety through increasing safe mobility options.

The South Australia HiAP approach is strongly linked to the achievement of the whole-of-government and whole-of-society objectives of South Australia's Strategic Plan (SASP), specifically when referring to Aboriginal healthy life expectancy and well-being. Policy changes calling for increasing the requirements for people to obtain a driving licence – in an effort to increase the perceived safety of the community – has had the unintended consequence of creating a system which makes it extremely difficult for Aboriginal people to successfully obtain a licence.

This results in people driving without a licence to go about their daily activities and risking the consequences: increased rates of mortality and morbidity, and/or conviction for driving-related offences. The case study illustrates how making the pathways to obtaining a driver's licence more accessible, through culturally appropriate systems and supports, can make a significant contribution to mobility, road safety and ultimately health and well-being.

This case represents an example of intersectoral cooperation and coordination for HiAP, where the health sector is a partner of the central state government that led the initiative.

Source: WHO (2013) *Moving towards Health in All Policies: a compilation of experiences from Africa, South-East Asia and the Western Pacific.* Geneva, WHO.

JORDAN

In order to address the burden of obesity in Jordan, the government steered the development of policy and programmatic measures that targeted food labelling, physical activity and the promotion of awareness of the social determinants of health and health equity.

Obesity was highlighted as a major health problem in Jordan in a case study presented at the World Conference on Social Determinants of Health in Rio 2011. The case study indicated that from the 2009 Demographic and Household Survey, it was estimated that 28% of women in Jordan were overweight and 29% obese. It indicated that overweight and obesity in women also showed a social gradient. Researchers recorded the factors influencing obesity in Jordanian society as including:

- The lack of appropriate places for women to practise exercise;
- Women with a large number of children;
- Low-income households; and
- The poor quality of foods consumed (mainly starchy foods).

In order to address the burden of obesity in Jordan, in relation to women in particular, the country trialled a social determinants of health programme that utilized policies by the government. These set of interventions were grouped into three headings: poor food choice, lack of exercise and lack of awareness. With respect to food choice, they targeted improving food labelling through the simplification of labelling. With respect to exercise, the Greater Amman Municipality opened four public gardens at specific times for women only, so that they could exercise and walk. With respect to awareness raising, a web presence on the issue of obesity and related social determinants was launched and instruments were developed to assess and improve knowledge, attitude and practice.

The key actors in the development of this work included: the Greater Amman Municipality, the Ministry of Health (who hosted the meeting for the nutrition labelling committee and the web page for SDH), and the High Health Council. Two additional mechanisms used for the intersectoral work included a technical committee and a steering committee. The nutrition labelling committee created included seven members with knowledge, expertise and interest in nutrition food labelling: Academia, MOH, Jordan Food and Drug Organization, Jordan Institution for Standards and Metrology, Amman Chamber of Industry, Jordan Chamber of Commerce and the Ministry of Industry and Trade. Further implementation and evaluation of the programmes is under way.

Source: Hourani HM, Naffa S and Fardous T (2011) National commitment to action on social determinants of Health in Jordan: Addressing obesity. World Conference on the Social Determinants of Health background paper, Rio de Janeiro, Brazil, WHO.

Handout 6.1a: Obesity and overweight

WHO Fact Sheet No. 311, updated August 2014; the complete factsheet including the policy recommendations which have been deleted from the handout text below is available at: www.who.int/mediacentre/factsheets/fs311/en/

Key facts

- Worldwide obesity has nearly doubled since 1980.
- In 2008, more than 1.4 billion adults, 20 and older, were overweight. Of these over 200 million men and nearly 300 million women were obese.
- 35% of adults aged 20 and over were overweight in 2008, and 11% were obese.
- 65% of the world's population live in countries where overweight and obesity kills more people than underweight.
- More than 40 million children under the age of five were overweight in 2012.
- Obesity is preventable.

What are overweight and obesity?

Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health.

Body mass index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of their height in metres (kg/m^2).

The WHO definition is:

- BMI greater than or equal to 25 is overweight;
- BMI greater than or equal to 30 is obesity.

BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages of adults. However, it should be considered a rough guide because it may not correspond to the same degree of fatness in different individuals.

Facts about overweight and obesity

Overweight and obesity are leading risks for global deaths. Around 3.4 million adults die each year as a result of being overweight or obese. In addition, 44% of the diabetes burden, 23% of the ischaemic heart disease burden and between 7% and 41% of certain cancer burdens are attributable to overweight and obesity.

Some WHO global estimates from 2008 follow:

- More than 1.4 billion adults, 20 and older, were overweight;
- Of these overweight adults, over 200 million men and nearly 300 million women were obese; and
- Overall, more than 10% of the world's adult population were obese.

In 2012, more than 40 million children under the age of five were overweight. Once considered a high-income country problem, overweight and obesity are now on the rise in low- and middle-income countries, particularly in urban settings. More than 30 million overweight children are living in developing countries and 10 million in developed countries.

Overweight and obesity are linked to more deaths worldwide than underweight. For example, 65% of the world's population live in countries where overweight and obesity kill more people than underweight (this includes all high-income and most middle-income countries).

What causes obesity and overweight?

The fundamental cause of obesity and overweight is an energy imbalance between calories consumed and calories expended. Globally, there has been:

- An increased intake of energy-dense foods that are high in fat; and
- An increase in physical inactivity due to the increasingly sedentary nature of many forms of work, changing modes of transportation, and increasing urbanization.

Changes in dietary and physical activity patterns are often the result of environmental and societal changes associated with development and lack of supportive policies in sectors such as health, agriculture, transport, urban planning, environment, food processing, distribution, marketing and education.

What are common health consequences of overweight and obesity?

Raised BMI is a major risk factor for noncommunicable diseases such as:

- Cardiovascular disease (mainly heart disease and stroke), which were the leading cause of death in 2012;
- Diabetes;
- Musculoskeletal disorders (especially osteoarthritis – a highly disabling degenerative disease of the joints);
- Some cancers (endometrial, breast, and colon).

The risk for these noncommunicable diseases increases, with the increase in BMI.

Childhood obesity is associated with a higher chance of obesity, premature death and disability in adulthood. But in addition to increased future risks, obese children experience breathing difficulties, increased risk of fractures, hypertension, early markers of cardiovascular disease, insulin resistance and psychological effects.

Facing a double burden of disease

Many low- and middle-income countries are now facing a "double burden" of disease.

- While they continue to deal with the problems of infectious disease and under-nutrition, they are experiencing a rapid upsurge in noncommunicable disease risk factors such as obesity and overweight, particularly in urban settings.
- It is not uncommon to find under-nutrition and obesity existing side-by-side within the same country, the same community and the same household.

Children in low- and middle-income countries are more vulnerable to inadequate pre-natal, infant and young child nutrition At the same time, they are exposed to high-fat, high-sugar, high-salt, energy-dense, micronutrient-poor foods, which tend to be lower in cost but also lower in nutrient quality. These dietary patterns in conjunction with lower levels of physical activity, result in sharp increases in childhood obesity while undernutrition issues remain unsolved.

Handout 6.1b Policy brief template

POLICY BRIEF TEMPLATE No more than 1–2 pages (400–800 words)
Preparation • Audience research – who am I writing for and why • Decide on key message and approach
Executive summary • A one- or two-sentence overview of the brief that entices readers to go further
Introduction • Answer the questions: "Why is the topic important?", "Why should people care?" • Answer the question: "What were the goals of the policy?" • Create curiosity about the rest of the brief
Approaches and results • Summarize facts, issues and context • Reduce detail to only what reader needs to know • Provide concrete facts or examples to support assertions
Conclusion • Base conclusions on results • Aim for concrete conclusions and strong assertions
Implications and recommendations • State clearly what could or should happen next

Handout 7.1: Stakeholder engagement case studies

Example of whole-of-society approach to HiAP: Awareness campaign on mental health and rights of people with mental illness in Egypt

From 2006 to 2011, the General Secretariat of Mental Health at the Egyptian Ministry of Health and Population ran an advocacy campaign with the theme: One Community Accepts All. This aimed to raise awareness and change Egyptians' conceptions and attitudes regarding the nature of mental illness, therapeutic approaches and the rights of people with mental illness. This campaign was timely support for the development, enactment and implementation of the 2009 legislation on the treatment of people with mental illness. Respect for the rights of people with mental illness could be achieved only through valuing the service users, their carers and professionals.

The advocacy campaign used television, short animation videos, street billboards, online materials disseminated through a dedicated web site, posters, community workshops, printed reading materials and radio programmes to reach the population. One example contains a narrated encounter between a job applicant and a human resource manager – the former is rejected on the basis of his psychiatric history. Service users, caregivers, nurses and psychiatrists in the field were invited to appear on television talk shows. Egyptian culture is traditionally spiritual at its base, so the appeal to righteousness encouraged protection of vulnerable individuals in the community.

The campaign worked through schools and universities. Mass communication faculties included the message in their educational programmes. Medical student associations from 10 universities arranged seminars and public awareness events including a cycling rally through the streets of Cairo to raise awareness of mental illness. Professional media producers volunteered advocacy tool kits and productions.

Programmes for physicians, nurses, and social workers strengthened implementation of the human rights approach embedded in the new Mental Health Act. Advocacy tool kits were produced for dissemination at primary health care centres. The large mental hospitals were opened up to the community, human rights organizations were invited to inspect them, and the media were invited to report on the living conditions. Parliamentarians, judges, prosecutors, lawyers and activists participated in community awareness events and training workshops focusing on human rights aspects for service users at psychiatric facilities.

Documentary films interviewing service users were produced, as well as exhibitions of photographs exposing living conditions within those hospitals. The single most effective approach in the campaign was the opportunity for service users to be heard. A long-term inpatient at Abbassia Hospital, Cairo, was invited to parliament to speak on the experience of being a patient in a psychiatric facility for decades. In collaboration with Cairo University, a study was implemented to evaluate the campaign's impacts on the Egyptian population.

Source: Loza N and Baghat F in Jenkins R and Minoletti A (2012) Promoting Mental Health: A Crucial Component of Public Health in Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies.* Finland, Ministry of Social Affairs and Health.

Example of whole-of-society approach to HiAP: Occupational safety and health (OSH) protection for grassroots farmers in Viet Nam and the Philippines

Agriculture accounts for 63% of the total workforce in Viet Nam and 36% in the Philippines. Both countries show a need to enhance awareness on safety and health among farmers. The Work Improvement in Neighbourhood Development (WIND) programme in Viet Nam has trained many volunteers to extend practical OSH information and methods to grassroots farmers. The training covers areas such as materials handling, work posture, machine and electrical safety, working environments, control of hazardous chemicals and welfare facilities. WIND farmer volunteers train their neighbours by demonstrating existing good local examples. The ILO/Japan Regional Programme for Capacity Building of Occupational Safety and Health trained 480 WIND farmer volunteers in 14 selected Vietnamese provinces between 2004 and 2007.

In the Philippines, the Department of Agrarian Reform and Department of Labour and Employment are working together to provide WIND training to farmers. The Vietnamese and Philippine experiences with WIND have been shared with Cambodia, India, Lao People's Democratic Republic, Nepal, Republic of Korea, Sri Lanka and Thailand. Countries in central Asia, Latin America, Africa and Eastern Europe have increasingly been applying the programme. Three factors contributed to the success of this approach:

- Well designed and validated methodology for training trainers using a training-by-doing approach, group learning and peer training strategies applied in villagers' own farms;
- Interventions were low-cost solutions affordable for farmers; and
- Involvement of volunteer villagers facilitated adjusting the methods to local conditions within a neighbourhood approach that generated trust and supported acceptance.

Source: Kawakami T, That Khai T, Kogi K (2012). Research that can support self-help initiative of local farmers to improve safety and health at work: birth and growth of WIND training program in Viet Nam. *Journal of Safety, Health & Environmental Research,* Vol. 8, No. 1, pp. 11–18 cited in Rantanen *et al.* (2012) Work, Health and Employment in Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies.* Finland, Ministry of Social Affairs and Health.

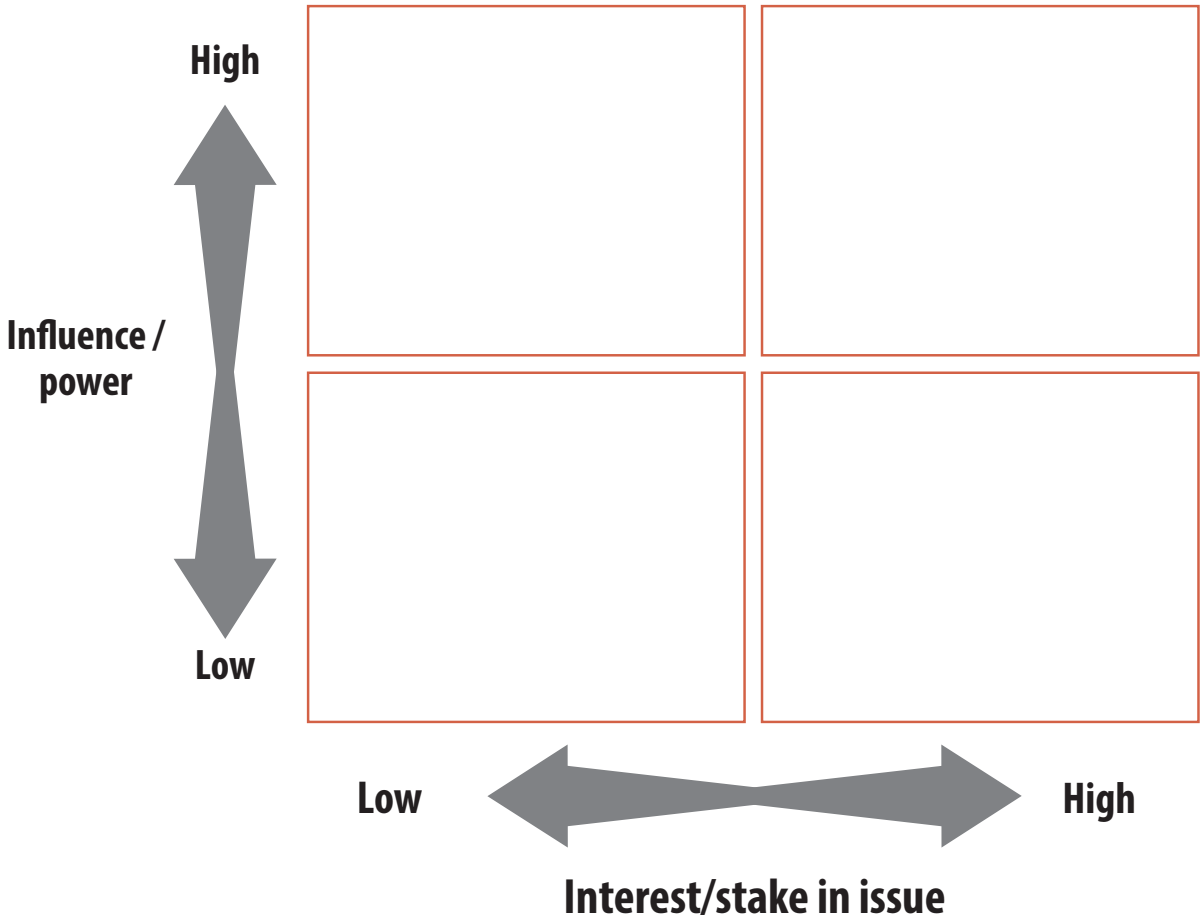
Handout 7.2: Stakeholder analysis

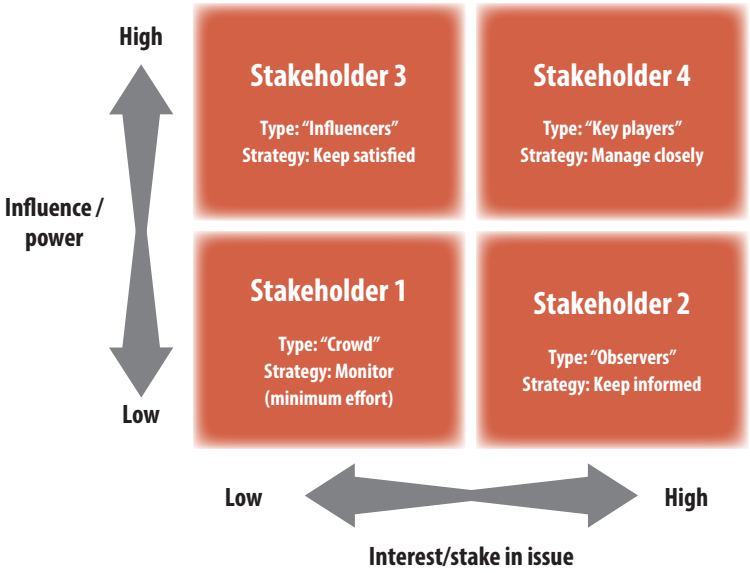
Instructions

In response to the UN Declaration on the Prevention and Control of NCDs, your health minister would like to establish a government task force to take action on NCDs. She wants to pursue a whole-of-society HiAP approach and has asked the NCDs team to conduct a stakeholder analysis of the most important actors, including government agencies, who are likely to be interested in or affected by the initiative. The minister would like to use this analysis to assess likely support and opposition before proposing the taskforce to her fellow ministers. If time permits, she would like you to also map these stakeholders onto a matrix of influence and interest.

Template

Name of stakeholder	Type (NGO, company, government department etc.)	Influence/ power (high or low)	Interest/stake in issue (high or low)	Likely position in relation to health ministry addressing NCDs through whole-of-society HiAP approach	Engagement priority (high, medium, low)


High
Influence / power
Low
Low
High
Interest/stake in issue


High
Influence / power
Low
Stakeholder 3
Type: "Influencers"
Strategy: Keep satisfied
Stakeholder 4
Type: "Key players"
Strategy: Manage closely
Stakeholder 1
Type: "Crowd"
Strategy: Monitor (minimum effort)
Stakeholder 2
Type: "Observers"
Strategy: Keep informed
Low
High
Interest/stake in issue

Handout 8.1: Cooperative or added-value negotiations

Cooperative negotiating or value-added negotiating (AVN)[1] seeks mutual gains for all parties by joint problem solving. It amounts to searching for ways to "add value" or make the "pie" bigger so that everyone gets a larger piece. Cooperative negotiators assume there are "win-win" solutions and behave in an open and collaborative way. This approach to negotiating consists of the following steps.

1. Clarify interests

Before you can even begin to formulate some possible agreements or "deals", you must know what you want and what the other party may want out of the negotiation. The AVN method begins with a search for interests on both sides. Starting with yours first, then those of the other, list the "big picture" issues that you're seeking to resolve.

2. Identify options

Every negotiation involves a number of principles or objectives of value, both tangible and intangible that can be traded off in the process of arriving at a satisfactory deal. Once you've clarified both parties' interests, take stock of these principles and objectives that are up for negotiation.

3. Create at least two or more "deal packages"

What makes cooperative negotiating or AVN so different from most other negotiating methods is its use of multiple deal opportunities. Instead of creating one offer and trying to force it on the other side, as in competitive negotiating, you create at least two, three or several possible deals, each with their own special appeal.

Once you've created at least two or three deals, it's time to become more critical and analyse them carefully. If you designed each deal on your own, taking the other party's needs into consideration, you'll have to give him or her time to evaluate what you have put together. You also may need to take some time to evaluate the packages from your own perspective, making sure these really are deals you want to offer.

4. Sell the deals and ask the other side to select one

This sales step is critical to the success of the AVN process. While you may understand the deal packages you've created for the other party, they may not. The more complex your deals, the more you need to describe the possibilities, including why you structured a certain suggested deal differently from another.

1 Based on online article with modification – Albrecht S (no date) Added Value Negotiating: Getting Win-Win Sales Success.

By discussing each of your deal packages in detail, you can help the other side feel more confident about the range of possibilities. If you simply give the deal packages to the other side with little or no explanation, they may not understand your thinking, or why you chose certain trade-offs over another. Selling the deals is crucial to helping the other side reach the next and last stage.

When you sit down with the other party, discuss only what you think are feasible deals. If none turn out to be attractive to the other party, design some more deals, either separately or together, or ask the other side to come up with some deal possibilities themselves. Compare all feasible deals, and settle on one you both like.

Once you both agree that there is at least one acceptable deal on the table, it's time to move to the last step.

5. Perfect the deal

People have a tendency to want to rush things as they reach this stage of the process. There is more involved at this point than just dotting the "i's" and crossing the "t's." This is your chance to make sure you've covered all the important details, that the relationship is still healthy and that you have a written agreement that all parties can live with.

Many people find out, to their great relief, that getting through all five steps of the AVN method is neither difficult nor stressful, especially when compared with the tug-of-war of a competitive or haggling negotiation.

AVN is based on openness, flexibility and a mutual search for the successful exchange of value. It allows you to build strong relationships with people over time. But the main advantage of added value negotiating comes down to one thing: better deals than could have been reached by any other method.

Handout 8.2: Ethical negotiating

The following tips will ensure that you build all your negotiations on a foundation of ethics[1] – which will increase your chances of achieving win-win outcomes. Ethical negotiators don't think only about what they can "get" out of a negotiation but also about what they can "give" to their counterpart. In this way, they take the long-term view. They know that a counterpart who walks away from a negotiation feeling successful will be willing to come back and negotiate again in the future.

Know what is non-negotiable

It is likely that there are some principles or positions that other parties will be unwilling or unable to abandon. This could be a permanent situation due to their beliefs or inherent interests. It could also be a temporary situation, such as the timing of the negotiations. It is important to know what is non-negotiable in order to avoid straining a relationship and wasting time. Knowing what is negotiable and what is not will make you a much more effective negotiator.

Remain honest

In a negotiation, whenever you are ethical and honest even though it costs you something, you gain points. If a counterpart makes an error that is to your advantage and you inform him or her of it, this costs you something – but it also earns you respect. The same principle of honesty applies to the way you present your position. Exaggerating the benefits of your preferred proposal and the disadvantages of the one preferred by another stakeholder is likely to create ill-will and suspicion that you are not sincerely searching for a win-win solution.

Keep your promises

In your eagerness to put a deal together, you may sometimes make promises and concessions you hadn't planned to make. You demonstrate your ethics when you fulfil those promises long after the desire to do so has left you.

Prepare multiple options

Going into a negotiation with multiple options will help both you and your counterpart achieve your goals. If someone proposes an option you feel is unethical, you will be ready with another, ethical option for accomplishing the same goal. Sometimes you may encounter negotiators who are unilateral thinkers who have only one option. With them, it's their way or the highway. If their way is unethical in your opinion, you have only one option – to walk away from the deal.

1 Based on online article with modification – Stark P and Flaherty J (2003) Ethical Negotiations: 10 Tips to Ensure Win-Win Outcomes. *Negotiator Magazine.*

Commit to saying "no" if necessary

Some negotiators are quite comfortable looking a counterpart in the eye and saying "no" when they feel something is not right. Others worry that saying "no" seems confrontational then later, they regret agreeing to the proposal. Committing to saying "no" when an agreement is not right despite genuine efforts to reach a solution is a great strength.

Know the law

Failing to properly research what is and isn't possible legally risks arriving at an unviable or unethical agreement. This compromises the negotiation and wastes time. When in doubt about the law governing some aspect of your negotiation, check it out.

Go with your gut

During negotiations, you might observe or note another stakeholder make a strange comment or behave in an unpredictable way. New information might create doubts or suspicions about the nature of the negotiations. In these situations, it is often sensible to trust one's gut feeling and act on it rather than ignoring what was noted.

Practise the concept of "no surprises"

Surprising another stakeholder and putting them in an uncomfortable situation is counter to the practice of cooperative negotiations based on honesty and searching for win-win solutions. Making sure that a negotiation does not contain any negative surprises will make you a more effective negotiator.

Respect others

The golden rule tells us to treat people the way we would like to be treated. Given differences in preferences and culture, it is often more sensible to treat other stakeholders in the particular way they want to be treated rather than according to your own unique preferences. Caring about your counterparts enough to treat them the way they want to be treated helps build long-term relationships based on ethics and trust.

Walk away from unacceptable deals

In negotiations, your head may try to rationalize deal points to make your gut feel more comfortable. Remember to go with your gut instinct, since it does not rationalize as well as your head. It is unproductive to make an agreement that you can't keep or one that ruins the possibility of future cooperation.

Handout 8.3: HiAP negotiations

Groups of stakeholders by city

BUENOS AIRES (6–9 Stakeholders)

- Mayor (chairperson/facilitator)
- Health ministry
- Education ministry
- Infrastructure, transport and housing ministry
- NGO
- Cattle farmers' association
- Tobacco lobby (optional)
- Food and beverages lobby (optional)
- Finance ministry (optional)

NAIROBI (6–7 Stakeholders)

- Mayor (chairperson/facilitator)
- Health ministry
- Education ministry
- Infrastructure, transport and housing ministry
- NGO
- Tobacco lobby
- Finance ministry (optional)

MEXICO CITY (6–8 Stakeholders)

- Mayor (chairperson/facilitator)
- Health ministry
- Education ministry
- Infrastructure, transport and housing ministry
- NGO
- Tobacco lobby
- Food and beverages lobby (optional)
- Finance ministry (optional)

MUMBAI (6–8 Stakeholders)

- Mayor (chairperson/facilitator)
- Health ministry
- Education ministry
- Infrastructure, transport and housing ministry
- NGO
- Food and beverages lobby
- Tobacco lobby (optional)
- Finance ministry (optional)

SÃO PAULO (6–8 Stakeholders)

- Mayor (chairperson/facilitator)
- Health ministry
- Education ministry
- Infrastructure, transport and housing ministry
- NGO
- Cattle farmers' association
- Tobacco lobby (optional)
- Finance ministry (optional)

SHANGHAI (6–7 Stakeholders)

- Mayor (chairperson/facilitator)
- Health ministry
- Education ministry
- Infrastructure, transport and housing ministry
- NGO
- Tobacco lobby
- Finance ministry (optional)

TEHRAN (6–7 Stakeholders)

- Mayor (chairperson/facilitator)
- Health ministry
- Education ministry
- Infrastructure, transport and housing ministry
- NGO
- Tobacco lobby
- Finance ministry (optional)

Mayor (chairperson/facilitator) (all cities)

As city mayor, you are chairman of the meeting. You are currently in the middle of your five-year term as mayor and a member of a centre-left political party. You are concerned about the poor health of many in the city and also view addressing the issue as an opportunity to gain popular support for when you stand as candidate in national elections in two years. This is not something you speak about openly. You tell the other stakeholders about the goal and the importance of the meeting to devise a plan to address cardiovascular disease. You are responsible for the smooth running of the meeting and managing time. You should ensure all stakeholders listen to each other and take turns presenting their views. The mayor is responsible for recording any agreements that are reached.

✂ . . . . . .

Health ministry (all cities)

Recently, the head of your ministry retired and was replaced by a well-respected deputy-head who has a reputation for publicly opposing vested interests counter to public health. She has directed you to call a meeting on addressing cardiovascular disease and to push for a strong and comprehensive action plan that has the support of as many sectors as possible. As negotiator for the health ministry, you are responsible for promoting the highest standard of health for the inhabitants of the city and the rest of the country. Your ministry defines health broadly as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It advocates for a HiAP approach to health challenges such as cardiovascular disease since it is caused by social, environmental and commercial determinants of health.

✂ . . . . . .

Education ministry (all cities)

As negotiator for the education ministry, you have been invited to attend a meeting on addressing cardiovascular disease. This is the first such meeting you have attended on a health issue and you are not clear about the causes of the disease or how the education sector can play a role. You do not want others to think you are ignorant so you will not reveal this to any of the other stakeholders. You have education meetings to attend later and it makes no difference to you whether an agreement is reached or not. You have some contributions to make but need to be actively convinced by other parties before you will adopt any position.

✂ . . . . . .

Infrastructure, transport and housing ministry (all cities)

You are an experienced former civil engineer and senior negotiator in the infrastructure, transport and housing ministry. You have been invited to attend a meeting to prepare an action plan to address cardiovascular disease. You are aware that poor transport and housing in the city, which is especially bad in some poorer neighbourhoods of the city, contributes to social conditions that cause cardiovascular disease. However, your ministry does not currently have any funds for major infrastructure work. One of the current priorities of your ministry is sustainable development including climate change mitigation and adaptation. Your ministry has a culture of working cooperatively with other ministries.

Finance ministry (all cities) (optional)

You recently heard about a meeting called by the health ministry and chaired by the mayor on an action plan to address cardiovascular disease. The head of your ministry has asked you to attend to "keep an eye on things". For the past three years, your country's economic growth has been positive but less than last decade. The priority of your ministry is to keep debt levels stable and promote economic activity. Your minister has publicly stated that youth unemployment is too high and he has privately expressed concern that job losses could create political instability.

✂ . . . . . .

NGO (all cities)

You are a senior adviser with the Non-Communicable Disease (NCD) Alliance, an international NGO focusing on the four main NCDs: cardiovascular disease, diabetes, cancer and chronic respiratory disease. The head negotiator of the health ministry has invited your organization to attend a meeting to devise an action plan for cardiovascular disease and has asked for your support.

✂ . . . . . .

Tobacco lobby (Mexico City, Shanghai, Nairobi, Tehran, all cities (optional)

As senior community liaison adviser for a coalition of local tobacco companies based in the country, you have been invited to attend a meeting to discuss an action plan for cardiovascular disease. The tobacco companies you represent see the country as a potentially growing market and are concerned by the prospect of greater government regulation of the promotion and advertising of tobacco, which is presently low compared with other countries. Your boss has instructed you to cooperate with the discussion as this is important for the image of the tobacco companies. However, this is less important than stopping the introduction of any anti-tobacco legislation. He suggests you look for ways to stop any agreement from being reached and if this isn't possible to weaken the action plan's effectiveness.

Food and beverages lobby (Mexico City, Shanghai, Nairobi, Tehran (all cities) (optional)

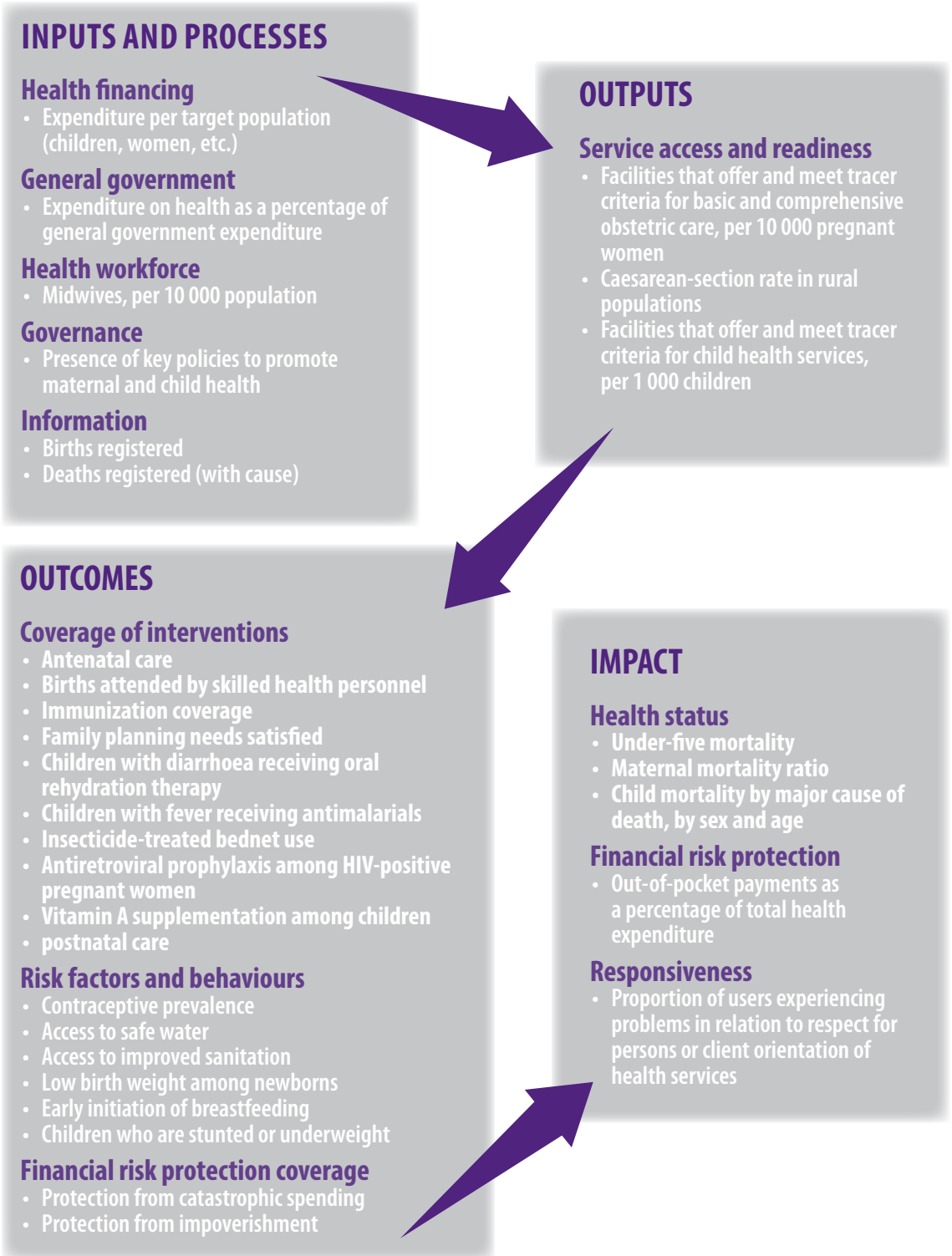
You are the senior communications officer for a coalition of local food and beverage companies in the country. These companies mainly manufacture soft drinks and snack foods high in fat, sugar and salt. Together, the companies directly employ around 50 000 workers in factories in the principal cities of the country and indirectly create further jobs associated with the delivery and sales of the goods. You have been invited to attend a meeting to discuss an action plan for cardiovascular disease. The companies that you represent are concerned about the possibility of government regulation that might harm their business. Your boss has instructed you to look for ways to stop any agreement from being reached and if this isn't possible to weaken the action plan's effectiveness.

✂ . . . . . .

Cattle farmers' association (São Paulo, Buenos Aires)

You are the head of the national cattle farmers' association and have been invited to a meeting to discuss an action plan for cardiovascular disease. The farmers that you represent produce large quantities of beef for national and international markets. They are also proud of the cattle industry's association with the country's culture but are concerned about the possibility of new government health regulations, such as dietary guidelines.

Handout 10.1a: Direct and indirect health indicators for reproductive maternal and child health monitoring[1]



1 Adapted from WHO (2013) *Handbook on Health Inequality Monitoring with a Special Focus on Low- and Middle-Income Countries.* Geneva, WHO, p. 5; WHO and World Bank (2014) Monitoring progress towards universal health coverage at country and global levels: framework, measures and targets. Geneva, WHO; International Health Partnership and WHO (2011) Monitoring, evaluation and review of national health strategies. A country-led platform for information and accountability. Geneva, WHO.

Handout 10.1b: Direct and indirect indicators for monitoring health

Sector	Indicator	Source
Demographics and socioeconomics	Population growth (annual %)	UN Population Division
	Urban population (% of total)	UN Population Division
	Population aged > 60 years (%)	WHO
	GNI per capita (PPP, USD)	World Bank
	Inequality (Gini coefficient)	World Bank
	Literacy	UNESCO
	Unemployment	ILO
Water	Improved sanitation facilities, urban (% of urban population with access)	WHO/UNICEF
	Improved water source, rural (% of rural population with access)	WHO/UNICEF
	Improved water source, urban (% of urban population with access)	WHO/UNICEF
	Water usage (% of total annual renewable water used)	FAO
Food	Malnutrition prevalence, height for age (% of children under 5)	WHO
	Under-nutrition (% of population below minimum level of caloric intake)	FAO
	Food supply (g/capita/day)	FAO
	Protein supply (g/capita/day)	FAO
	Fat supply (g/capita/day)	FAO
	Fruit and vegetable consumption	WHO
Energy and infrastructure	Solid fuels (% of population using solid fuels)	WHO
	Access to electricity (% of population)	IEA
	Passenger cars (per 1 000 people)	World Bank
	Rail lines (total route, km)	World Bank
	Traffic fatalities (estimated road traffic fatalities per 100 000)	WHO
Housing	Durable housing (% urban population living in durable housing)	UN-Habitat
	Slums (% of urban population living in slums)	UN-Habitat
	Overcrowding (% of urban population with sufficient living area)	UN-Habitat
Environment and pollution	Waste collection (% of population served by municipal waste collection)	UN Statistics Division
	Air pollution (PM10 micrograms per cubic metre)	World Bank
	Hazardous wastes generated (tonnes)	UN Statistics Division
	Forests (% total land area)	FAO
	Urban green space	Global City Indicators Facility

Handout 10.2: HiAP Key Results Annex, WHO Framework for Country Action[1]

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

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

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

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

3. **Assessing effectiveness of the HiAP approach:**
   a. Measuring longer term outcomes – what are trends in health, health equity, social determinants over time?
   b. Are there measureable changes in attitudes towards understanding of health determinants over time among the health sector, other sectors and individuals and communities?
   c. Assessing continued need and effectiveness.

1 http://www.who.int/healthpromotion/frameworkforcountryaction/en/

Handout 10.3: M&E case studies

NORWAY

In Norway, a national cross-sectoral monitoring system to track determinants explaining the social gradient in health has been institutionalized. Evidence on the social determinants of health and health equity outcomes are collected and reviewed by theme working groups to assess relationships with budgets and actions. Technical groups set up across relevant sectors to identify and review evidence on outcomes provided a means of subjecting the assumptions and judgements on attribution to more collective and transparent review, so as to improve their credibility and quality. In a review of several evaluation experiences, the review by Loewenson (2013) suggests that the evaluation of impact is still an underdeveloped area, and one where further work is needed on the methods and approaches that may be applicable in different contexts.

Sources: Norwegian Ministry of Health and Care Services (2006–2007). National strategy to reduce social inequalities in health. Oslo, Norwegian Ministry of Health and Care Services; Loewenson R (2013) Evaluating intersectoral processes for action on the social determinants of health: learning from key informants (Social Determinants of Health Discussion Paper 5: Policy & Practice). Geneva, WHO.

THAILAND

Through its National Health Act aimed at health system reform, Thailand created the National Health Assembly (NHA), which is "a legitimate multi-stakeholder platform to support participatory public policy formulation taking into account a health lens in such policy-making with full engagement by the three powers at all stages of policy development." The NHA uses the whole-of-government approach recognizing all levels of government in planning, decision-making and in creating policies and programmes.

In 2000, the National Health System Reform Committee and the National Health System Reform Office were established to steer health systems reform in Thailand and mandated to draft the National Health Bill. The roles of civil society were promoted to engage in the health reform activities, and, since then, active intersectoral collaboration has begun.

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

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

Sources: WHO (2013) *Moving towards Health in All Policies: a compilation of experiences from Africa, South-East Asia and the Western Pacific.* Geneva, WHO.

Handout 10.4a: HIA case study[1]

Background information and task description

One of the largest automobile manufacturers in the region has announced a search for a new factory site, and the government of your country has put forward your city as a candidate for the tender.

Your city has to make the proposal during a sensitive period of economic transition. The proposal must reflect the main political drivers for your country, which are to attract more foreign direct investment and to increase both the profile and prestige of your country. These drivers are associated with including tax sweeteners in the proposal with the aim of making the proposal more attractive to the manufacturer. As economic development is one of the main priorities for your city, submitting a response to this tender fits with the city's strategy. In addition, this investment will create about 5 000 jobs, which will help reduce the unemployment currently being experienced in your city. This is especially important, since a significant industrial site near the city is about to close during the same time period.

There appears to be substantial interest in this proposal and a range of stakeholders have asked for greater clarity about the potential economic, social and environmental impact of the construction and long-term presence of a car factory. To inform whether the city should tender for the project, the mayor has commissioned an impact assessment and asked for the assistance of the federal health ministry to analyse the direct and indirect benefits and risks to health.

You and your colleagues in the HIA team of the health ministry have been tasked with submitting draft terms of reference for a health HIA. You are asked to:

1. Identify stakeholders that should be consulted.
2. List the primary issues that must be considered to conduct a robust HIA and the secondary issues that ideally would be included if time and resources permitted.
3. Outline a methodology describing some of the questions you plan to ask the identified stakeholders and the data you plan to collect.

1 With modification, based on case study from WHO (2005) *Health Impact Assessment Toolkit for Cities, Training Module.* WHO, Copenhagen, p. 38.

Handout 10.4b: HIA terms of reference template

HIA terms of reference	
1. Stakeholders to engage	
i. Environment Ministry ii. . . . iii. . . . iv. . . . v. . . .	
2. Issues to investigate	
Primary	**Secondary**
i. Pollution ii. . . . iii. . . . iv. . . . v. . . .	i. . . . ii. . . . iii. . . . iv. . . . v. . . .
3. Methodology	
Interviews	
Stakeholder	**Questions**
i.	
ii.	
Data collection	
Indicator/measure	
i. Air quality ii. . . . iii. . . . iv. . . . v. . . .	

Handout 11.1: Case studies of innovative health sector leadership

SLOVENIA

The first initiative to address health inequities took place in 2000, with a regional development agenda aimed at reducing regional disparities including health. Supported by the policies – Strategy to Tackle Health Inequalities and Health Promotion Strategy and Action Plan for Tackling Health Inequalities in Pomurje – the MURA programme (named after the River Mura) aimed at reducing inequalities in economic growth in Pomurje. This is an example of a pilot initiative requiring innovative leadership by the ministry of health. The programme aimed to address disparity in economic growth in one of the country's most deprived areas. Reductions in health inequalities was an implicit goal. Actions carried out involved financial support for the programme, collaboration at different levels of government and integration of health promotion into policies in different sectors.

In the eight years since the issues tackled through MURA were first raised, significant influence in terms of establishing an investment for health approach to regional development has resulted. Accordingly, the programme was repeated as one of three policy priorities in the Implementation Plan (which ran from 2004 to 2006) of the 2000–2006 Regional Development Plan for Pomurje. It is an example of where the primary motivation was not health equity but tackling the social determinants as part of regional development in order to reduce the differences in economic and development opportunities between Pomurje and other regions in Slovenia. The MURA programme is of interest to policy-makers wanting to take action in this area because it highlights:

- How to do this successfully, particularly in getting different sectors (such as agriculture and education) to engage and collaborate on a common agenda; and
- How this was done without health or health equity having to be the end goal. Its innovative approach recognizes the importance of the wider socioeconomic determinants of health and provides concrete examples of how these may be addressed in a collaborative way across sectors to achieve several aims at once, including improvements in health and a reduction in the differences between regions in terms of health outcomes.

Sources: Buzeti T and Zakotnik J (2008) Investment for Health and Development in Slovenia: Programme MURA. Murska Sobota: Centre for Health and Development; WHO (EURO) Resource of health system actions on socially determined health inequalities; and The European Portal for Action on Health Inequalities.

SOUTH AFRICA

This case study describes the Health Promoting Schools (HPS) programme in South Africa from 1995 to date. The case study describes a situation where the health sector partners with education and actively participates in policy development and implementation. The school provides a setting for cross-sectoral work between education, health and other sectors to prevent factors that place learners at risk, such as poverty, violence, substance abuse and HIV/AIDS. It is a national level policy and programme, with further exploration of evidence from a rural primary school site in Western Cape initiated in 1996.

This programme was initiated as a response to shared policy actions across health and education sectors and with support from WHO, to address concerns based on international experience. Following increasing demand for processes to support institutionalization, including guidelines on roles and responsibilities, consistent training, budget support and formal tools for monitoring and evaluation, the policy and programme were progressively institutionalized and integrated between 1994 and 2000. In 2000, the National Committee for Education Support Services recommended that all aspects of the HPS strategy be adopted to ensure the development of healthy school policies, supportive learning environments, strong community links, personal skills development and the provision of appropriate education support services. Additionally, the National Directorate of Health Promotion included the HPS in its five-year plans and provided support through provincial structures. At local level, for example, Western Cape set up an intersectoral provincial reference group comprising members of the departments of health and welfare and education, community-based organizations, volunteers and members of the private sector to introduce, implement and sustain the HPS concept in schools. In all cases, health and education departments seemed to be co-leaders. There also seems to have been a limited budget for implementation.

The issues addressed in South Africa were many, including road safety, personal hygiene, substance abuse, HIV and nutrition, with processes such as teenage clubs, after-care programmes for cultural activities, outdoor educational activities such as camps, and support groups for teachers' health promotion.

Source: WHO (2013). Moving towards Health in All Policies: a compilation of experiences from Africa, South-East Asia and the Western Pacific. Geneva: WHO.

Handout 12.1: Next steps

The images below or a similar range of photos applied to another subject, as described in Module 12, can be enlarged on separate pieces of paper to prompt discussion of applying HiAP in practice.

F: EVALUATION FORMS[1]

Template one

TRAINING WORKSHOP EVALUATION	
Please indicate your agreement/disagreement with the statements below using the following scale: 1 = Strongly disagree 3 = Somewhat agree 2 = Somewhat disagree 4 = Strongly agree	
DESCRIPTION	YOUR SCORE
ABOUT THE TRAINING	
1. The training objectives set were made clear at the beginning of each activity	
2. The training objectives have been achieved	
3. The presentations were helpful for the participants' learning	
4. The methods of training used during the workshop were appropriate	
5. Training materials were consistent with the training objectives	
6. Training materials were adequate	
7. The training flowed in such a way that learning was enhanced	
8. Time provided during the training to share trainer's experiences was adequate	
ABOUT THE PARTICIPANTS	
9. Most participants were active in the discussion	
10. Most participants enhanced my learning process	
11. There was good collaboration in my group	
12. Most of the participants were open to new ideas	
13. I have had the opportunity to ask questions	
14. I learned new things in the workshop	
15. I shall be able to use the skills I have gained for improving my performance	
16. My expectations were met	
ABOUT THE FACILITATORS	
17. Good knowledge of the topic	
18. Enough content presentation	
19. Objective in discussing topics	
20. Immediate response to changes in situation based on participants' needs	
21. Appropriate teaching methodologies	

1 WHO (2010) WHO Training Evaluation Guide. Geneva, WHO.

22. Effective in motivating participants	
23. Skilled in relating with participants	
24. Good listener	
25. There was good time management	
26. Comments, insights, lessons learned on the whole training including how to improve future training:	

Thanks a lot!

PARTICIPANTS' TRAINING EVALUATION

Instructions: For each component of the course, please select the score which best fits your rating. Comments are welcome. Thanks!

COURSE	STRONGLY DISAGREE	DISAGREE	+/-	AGREE	STRONGLY AGREE
I had the prerequisite knowledge and skills for this course	1	2	3	4	5
The content is relevant to my work	1	2	3	4	5
The course met my expectations	1	2	3	4	5
Comments on the course:					

COURSE CONTENT AND ACTIVITIES	STRONGLY DISAGREE	DISAGREE	+/-	AGREE	STRONGLY AGREE
The course content is consistent with the objectives	1	2	3	4	5
The course activities stimulated my learning	1	2	3	4	5
The content of the documents is clear	1	2	3	4	5
The content of the documents is appropriate to the course content	1	2	3	4	5
The content of the documents was sufficient	1	2	3	4	5
Comments on the course:					

FACILITATION	STRONGLY DISAGREE	DISAGREE	+/-	AGREE	STRONGLY AGREE
The facilitators were helpful for my learning process	1	2	3	4	5
The facilitators performed a good facilitation of the course	1	2	3	4	5
Comments on the course:					

COURSE ENVIRONMENT AND ORGANIZATION	STRONGLY DISAGREE	DISAGREE	+/-	AGREE	STRONGLY AGREE
The training room was comfortable	1	2	3	4	5
The administrative support was helpful	1	2	3	4	5
The travel arrangements were well done	1	2	3	4	5
The venue and accommodation were comfortable	1	2	3	4	5
Comments on the course:					

OVERALL COMMENTS
In general, what worked well?
In general, what didn't work well?
What did you think about the length of the course? ❑ Too long ❑ Just right ❑ Too short
Any other comments or suggestions you have will be greatly appreciated:

Template two

END OF WORKSHOP EVALUATION

Date:
On a scale of 1–4, circle the answer that best indicates your level of agreement.

1. Before coming to the workshop, to what extent were you informed about the purpose of this workshop?	Not at all 1	2	3	Completely 4
2. Was the workshop content consistent with the stated objectives?	Not at all 1	2	3	Completely 4
3. To what extent did the workshop meet your expectations?	Not at all 1	2	3	Completely 4
4. To what extent do you expect this workshop to make a difference in the way you do your job?	Not at all 1	2	3	Big Difference 4
5. Overall, how would you rate the usefulness of this workshop?	Not useful 1	2	3	Very useful 4
6. To what extent did the workshop provide the following?	Very poor			Excellent
A. Applicable theoretical information	1	2	3	4
B. Practical examples	1	2	3	4
C. Time for discussion	1	2	3	4
D. Appropriate exercises for learning the content	1	2	3	4

Additional comments about these topics:

7. Overall, how would you rate the following aspects of the workshop?	Very poor			Excellent
A. Organization of the training	1	2	3	4
B. Organization of the training manual	1	2	3	4
C. Workshop content in the manual	1	2	3	4

Additional comments about these topics:

8. What did you like most about this workshop?

9. What did you like least about this workshop?

10. If you were given the task of redesigning the workshop, what would you change?

11. Any other suggestions?

TRAINING EVALUATION FORM

Name: Date:

The statements below relate to aspects of this training programme. Please indicate to what extent you agree or disagree with these statements on a scale of 1 to 5, as follows:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

After each statement, circle the number you feel is appropriate. You may add comments beneath each section if you wish.

CONTENT

A. The objectives of the training were explained clearly	1	2	3	4	5
B. The objectives were achieved	1	2	3	4	5
C. I understood the presentations and explanations	1	2	3	4	5
D. The training was relevant to my work	1	2	3	4	5

Comments on the content of training:

METHODS

A. The trainee's workbook helped me understand the content	1	2	3	4	5
B. Class discussions helped me achieve the objectives	1	2	3	4	5
C. The role play was a useful exercise	1	2	3	4	5
D. The slide presentation made difficult points clearer	1	2	3	4	5

Comments on the training methods:

FACILITIES

A. The training room had all the facilities we needed	1	2	3	4	5
B. The meals were adequate	1	2	3	4	5
C. The accommodation was comfortable	1	2	3	4	5

Comments on the facilities:

FACILITATOR

A. Knew the subject matter in detail	1	2	3	4	5
B. Gave clear explantion of the topic	1	2	3	4	5
C. Encouraged group discussion and got everyone involved	1	2	3	4	5
D. Asked for questions and responded to them appropriately	1	2	3	4	5

Comments on the facilitator:

OVERALL TRAINING SESSION

On a scale of 1 to 10, where 1 is "Hopeless" and 10 is "Extremely helpful", give a rating to the training session as a whole.

Hopeless									Extremely helpful
1	2	3	4	5	6	7	8	9	10

Overall comments:

G: GLOSSARY[1]

Burden of disease

The burden of disease is a measurement of the gap between a population's current health and the optimal state where all people attain full life expectancy without suffering major ill-health.

Capacity building

Capacity building is the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion.

Community

A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them.

Cross-sectoral action

See intersectoral action.

DALY

Disability-adjusted life year (DALY) is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death.

Determinants of health

The range of personal, social, economic and environmental factors that determine the health status of individuals or populations. The determinants of health can be grouped into seven broad categories: socioeconomic environment; physical environments; early childhood development; personal health practices; individual capacity and coping skills; biology and genetic endowment; and health services. To this, some also add commercial and political determinants.

Epidemiology

Epidemiology is the study of the distribution and determinants of health-states or events in specified populations, and the application of this study to the control of health problems.

Equity

The absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically or geographically.

Evidence-based health promotion

The use of information derived from formal research and systematic investigation to identify causes and contributing factors to health needs and the most effective health promotion actions to address these in given contexts and populations.

1 Compilation based on the glossaries contained in Leppo K *et al.* (2013) *Health in All Policies: Seizing Opportunities, Implementing Policies.* Finland, Ministry of Social Affairs and Health; WHO (1998) *Health Promotion Glossary.* Geneva, WHO; and Smith B *et al.* (2006) WHO Health Promotion Glossary: New Terms. *Health Promotion International,* Vol. 21. No. 4. Oxford University Press, pp. 340–345.

Framing

Framing refers to how an issue is defined, which can in turn influence how the issue is viewed (non-issue, problem, crisis etc.), who is considered responsible and the cause and possible solutions.

Global health

Global health refers to the transnational impacts of globalization upon health determinants and health problems which are the beyond the control of individual nations.

Governance

Broadly concerns the agreed actions and means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals. Governance can be formed at different levels of social organization – local, state/provincial, national, regional and global – which can become closely intertwined.

Health

A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Reference: WHO Constitution. Geneva, WHO, 1948.

Health expectancy

Health expectancy is a population-based measure of the proportion of expected life span estimated to be healthful and fulfilling or free of illness, disease and disability according to social norms and perceptions and professional standards.

Health for all

The attainment by all the people in the world of a level of health that will permit them to live a socially and economically productive life. Health for all has served as an important focal point for health strategy for WHO and its Member States for almost 20 years.

Health impact assessment (HIA)

A combination of procedures, methods and tools that assess the potential effects of a policy or project on the health of a population and the distribution of those effects within the population. HIAs also identify appropriate actions to manage those effects.

Health in All Policies (HiAP)

Health in All Policies (HiAP) 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. It improves accountability of policy-makers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being.

Health inequity

Differences in health that are unnecessary and avoidable and, in addition, are considered unfair and unjust. The CSDH states that such differences must be systematic and considered avoidable by reasonable action globally and within societies.

Health outcomes

A change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.

Health policy

A formal statement or procedure within institutions (notably government), which defines priorities and the parameters for action in response to health needs, available resources and other political pressures.

Health promotion

The process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. An evolving concept that encompasses fostering lifestyles and other social, economic, environmental and personal factors conducive to health. Reference: Ottawa Charter for Health Promotion. Geneva, WHO, 1986.

Health sector

Organizations that are held politically and administratively accountable for the health of the population at various levels: international, national, regional and local.

Health service

A formally organized system of established institutions and organizations, the multi-purpose objective of which is to cope with the various health needs and demands of the population.

Health status

A description and/or measurement of the health of an individual or population at a particular point in time against identifiable standards, usually by reference to health indicators.

Health system

All the organizations, institutions and resources that are devoted to producing health actions.

Healthy cities

A healthy city is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.

Healthy public policy

Healthy public policy is characterized by "an explicit concern for health and equity in all areas of policy, and by accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens. It makes social and physical environments health enhancing". The term "healthy public policy" is a synonym for HiAP and an early term used in the health promotion movement. See also whole-of-government. Reference: Adelaide Recommendations on Healthy Public Policy. Geneva, WHO, 1988.

Indicator

A health indicator is a characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population (quality, quantity and time).

Intersectoral action

Intersectoral action refers to the coordinated efforts of two or more sectors within government to improve health outcomes. This can include working across different levels of government such as district, provincial and national jurisdictions. The term intergovernment is sometimes used to refer to these horizontal and vertical linkages between levels of government within a country. Whole-of-government, joined-up government and healthy public policies are similar terms used in the HiAP literature.

Joined-up government

See whole-of-government.

Lifestyle

Lifestyle is a way of living based on identifiable patterns of behaviour which are determined by the interplay between an individual's personal characteristics, social interactions and socioeconomic and environmental living conditions.

Living conditions

Living conditions are the everyday environment of people, where they live, play and work. These living conditions are a product of social and economic circumstances and the physical environment – all of which can impact upon health – and are largely outside of the immediate control of the individual.

Monitoring and evaluation

Monitoring can be defined as the systematic collection of data about an indicator or variable of interest. Evaluation, in contrast, involves a judgement about the value of or change in that variable.

Policy brief

A policy brief is a document which outlines the rationale for choosing a particular policy alternative or course of action in a current policy debate. It is part of the agenda setting and policy formation stages of the policy cycle.

Policy champion/entrepreneur

Policy champions and policy entrepreneurs are crucial to the HiAP approach. A policy champion is a person or team willing and able to lead and manage the policy process. Entrepreneurial policy-makers are able to break with habits and initiate new policies. Their creative acts have transformative effects on politics, policies or institutions.

Population health

The health outcomes of a group of individuals, including the distribution of such outcomes within the group. Crucial to the concept of population health is the idea that most cases in a population come from individuals with an average level of exposure (rather than high-risk groups). A small (clinically insignificant) change at a population level yields a greater impact on population health and well-being than an intervention on high-risk groups.

Primary health care

Primary health care is essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable. Reference: Alma-Ata Declaration. Geneva, WHO, 1978.

Public health

Public health refers to all organized efforts of society to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases.

Risk conditions

The social, economic, geographical and environmental conditions into which people are born. They encompass the social determinants of health; condition and constrain health opportunities; and are causally associated with an increased probability of a disease or injury, lower self-reported health and with risk factors.

Risk factor

An attribute or exposure which is causally associated with an increased probability of a disease or injury.

Social determinants of health

The WHO CSDH defined this as the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. The CSDH took a holistic view of social determinants of health, arguing that "the poor health of the poor, the social gradient in health within countries and the marked health inequities between countries are caused by the unequal distribution of power, income, goods and services."

Stakeholder

A stakeholder is a person, or group of persons, who have an interest or concern in a particular process or issue due to direct or indirect involvement. Examples include government ministries, politicians, non-government organizations, religious organizations, research institutes, labour unions, professional associations and businesses.

Strategy

Broad lines of action to be taken to achieve goals and objectives, incorporating the identification of suitable points of intervention; ways of ensuring the involvement of other sectors; the range of political, social, economic, managerial and technical factors; as well as constraints and ways of dealing with them.

Universal health coverage

The goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. This requires: a strong, efficient, well-run health system; a system for financing health services; access to essential medicines and technologies; and a sufficient capacity of well-trained, motivated health workers.

Wellness

Wellness is the optimal state of health of individuals and groups. There are two focal concerns: the realization of the fullest potential of an individual physically, psychologically, socially, spiritually and economically, and the fulfilment of one's role expectations in the family, community, place of worship, workplace and other settings.

Whole-of-government

A whole-of-government approach refers to the coordinated efforts of two or more sectors within government to improve health outcomes. This can include working across different levels of government such as district, provincial and national jurisdictions. Joined-up government and healthy public policies are similar terms used in the HiAP literature.

Whole-of-society

A whole-of-society approach refers to coordinated efforts to improve health by multiple stakeholders within and outside government that may also be from several sectors.

Window of opportunity

Windows of opportunity are short periods of time in which, simultaneously, a problem is recognized, a solution is available and the political climate is positive for policy change.

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ISBN 978 92 4 150798 1