

Report

of the

Expert Consultation on “Intersectoral Action on Health, a path for policy-makers to implement effective and sustainable action on health”

29-30 May 2014

Kobe, Japan



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List of abbreviations

APHA	American Public Health Association
CRICH	Centre for Research on Inner City Health
FCTC	Framework Convention on Tobacco Control
HiAP	Health in All Policies
HIA	Health Impact Assessment
ISA	Intersectoral Action
ISAHE	Intersectoral Action for Health Equity
NCD	Non-communicable Disease
NSA	Non-State Actors
NGO	Non-governmental Organization
SA	South Australia
SDH	Social Determinants of Health
WHA	World Health Assembly
WHO	World Health Organization
WKC	World Health Organization Centre for Health Development (WHO Kobe Centre)
UHC	Universal Health Coverage
UN	United Nations

Executive summary

In 2011, WHO Centre for Health Development (WKC) with WHO Headquarters, Regional Offices, and other collaborators, published a guidance booklet on intersectoral action on health (ISA) titled *“Intersectoral Action on Health, a path for policy-makers to implement effective and sustainable action on health”* (‘ISA booklet’ hereafter). Since the publication of the ISA booklet, WKC and other WHO offices have conducted case studies and other research activities and organized meetings in reference to the ISA booklet. More evidence on the practical implementation of ISA was produced. Attention to ISA has increased at the global level, and is supported by high-level declarations, such as:

- *The Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases;*
- *The Rio Political Declaration on Social Determinants of Health at the World Conference on Social Determinants of Health;*
- *The Helsinki Statement on Health in All Policies (HiAP) and the subsequent WHO Health in All Policies Framework for Country Action; and*
- *The 67th WHA Resolution A67/R12 on Contributing to social and economic development: sustainable action across sectors to improve health and health equity.*

Based on these recent global developments and evidence on ISA/HiAP, WKC proposed to revise the ISA booklet. WKC’s goal is to develop a new version of the ISA booklet to give guidance for policy-makers on how to implement ISA, and to support WHO’s organization-wide work on ISA and HiAP (e.g. including the implementation of the WHA Resolution A67/R12 and its follow up of the HiAP Framework for Country Action), urban health (e.g. responses to Urban HEART), and universal health coverage.

The Expert Consultation on *“Intersectoral Action on Health, a path for policy-makers to implement effective and sustainable action on health”* held in Kobe, Japan, 29-30 May 2014, was held to collectively examine and critique the ISA booklet and develop recommendations for its revision. The meeting was attended by 36 participants, including policymakers and practitioners from different sectors and levels of government, representatives of the civil society, academia and WHO.

The ISA booklet was thoroughly reviewed and recommendations for the revision were collected through the following sessions during the 2-day meeting:

- The background documents for the meeting included a synthesis of 16 WHO case studies on ISA, using the 10 steps in the ISA booklet as the framework for analysis, and an online survey of the participants’ views and comments on the ISA booklet conducted prior to the meeting;
- Four plenary sessions with presentations and discussions on recent studies and guidance on ISA/HiAP and ISA/HiAP experiences at the national government, local government and civil society;
- Three breakout group work sessions to further discuss and suggest recommendations on the overall utility and purpose of the revised ISA booklet and on the 10 steps mentioned in the ISA booklet.

A summary of the recommendations for the revision of the ISA booklet is as follows:

A. General recommendations on the revised ISA booklet

- Consider developing two products, each targeting different audiences: (i) Short (advocacy) document for high-level policy-makers; (ii) Detailed “How-to” guideline for technical staff.
- Align with the WHO HiAP Country Framework and other relevant documents. Build on the existing ISA and HiAP literature and history. Clarify the key concepts and terms around ISA (i.e. HiAP, multisectoral action, whole-of-government approach, etc.)
- Focus on the implementation of ISA and technical “how-to” elements such as skills and techniques on how to perform ISA. For example, include practical information such as case examples to highlight the elements and concepts, indicators that show the results of ISA, expected timeline for ISA, etc.
- Develop a systematic dissemination plan and plan a launch event. Utilize key events and conferences for dissemination and provide capacity building opportunities such as webinars or on-line lectures.
- Monitor and evaluate the use of the booklet. Develop a feedback mechanism.
- Keep the ISA booklet concise, and supplement with other tools and documents.
- Use interactive multimedia, info-graphics and other visual resources.
- Use more approachable language (especially to other sectors), i.e. less jargon and less technical terms, so it can be more easily understood by other sectors and policymakers.
- Translate the ISA booklet into other languages to reach a wider audience.

B. Recommendations on the key elements for ISA

- Reduce the number of steps by combining/grouping and rearranging the current 10 steps. Add ‘building capacity’ and ‘sharing and celebrating success’ as separate elements.
- Emphasize the iterative process of ISA, use a different term to replace ‘steps’.
- Emphasize and strengthen details on the use of laws as a mandate and operational rules for ISA and other governance tools/instruments/mechanisms that strengthen ISA.
- Individual and institutional competencies are required to understand other sectors’ priorities and to facilitate engagement with other sectors. Practical guidance on building and utilizing these skills, techniques, arguments should be addressed in the ISA booklet.
- The role and participation of private sector in ISA should be addressed in the ISA booklet, and the complexity and the issue of conflict of interest should be recognized.

1. Background

- 1.1. In 2011, after a series of expert consultations, WHO Centre for Health Development (WKC) with WHO Headquarters, Regional Offices, and other collaborators, developed and published a guidance booklet on intersectoral action on health (ISA) titled *“Intersectoral Action on Health, a path for policy-makers to implement effective and sustainable action on health”* (ISA booklet hereafter)¹;
- 1.2. This short booklet summarizes a set of recommendations, lessons and approaches to initiating and implementing intersectoral action on health as an overall strategy for public policy. The ISA booklet includes a series of steps which policy-makers can take to promote multi-sector health initiatives, which is further illustrated by six case examples;
- 1.3. WKC and other WHO offices have conducted a number of activities in reference to the ISA booklet:
 - 1.3.1. The ISA booklet was included in Annex 6 of the *“Global status report on noncommunicable diseases 2010: Description of the global burden of NCDs, their risk factors and determinants”* as a recommended approach to implementing effective and sustainable multisectoral action on health;
 - 1.3.2. It was also included as a background material for “taking action” to the “whole of government” and “whole of society” responses of the *UN Political Declaration on the Prevention and Control of Non-communicable Diseases*;
 - 1.3.3. WKC, in collaboration with the WHO Regional Offices, funded and conducted a series of case studies to further describe and gather evidence on ISA in multiple settings;
 - 1.3.3.1. Case studies on intersectoral action on health in urban settings;
 - 1.3.3.2. Case studies on intersectoral action in healthy urban planning;
 - 1.3.3.3. Case studies on intersectoral action at different levels of government, conducted in collaboration with WHO Regional Offices.
- 1.4. Since the publication of the ISA booklet in 2011, WHO and Member States have gathered more evidence of practical implementation of ISA through compilation of several case studies, new research, and sharing information through meetings. Attention to ISA and related concepts including Health in All Policies has increased, and have emerged in international conference declarations;
 - 1.4.1. The *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases* adopted at the UN General Assembly in September 2011;

¹ WHO Centre for Health Development. (2011): *Intersectoral action on health: A path for policy-makers to implement effective and sustainable action on health*. Kobe, Japan. Available at: http://www.who.int/entity/kobe_centre/publications/ISA-booklet_WKC-AUG2011.pdf

- 1.4.2. The *Rio Political Declaration on Social Determinants of Health at the World Conference on Social Determinants of Health* in Rio de Janeiro, Brazil, October 2011;
 - 1.4.3. The *Helsinki Statement on Health in All Policies (HiAP)* at the 8th Global Conference on Health Promotion in Helsinki, Finland, June 2013 and the subsequent *WHO Health in All Policies Framework for Country Action*;
 - 1.4.4. The 67th WHA Resolution A67/R12 on *Contributing to social and economic development: sustainable action across sectors to improve health and health equity* in May 2014.
- 1.5. Based on these recently accumulated evidence and developments in ISA/HiAP, WKC proposed to review the new literature and documentation that has emerged and to gather expert opinion on how best to revise the ISA booklet. WKC's goal is to revise/test the new version to contribute guidance for policy-makers on how to implement ISA, and as such, support WHO's organization-wide work on ISA and HiAP, including the development of a HiAP Framework for Country Action, supporting urban health (e.g. responses to Urban HEART), and the roll out of universal health coverage;
 - 1.6. WKC conducted a preliminary study of 16 WHO case studies on ISA, using the recommendations in the ISA booklet as a framework for analysis. The results indicate that some updates to the guidance ISA booklet are required. This study was used as a background document of the meeting, along with other synthesis of evidence;
 - 1.7. Prior to the expert consultation meeting, the participants were sent an online survey. This survey was conducted to collect the participants' opinions and comments on some of the key topics in order to facilitate the discussions during the meeting;
 - 1.8. The Expert Consultation on *"Intersectoral Action on Health, a path for policy-makers to implement effective and sustainable action on health"* held in Kobe, Japan, 29-30 May 2014, brought together well-known ISA experts, including participants of previous WHO expert consultations, selected WHO-supported case study authors, policy-makers and practitioners from different sectors and levels of government, and representatives of the civil society (see Annex 1 for list of participants);
 - 1.9. A combination of plenaries and groups work was utilized to solicit opinions on future modification and revision of the ISA booklet (see Annex 2 for the programme);
 - 1.10. The **objectives** of the expert consultation meeting were:
 - 1.10.1. To collectively examine and critique the WHO guidance booklet *"Intersectoral Action on Health, a path for policy-makers to implement effective and sustainable action on health"* based on the new literature and guidance documents that has emerged since the booklet's publication in 2011;
 - 1.10.2. To develop recommendations for the revision of the ISA booklet (including linking it to the new literature and guidance documents);
 - 1.10.3. To explore opportunities for dissemination of the ISA booklet.

Day ONE: Thursday, 29 May

2. Setting the Context

- 2.1. **Opening Remarks** for the meeting were given by Mr Alex Ross, Director, WKC, who stated the key objectives of the expert consultation meeting. He also gave a presentation on the recent global developments in the field of ISA and HiAP, and the relevance with the 67th WHA Resolution A67/R12 on HiAP;
- 2.2. Dr Hoda Rashad was appointed as chair of the meeting and remarks were made;
- 2.3. A presentation on the **background of the ISA booklet** was given by Ms Riikka Rantala (WKC):
 - 2.3.1. Ms Rantala explained the timeline of the development of the booklet from 2009, leading to its publication in 2011. The contents of the booklet were presented in detail, with the ten steps regrouped into four categories – assess, engage, implement, evaluate – to facilitate understanding (Annex 3);
 - 2.3.1.1. The “assess” category includes step 1 (‘self-assessment’), step 2 (‘assessment and engagement of other sectors’), step 3 (‘analyse the area of concern’);
 - 2.3.1.2. The “engage” category includes step 4 (‘select an engagement approach’), step 5 (‘develop an engagement strategy and policy’), step 6 (‘use framework to foster common understanding between sectors’), and step 9 (‘choose other good practices to foster intersectoral action’);
 - 2.3.1.3. The “implement” category includes step 7 (‘strengthen governance structures, political will and accountability mechanisms’) and step 8 (‘enhance community participation’);
 - 2.3.1.4. The “evaluate” category includes step 10 (‘monitor and evaluate’).
 - 2.3.2. WKC conducted a synthesis report of 16 ISA case studies using the booklet as the framework for analysis. Results and comments from the pre-meeting online survey were presented;
 - 2.3.3. Ms Rantala mentioned the various guidance and documents that have emerged since 2011, calling for the need to revise the booklet and link it to the new literature and guidance documents.
- 2.4. Some general comments and suggestions for the revision of the booklet were made during the **plenary discussion** session that followed the presentation;
 - 2.4.1. Given that ISA/HiAP is a major concern in all major health programmes, there is a need for understanding and choosing a strategy to engage other sectors. A ‘push’ or ‘pull’ strategy was suggested to be reviewed to be included in the booklet. A ‘push’ strategy is one where the other sectors are encouraged to consider health in their decisions, while a ‘pull’

strategy would be one where the health sector invites other sectors to participate in their activities;

2.4.2. It was suggested that monitoring the utilisation of the ISA booklet is needed. The WHO Regional Offices are being introduced to many different types of tools and guidelines. Among these different instruments, those that are strategically disseminated and followed-up seem to be used more frequently;

2.4.3. It was advised to review the gaps in the other existing tools and guidance. By filling the gap, this ISA booklet can play a complementary aspect;

2.4.3.1. For example, the WHO Sectoral Briefing Series documents² offer guidance on how to talk with other sectors in policy dialogue;

2.4.3.2. The Sectoral Briefing Series was mentioned to be missing from the list of documents.

2.4.4. One participant reflected that dissemination of the ISA booklet could have been stronger. Some other participants also mentioned that they were not aware of the document before being invited to the consultation meeting. It was suggested that a more systematic dissemination strategy should be developed for the new version;

2.4.5. Gender and equity should be kept at centre of the document. It was noted that health equity should be recognized central to ISA. The booklet should state this more explicitly, along with other cross-cutting issues such as gender and human rights. Unless kept proactively, these concepts often get lost;

2.4.5.1. In a recent consultation in the PAHO Region, equity was a key discussion point and the term Equity in All Policies was mentioned;

2.4.6. Different approaches to ISA can be taken. The ISA booklet explains two approaches. One general approach is known as the Health in All Policies approach where the goal is to integrate systematic consideration of health concerns into all sectors' routine policy processes. The other is a narrower and more issue-centred strategy, where the goal is to integrate a specific health concern into other relevant sectors' policies, programmes and activities. In addition to these, a target group-based approach was suggested. Because various ministries already have funds and programmes targeted by age groups, gender

² WHO. *Housing: shared interests in health and development*. Social Determinants of Health Sectoral Briefing Series 1. Geneva, Switzerland.
WHO. *Education: shared interests in well-being and development*. Social Determinants of Health Sectoral Briefing Series 2. Geneva, Switzerland.
WHO. *Transport (road transport): shared interests in sustainable outcomes*. Social Determinants of Health Sectoral Briefing Series 3. Geneva, Switzerland.
WHO. *Social protection: shared interests in vulnerability reduction and development*. Social Determinants of Health Sectoral Briefing Series 4. Geneva, Switzerland.
WHO. *Energy: Shared interests in sustainable development and energy services*. Social Determinants of Health Sectoral Briefing Series 5. Geneva, Switzerland.

groups, ethnic groups, etc., taking a target group-based approach can be an effective approach for ISA;

2.4.7. The ISA booklet could be enriched with online multimedia resources (YouTube videos, music, posters, etc.) by inserting QR codes. The booklet can function as a channel that links these resources;

2.4.8. There were multiple comments and general agreement on the need to specify the target audience and determine the purpose of the ISA booklet. The final goal of the booklet should be explicitly stated;

2.4.9. It was also suggested to develop more than one booklet, each tailored to the target audience. This suggestion was confirmed by many other participants;

2.4.10. There were some recommendations regarding practical aspects of the ISA process to be included in the ISA booklet:

2.4.10.1. The language of the current version was regarded as being too technical and health-oriented. For example, when talking about SDH with other sectors, give examples of how it can be translated into their language;

2.4.10.2. How long it would take to initiate ISA should be made more explicit;

2.4.10.3. Examples of small wins and communicating co-benefits should be considered;

2.4.10.4. Measurements/indicators to measure progress should be suggested.

2.4.11. Experts from non-English speaking countries (Brazil, Spain, the Netherlands) expressed the need for translations of the ISA booklet, especially if it is to be read and used by civil servants;

2.4.12. It was also noted that the 'implementation' aspect needs to be strengthened in the ISA booklet.

2.5. After the plenary discussion, four presentations on **Recent Studies and Guidance on ISA/HiAP** were made:

2.5.1. WHO HiAP Framework for Country Action (Dr Kwok-Cho Tang, WHO/HQ)

2.5.2. South Australia and WHO HiAP training materials (Ms Carmel Williams, Government of South Australia, Australia)

2.5.3. Systematic scoping reviews of HiAP and other ISA for health equity (Dr Ketan Shankardass, Centre for Research on Inner City Health at St. Michael's Hospital, Canada)

2.5.4. California Health in All Policies guide for state and local governments (Ms Julia Caplan, Public Health Institute, USA)

2.6. WHO HiAP Framework for Country Action (Dr Kwok-Cho Tang)

- 2.6.1. Dr Tang highlighted that HiAP is endorsed by numerous political declarations and mandates and there is increasing evidence that demonstrate the effectiveness of HiAP;
- 2.6.2. The concept of HiAP has been around in history for a long time, however, there is still a lack of understanding on how to implement and adopt the concept into action;
- 2.6.3. The WHO HiAP Framework for Country Action was developed in collaboration with members of the Conference Committees, external experts and WHO staff. It serves to facilitate country action for applying HiAP in decision-making and implementation. There are six components to this framework;
- 2.6.4. The next step emphasizes action on implementing the Framework and producing evidence and theory that will drive the practice. WHO plans to implement the HiAP Framework, document country examples, develop action plans, provide countries with training modules and how-to guides, and report the progress at the 9th Global Conference on Health Promotion, scheduled to be held in late 2016.

2.7. South Australia and WHO HiAP training materials (Ms Carmel Williams)

- 2.7.1. Ms Williams gave a presentation on the South Australian (SA) HiAP training manual and the WHO Train the Trainer HiAP manual;
- 2.7.2. SA was introduced to the HiAP concept in 2007 by Ilona Kickbusch. The central government provides mandate for HiAP, and SA has developed the health lens analysis as the methodology to implement HiAP;
- 2.7.3. The SA HiAP training was developed in collaboration with the WHO and as a product of the HiAP Summer School which was held in 2011. The five-day programme is designed to build the capacity of health professionals and policy makers to apply HiAP principles, practices and processes. The South Australian manual focus on “How to apply HiAP”;
- 2.7.4. The WHO Train the Trainer HiAP manual forms the basis of a 2-3 day workshop for middle to senior level policy-makers and government officials from all sectors influencing health. The WHO manual focussed on *training people*, who in turn will train others to apply HiAP. It is envisaged that these workshops will be held with the support of WHO. The final version of the manual is scheduled to be launched in Oct/Nov of 2014 as part of the WHA resolution;
- 2.7.5. The SA HiAP Training manual and the WHO “Train the Trainer” manual are complimentary and aim to support further implementation of HiAP and ISA across member states.

2.8. Systematic scoping reviews of HiAP and other ISA for health equity (Dr Ketan Shankardass)

- 2.8.1. Dr Shankardass gave a presentation on the findings of a scoping review on cases of intersectoral action for health equity (ISAHE) and a scoping review on cases of HiAP. The

reviews were conducted and published by the Centre for Research on Inner City Health in 2011;

2.8.2. These scoping reviews were conducted to develop a conceptual framework of the core factors influencing how and why “Health in All Policies” initiatives have been initiated and implemented. In the scoping review of ISAHE, 128 articles were found across 43 countries. A variety of strategies, actors, tools and structures were used to carry out ISAHE;

2.8.3. Meanwhile, in the scoping review of HiAP, 16 countries were found. The initiation of HiAP is context dependent and is based on high levels of interaction and interdependence across sectors. HiAP approaches are supported by tools such as HIA to identify opportunities for ISA;

2.8.4. Dr Shankardass emphasized that, while there is no single ‘recipe’ for HiAP implementation, HiAP approaches were usually preceded by ad hoc ISAHE initiatives.

2.9. California Health in All Policies guide for state and local governments (Ms Julia Caplan)

2.9.1. Ms Caplan gave a presentation on the California HiAP Task Force and the HiAP Guide for State and Local Governments;

2.9.2. The California HiAP Task Force was established in 2010 by the Governor’s Executive Order and is composed of 22 state agency members;

2.9.3. The “HiAP: A Guide for State and Local Governments” was published with support from the American Public Health Association (APHA) as a response to the growing interest in addressing SDH in the US and frequent requests for technical assistance for HiAP. The Guide offers key messages and practical tools for public health practitioners, community leaders, and ‘non-health’ allies in using intersectoral collaboration to promote healthy environments;

2.9.4. The Guide is well received and there are many requests for technical assistance, consultation and training. A one-day curriculum training programme is developed and an evaluation is currently underway.

2.10. In the **plenary discussion** that followed, participants gave comments and recommendations on the presentations and on the revision of the ISA booklet:

2.10.1. It was mentioned again by many participants to consider developing multiple products tailored for different target audiences in the revision of the ISA booklet. A suggestion was made to produce two documents, one targeting policy-makers and another targeting technical staff;

2.10.1.1. A high-level policy document is needed. Technical documents produced by the health sector are only read and understood by health sector. It is hard for other sectors to understand technical documents;

- 2.10.1.2. It was also advised to consider developing products in addition to a document format – e.g. one-pager, flyers, interactive tools, etc.
- 2.10.2. Following the historical development of ISA and the different types of tools and guidance available, it was mentioned that the added value of the revised ISA booklet should be carefully considered. One suggestion made was to consider including the economic arguments³;
- 2.10.3. It was mentioned that while there has been much practice of ISA in interventions and programmes, there are less examples on ISA at the policy-level. There has been some good examples that show potential in policy-level ISA , such as FCTC and HIA in Thailand FTA;
- 2.10.4. Participants mentioned the context for initiating and implementing ISA is different in different regions and countries. It was noted that the current dialogue on HiAP focuses more on developed countries’ context. The current ISA booklet focuses on ISA process, but countries have different contextual issues .The following comments were made on the diversity of the context for ISA:
- 2.10.4.1. In developing countries, multiple agencies run vertical programmes. There should be recommendations on how to work with other sectors in this given context. In the case of Africa, ISA on the issue of HIV/AIDS can be a good example;
- 2.10.4.2. ISA depends on the governance system of the country;
- 2.10.4.3. In some cases, there are health issues/policy issues that lend themselves to working from a co-benefits framework, where you can take time to look for co-benefits. At other times the health issues are urgent and co- benefits limited. In these circumstances, regulation and enforcement are better tools;
- 2.10.4.4. It was also mentioned that health is not considered as a human rights issue in all countries.
- 2.10.5. It was mentioned that the issue of accountability should be discussed more in this meeting;
- 2.10.6. Many comments were made concerning the alignment of the ISA booklet and the WHO HiAP Country Framework;
- 2.10.6.1. One participant noticed that the definition of ISA is different;
- 2.10.6.2. A comment was raised about aligning the 10 steps and the 6 components. In response to this, it was noted that more evidence needed to make this decision.

³ This is not an uncontroversial issue, and careful consideration of inputs and time windows need to be considered when trying to assess economic costs and benefits of ISA. Also economic benefits may not always outweigh the costs.

Also, reviewing the existing literature and utilizing the realist synthesis approach research are required;

2.10.6.3. The two documents talk to different audiences with different purposes.

2.10.7. One participant pointed out that it is not the lack of technical skills that is the barrier for ISA, it is the lack of awareness;

2.10.8. Some suggestions were made for the ISA booklet to reflect the reality in initiating ISA and engaging other sectors. Some recommendations were drawn from the participants' experiences:

2.10.8.1. Using issue-based 'pull' approaches to convince other sectors to participate in health issues can be effective. When talking to other sectors, it is effective to start from co-benefits and explaining the social determinants of health. It was advised that the health sector should give specific guidelines on priority areas. When the other sectors are asked to develop policies and programmes that require ISA, they sometimes suggest topics that are less prioritized by the health sector;

2.10.8.2. Include expected timeline and estimated resources for ISA in the ISA booklet. Time, staffing, and coordination mechanisms are all investments that need consideration. Also in most cases, the funding cycle does not allow for long-term ISA;

2.10.8.3. Make language more approachable to other sectors. For example, equity means different things to different sectors. Often, working with vulnerable groups is regarded as an equity approach, however, the focus should be on dealing with the social gradient;

2.10.8.4. Include strategies to link ISA with the broader national policy agendas;

2.10.8.5. In reality, policy advisors are the primary target audience to approach policymakers or decision makers;

2.10.8.6. One participant offered advice to those who are first initiating ISA as follows:

2.10.8.6.1. Start with what is feasible in your context, then incrementally develop;

2.10.8.6.2. Think outside of the health box and understand politics and policymaking process;

2.10.8.6.3. In some cases, information sharing is sufficient. You might not need a full-scale HiAP;

2.10.8.6.4. The health sector should stay strong not subordinate.

2.11. A presentation on the **Synthesis: Review of 16 WHO case studies using the ISA booklet** as a framework was given by Ms Jinhee Kim (WKC).

2.11.1. Ms Kim presented the main findings from the synthesis of 16 WHO ISA cases which was conducted to illustrate how the ten steps in the ISA booklet are being implemented and translated in real-life cases;

2.11.2. Key findings of the synthesis were as follows:

2.11.2.1. Cases most completed 'Set up regular mechanism to maintain and strengthen ISA (step 2)', 'Political will (step 7)', 'Use governance mechanisms (step 7)', 'Coordination mechanisms (step 7)', and 'enhance community participation (step 8)';

2.11.2.2. Cases least completed 'Use HIA (step 2)', 'Take advantage of human rights treaties and reporting mechanisms mandated by international agreements (step 7)', 'Consider political route to adopt policy (step 7)', 'Provide tools and techniques to include health in other sectors' policies (step 9), and 'Research collaboration with research institutions(step 10)'.

2.11.2.3. Cases further mention 'Advocacy and media campaigns', 'Using various windows of opportunity and strengthening political will', 'Various internationally promoted frameworks and initiatives', 'Vertical ISA between national and local governments', and 'Cross-cutting issues such as health equity, gender issues, participatory policy-making, human rights, universal health coverage, etc.' These are issues that could possibly be covered in more detail in the revised version of the ISA booklet.

2.12. In the **plenary discussion** that followed, additional comments and observations made by participants as follows:

2.12.1. In general, the main findings of the study were well received by the participants, with minor concerns on the selection and production of case reports.

2.12.2. There were some discussions and comments regarding the use of HIA across the 16 cases:

2.12.2.1. One participant pointed out that there may be more HIA cases but might not have been included in the case reports;

2.12.2.2. There are many different approaches to HIA which can be applied according to each country's context. In the case of US, HIA takes a quantitative approach which is more resource-intensive. Recently, there is a shift towards doing less HIA and investing those resources on the intervention itself;

2.12.2.3. WKC had previously convened a meeting on Impact Assessment for multisectoral action for health, and is in the process of finalizing policy briefs tailored for

specific audiences including the health sector, non-health sector, private sector and the media.

2.12.3. It was noted that collaboration with research institutions was less frequent than expected. If research collaboration is helpful for ISA, it was suggested that the revised ISA booklet should include emphasis and guidelines on how the research institutions can conduct policy-based research;

2.12.4. These findings were confirmed to show a preliminary overview of what elements the cases have implemented. The next steps would be to explore in-depth of how these elements were implemented.

3. Group work session 1: Linking recent evidence and guidance to the ISA booklet

3.1. An **introduction to the group work session 1** was presented by Mr Amit Prasad (WKC):

3.1.1. Mr Prasad summarized the main points for discussion for the group work and posed four group work questions.

3.2. Participants were divided into four groups for the first group work. All groups were asked the same questions;

3.3. The questions and main points of group discussions were as follows:

3.3.1. *What is, or should be, the unique utility of the ISA booklet given recent research and publications on the topic?*

3.3.1.1. The ISA booklet is in itself an endorsement by the WHO of the ISA methodology and call for action, promote, encourage and support the adoption of ISA;

3.3.1.2. Clarify the final goal of ISA. The goal of ISA is not ISA itself, but achieving ‘integrated decision-making’, and ultimately better health outcome and health equity;

3.3.1.3. Given the diversity of terms around ISA, such as HiAP, multisectoral action, whole-of-government approach, etc., the revised ISA booklet can offer clarification on the definitions of key terms and language;

3.3.1.4. The need for alignment with the WHO HiAP Framework for Country Action was discussed. The purpose of the ISA booklet and its target audience should be clarified and aligned with the WHO HiAP Framework for Country Action;

3.3.1.4.1. One group suggested that the ISA booklet be used as an introductory document or a starter’s kit for sectors not familiar with ISA, and the WHO HiAP Country Framework can cover the technical details;

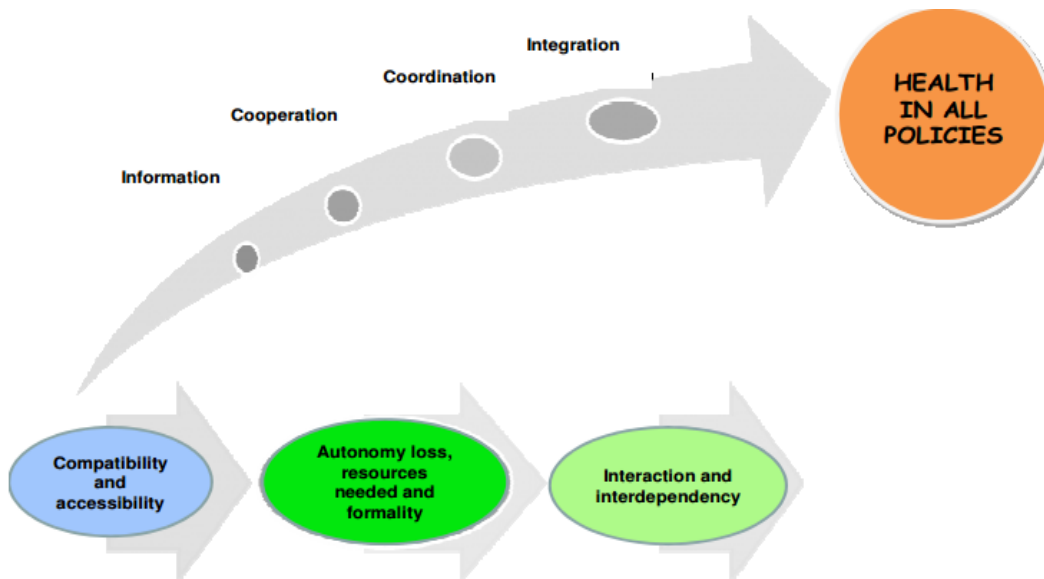
- 3.3.1.4.2. It was suggested that the 10 steps in the ISA booklet and the 6 components of the WHO HiAP Framework for Country Action should be aligned.
- 3.3.1.5. If the ISA booklet is to be targeted to policy-makers, advocacy is needed. Currently, the ISA booklet is not used as a tool for dialogue;
- 3.3.1.6. Filling the gap of what is missing from the current inventory of available tools and booklet is needed. Currently the ISA booklet is a mixture of 'how to' document and an advocacy document for high-level politicians. Some mentioned that a more concrete, simple, precise 'how to' document is needed;
- 3.3.1.7. Acknowledge the history of ISA and HiAP;
- 3.3.1.8. The diversity of target audiences was discussed in the groups, and different documents for different groups were suggested.

3.3.2. Health in All Policies versus issue-specific Intersectoral Action on Health?

- 3.3.2.1. The groups had discussions on how these approaches differ. Some major points made are as follows:
 - 3.3.2.1.1. Instead of the terms 'HiAP' and 'issue-specific', the terms 'policy-level approach' versus 'specific issue approach' could be more generic and less academic;
 - 3.3.2.1.2. Issue-specific approaches have specific goals to achieve, while HiAP is a plan to achieve a goal;
 - 3.3.2.1.3. Review the available literature and the new glossary (Freiler et al., 2013)⁴ to clarify the definitions.
- 3.3.2.2. One group discussed that the entry points would be different. For example, HiAP relies on the lead by the central government, whereas issue-specific approaches often starts with the health sector leading;
- 3.3.2.3. Another group suggested these approaches are stepwise and not separate approaches. It was discussed that the goal of ISA is not always HiAP.
 - 3.3.2.3.1. Issue-specific approach is good for short-term wins;
 - 3.3.2.3.2. The typology of approaches to engage with other sectors compiled by Solar et al. (2009)⁵ can be a good example.

⁴ Freiler, A. et al. (2013): *Glossary for the implementation of Health in All Policies (HiAP)*. J Epidemiol Community Health, 67, 1068-1072.

⁵ Solar, O., Valentine, N., Rice, M., & Albrecht, D. (2009): *Moving forward to equity in health: what kind of intersectoral action is needed? An approach to an intersectoral typology*. Partnership and Intersectoral Action Conference Working Document for the 7th Global Conference on Health Promotion, "Promoting Health and Development: Closing the Implementation Gap", Nairobi, Kenya, 26-30 October 2009.



[Figure 1] Typology of approaches to engage with other sectors (Solar et al., 2009)

3.3.3. Target audience and level of authority for guidance?

3.3.3.1. All groups mentioned that the message and format of the document depend on its target audience. It was suggested that separate documents for different audiences could be considered. Some options were discussed. The documents should complement each other:

3.3.3.1.1. The key message for the high-level policymakers should be on the rationale for ISA. Provide information on the 'key lessons'. Emphasize the legacy of the approach. A one-pager document (or a policymaker document with an executive summary) is effective;

3.3.3.1.2. For the technical, mid-level, practitioner level, a more detailed "how-to" guideline is needed;

3.3.3.1.3. Furthermore, it was noted that if the target audience is the health sector, the contents could be focused more on explaining "how to" do ISA. If the target audience is the non-health sector, explaining "why" to do ISA is needed;

3.3.3.1.4. There should be a distinction between ISA in national and local levels of governments.

3.3.3.2. There were additional discussions on selecting the target audience for the revised ISA booklet.

3.3.3.2.1. When considering the different target audiences, the message, the messenger, and the language should be tailored to serve its purpose;

3.3.3.2.2. When considering which sector to target, consider the level of power that sectors has within the government;

3.3.3.2.3. When targeting the health sector, the message would be different depending on the health minister, high-level managers, middle managers or technical staff.

3.3.3.3. Complement with other technical tools and documents. For example, the ISA booklet can be linked with other available training documents, assessment and monitoring tools, etc.

3.3.4. What additional resources should be provided with the ISA booklet to make it useful in your area of work?

3.3.4.1. A website with electronic/interactive online components can be developed as a complementary tool. This tool should be dynamic with animations, include all available tools, videos and links to other websites. Insert QR codes in the ISA booklet to lead to them;

3.3.4.2. More information on “how to” should be included. For example, skills and techniques on how to perform integrated decision-making process or how to implement/perform each step should be explained. Other tactical skills such as negotiation, diplomacy or persuasion skills should be discussed. For example, suggest using focus group discussion as a method or HIA as one of the tools;

3.3.4.3. Provide a strong rationale for ISA. Show the causal pathways showing how a public policy decision impacts health. Ethical arguments like equity issues needs to be mentioned;

3.3.4.4. Enrich with case examples to highlight and contextualize the steps. If the revised ISA booklet is to be concise, provide a link to the component;

3.3.4.5. Show data or results of ISA case studies. Provide indicators such as process indicators or composite index, and co-benefits of non-health outcomes;

3.3.4.6. Include realistic issues such as the expected timeline required for ISA;

3.3.4.7. Use info graphics, more visuals and pictures;

3.3.4.8. Produce translations into other languages;

3.3.4.9. However a cautionary remark was made on the danger of overloading;

3.3.4.9.1. It was advised that the ISA booklet should be kept simple and slim. The additional resources do not have to be ‘within’ the booklet, but must be linked ‘with’ the booklet;

3.3.4.9.2. Another suggestion was made to provide the list of strategies, tactics and tools in an appendix document, and more detailed case studies in a separate document.

3.4. In the **plenary discussion** that followed, a number of comments were made:

3.4.1. It was noted that all four groups mentioned the following points :

3.4.1.1. The need for multiple number of documents targeting different audiences;

3.4.1.2. Suggested to keep the ISA booklet simple;

3.4.1.3. Suggested the ISA booklet to focus more on policy level and on how to get others on board, especially mentioning the ministry of health as the main target audience;

3.4.1.4. Link to more contents building on the existing ISA and HiAP literature;

3.4.1.5. Practical/how to information is important.

3.4.2. Participants urged WHO to coordinate activities and align the ISA booklet with the WHO HiAP Framework for Country Action. Make effort to ensure all related WHO materials are compatible with each other;

3.4.3. Participants requested to the WHO to make use of its unique role to make a stronger impact. As the 'messenger' is as important as the message, WHO should consider inviting other international organizations for joint endorsement of the ISA booklet;

3.4.4. Dissemination strategy of the revised ISA booklet was discussed extensively. For example, a launch event with non-health sectors can be a good opportunity. As it is important to get others on board, use the launch as advocacy opportunity for ISA. Also, it was suggested to invite and highlight champions, publicize case studies, increase profile of the ISA activities and the other sectors, etc.;

3.4.5. It was reminded that ISA is an inherently political process, therefore leadership and political tactics, techniques should be emphasized in the ISA booklet;

3.4.6. A note on using more approachable language to other sectors was made. In addition to the term 'health', it was suggested to use other terms that surround health, such as well-being and quality of life;

3.4.7. Discussions on the format and target audience of the ISA booklet were made again during this session.

Day TWO: Friday, 30 May

4. ISA/HiAP Experiences

- 4.1. The chair opened the second day with some reflections on the main points discussed on the previous day:
 - 4.1.1. There are many entry points and frameworks that can introduce ISA, e.g. health equity, health promotion, initiatives such as NCD prevention and control and ageing. In the introduction of the ISA booklet, clarifying that ISA and health is for everyone can help bring in more players;
 - 4.1.2. The definition of ISA depends on the focus and point of departure of ISA. For example, if the focus is on efficient delivery of programmes, ISA involves engaging other sectors of the government. On the other hand, if the focus is on good governance and accountability, ISA involves social involvement of the non-governmental sectors;
 - 4.1.3. There are needs for the ISA booklet to describe the prerequisites for institutionalizing the ISA modality, as well as a need for a technical guideline explaining the practical elements for implementing ISA.
- 4.2. **Three presentations** were made in this session:
 - 4.2.1. National government ISA/HiAP: experiences from Finland (Dr Eeva Ollila, Ministry of Social Affairs and Health, Finland);
 - 4.2.2. Local government ISA/HiAP: the case of Bhaktapur, Nepal (Dr Shiva Adhikari, Tribhuvan University, Nepal);
 - 4.2.3. Engaging the civil society in ISA (Dr Vandana Prasad, Peoples Health Movement, India).
- 4.3. National government ISA/HiAP: experiences from Finland (Dr Eeva Ollila)
 - 4.3.1. Dr Ollila presented an overview of the history of HiAP in Finland and lessons learned;
 - 4.3.2. Finland has introduced intersectoral public health programmes since the 1970s and progressed to the Health Care Act of 2010, which provided the mandate for establishing HiAP in the context of all government structures;
 - 4.3.3. Dr Ollila emphasized that it is important for the health sector to understand the policy process. By understanding the policy process, the health sector can find ways in the process where they can participate and engage other sectors;
 - 4.3.4. Some key lessons from Finland include using public health data and research for policy options; establishing structures and processes that are enforced by legal measures; focusing on implementation; being aware of various windows of opportunities, changing contexts and power relationships; and building political will.
- 4.4. Local government ISA/HiAP: the case of Bhaktapur, Nepal (Dr Shiva Adhikari)

- 4.4.1. Dr Adhikari gave a presentation on local government ISA in urban planning to increase open and green spaces in Bhaktapur, Nepal;
 - 4.4.2. In Bhaktapur, the User's Committee and formal interdepartmental coordination mechanisms ensure public participation at various phases of the decision-making process. The departments work in coordination and have regular meetings for supporting each other and preventing duplication of work. Execution of work at the ground level done in direct involvement of local people in the decision making process through the User's Committee;
 - 4.4.3. The needs-based approach of involving communities in identifying and addressing the right issues was one of the key lessons learnt. Endogenous knowledge and information can be utilized to identify the appropriate mechanisms for increasing access to open space;
 - 4.4.4. Dr Adhikari also emphasized that the involvement of the User's Committee had impact on developing a sense of ownership, improving the quality of construction, and decreasing the cost of implementation.
- 4.5. Engaging the civil society in ISA (Dr Vandana Prasad)
- 4.5.1. Dr Prasad gave a presentation on the civil society's response to the ISA booklet and suggested a number of recommendations to consider for revision;
 - 4.5.2. Dr Prasad indicated that the role of civil society is under-emphasized in the current ISA booklet and that human rights should be emphasized as a non-negotiable principle;
 - 4.5.3. When addressing the participation of the civil society, conflict of interest should be considered upfront and Non-State Actors (NSA) should be recognized and differentiated from private sector;
 - 4.5.4. Dr Prasad also urged that the ISA booklet should take a more active approach in offering real solutions to achieve ISA and in facing the challenges to promote public participation.
- 4.6. In the **plenary discussion** that followed, a number of comments and observations were made by the participants:
- 4.6.1. It was mentioned that in some contexts, the health care sector is often excluded in ISA. As there is growing need for the health care sector to participate for equity, the ISA booklet should be more explicit to mention both health care and health promotion sectors as key actors;
 - 4.6.2. In all the three presentations, law was used as a mechanism for ISA. While the use of law depends largely on the political and legal culture of the country, laws can play diverse roles for ISA. For example, at the legislative level, law provides the impetus or the duty to governments to act, at the regulatory or operational level, law provides specific guidance and standards, and countries are required to consider laws at the treaty level such as those on trade and human rights. Laws should be an integral part of the considerations, as they are strong tools we can use;

- 4.6.3. There was a recommendation for the ISA booklet to target mayors and encourage more local governments to implement ISA. There are much more city government leaders than national leaders, and it was noted that in many cases, such as the implementation of the Kyoto Protocol on climate change, local government responses may be better than the national government;
- 4.6.4. Some examples of reporting mechanisms were offered:
- 4.6.4.1. In the case of New York, there is no tracking or measuring the ISA process itself. However, in the case of reporting sustainability outcomes, the creation and tracking of the indicators were done in an intersectoral manner;
- 4.6.4.2. In Singapore, a mechanism to track the outcome and implementation of the Healthy Living Masterplan was put into place. Progress is reported on an annual basis in terms of how the initiatives are being implemented;
- 4.6.4.3. In South Australia, instead of developing new mechanisms, HiAP progress report was tied into existing regular government monitoring and reporting mechanisms. There is also an independent audit mechanism.

5. Group work session 2: Review of ISA booklet part 1 – key elements related to assessment and engagement of other sectors, and developing a strategy

- 5.1. An **introduction to the group work session 2** was made by Ms Suvi Huikuri (WKC):
- 5.1.1. Ms Huikuri presented a review of the steps on assessing and engaging, including the pre-meeting online survey results and the key finding from the synthesis report.
- 5.2. Participants were divided into four groups.
- 5.2.1. Groups 1 & 2 were composed of academics and experts;
- 5.2.2. Groups 3 & 4 were composed of practitioners;
- 5.3. The questions and main points of group discussions for Groups 1 & 2 were as follows:
- 5.3.1. What kind of capacity building activities would be important to carry out before initiating ISA (for both lead and other sectors)? References?**
- 5.3.1.1. Different types of competencies and capacity building is needed at the individual and institutional levels;
- 5.3.1.1.1. Individual competencies include : Health diplomacy, negotiation skills, communication, agenda setting, framing, project planning skills,

building rapport, public health theory and practice, politics, flexibility and adaptability, knowledge to use ISA/SDH tools;

5.3.1.1.2. Institutional competencies include: dedicating human resources, institutional leadership, political capital, understanding legal framework, learning by doing, supporting communities of practice, doing your 'homework';

5.3.1.1.3. It was mentioned that there are different sets of skills for capacity building, i.e. generic capacity building activities and capacity building for specialized skills.

5.3.1.2. Knowing and understanding other stakeholders/sectors and taking respectful approach in terms of the sector and of the experts are important. The health sector should know what the other sectors' programmes and priorities are;

5.3.1.3. Developing joint programmes between sectors;

5.3.1.4. Build on your existing, local capacities;

5.3.1.5. References include working with the WHO Collaborating Centres, WHO HiAP Country Framework, SA HiAP Training Manual, HiAP books, etc.

5.3.2. What kind of guidance should the booklet provide on approaching and engaging other sectors? References?

5.3.2.1. Building rapport, negotiation, regular informal meetings, mechanisms and opportunities for engaging other sectors, engaging effectively with the media, mapping co-benefits;

5.3.2.2. Language, doing research on other sectors, pull/co-benefit approach should be highlighted;

5.3.2.3. Focus on solving problem together (participation and ownership at initiation stage), asking what other sectors goals/priorities/challenges, etc.;

5.3.2.4. Investing in strategic engagement with diverse groups (e.g. student and medical associations, health NGOs, etc.);

5.3.2.5. The WHO Sector Briefing Series can be a reference when talking with other sectors.

5.4. The questions and main points of group discussions for Groups 3 & 4 were as follows:

5.4.1. Based on your experience, what are the facilitators and challenges in approaching other sectors? What kind of guidance would be helpful in this regard?

5.4.1.1. Facilitators in approaching other sectors were discussed as follows:

5.4.1.1.1. Responses to crisis and emergencies are good examples of ISA;

- 5.4.1.1.2. Resilience models;
- 5.4.1.1.3. Awareness of other sectors;
- 5.4.1.1.4. Learning other sectors' languages and priorities;
- 5.4.1.1.5. Common goals and slogans, common national goals and agendas;
- 5.4.1.1.6. Appreciation mechanisms such as publicizing activities and high profiles;
- 5.4.1.1.7. Identifying co-benefits;
- 5.4.1.1.8. Identifying short-term concrete wins.

5.4.1.2. Challenges in approaching other sectors were discussed as follows:

- 5.4.1.2.1. Lack of awareness of SDH, lack of tradition of working in partnerships, lack of awareness of the health sector and other sectors on how they can be mutually supportive;
- 5.4.1.2.2. Lack of trust and confidence among sectors;
- 5.4.1.2.3. Conflict on who the lead champion is. Conflict over who gets the credit. In some cases, the less credit the health sector gets, the more successful the ISA;
- 5.4.1.2.4. Other sectors' view on health being an additional burden;
- 5.4.1.2.5. Financial mechanism is not designed to support ISA. Financial resources are often targeted to specific purposes;
- 5.4.1.2.6. Structure of governmental and governance systems hinders ISA;
- 5.4.1.2.7. Lack of good accountability system;
- 5.4.1.2.8. Demonstrating how ISA for health is for the benefit of all;
- 5.4.1.2.9. Time limitations;
- 5.4.1.2.10. Overcoming different priorities among sectors;
- 5.4.1.2.11. Lack of information.

5.4.1.3. Helpful guidance for addressing facilitators and challenges in approaching other sectors were suggested as follows:

- 5.4.1.3.1. Use the above mentioned facilitators to address challenges;
- 5.4.1.3.2. Build up co-ownership by engaging other sectors from the start of setting the agenda;
- 5.4.1.3.3. Tips on engagement, strategy, implementation is more required;
- 5.4.1.3.4. Using co-benefits;
- 5.4.1.3.5. Examples of health sector working with other sectors, examples of health sector helping other sectors, and demonstrating the added value;

- 5.4.1.3.6. Focusing on other sectors' priorities and showing how they can have health consequences;
- 5.4.1.3.7. City councils as agents for ISA;
- 5.4.1.3.8. Identifying other sectors that have broad relationships to key stakeholders;
- 5.4.1.3.9. Cooperating with research institutions (depending on the issue) for evaluation, data facilitation, building the case;
- 5.4.1.3.10. Much guidance is already available.

5.4.2. *What kind of arguments could the lead sector use to convince other sectors to engage in ISA?*

- 5.4.2.1. It was emphasized that understanding the other sectors' priorities is essential in developing the arguments;
- 5.4.2.2. Co-benefits, 'need' arguments, arguments related with other sectors' priorities;
- 5.4.2.3. Economic arguments, impact on the broader social development goals;
- 5.4.2.4. Supporting wider strategic goals and objectives;
- 5.4.2.5. Ethical arguments on social justice, human rights;
- 5.4.2.6. Political wins, e.g. winning next elections;
- 5.4.2.7. Public support;
- 5.4.2.8. Healthy competition, benchmarking other successful places as an example or inspiration;
- 5.4.2.9. Explaining who will do the work;
- 5.4.2.10. Use of social marketing techniques;

5.5. The shared questions to all four groups and main points of group discussions were as follows:

5.5.1. *Could any of the steps on assessing and engaging (steps 1-6, 9) be combined to reduce duplication and the number of steps?*

- 5.5.1.1. General comments on the steps were made as follows:
 - 5.5.1.1.1. Align with the six components of the HiAP Framework on Country Action, use same language;
 - 5.5.1.1.2. Emphasize the iterative process, 'steps' is not a good term;
 - 5.5.1.1.3. Grouping the steps to broader categories, such as– assess, engage, implement, evaluate – was considered useful and recommended;
 - 5.5.1.1.4. Reduce the number of steps;

- 5.5.1.1.5. Strengthen details related to programme development and implementation steps;
 - 5.5.1.1.6. Community engagement should come in the beginning;
 - 5.5.1.1.7. Use softer language, e.g. instead of ‘assessment’ of other sectors, ‘understanding’ other sectors is more important and softer.
- 5.5.1.2. Specific suggestions on combining and rearranging the steps were made as follows:
- 5.5.1.2.1. Steps 1 and 3 fall under ‘identifying priorities’ including self-assessment and analysing area of concern;
 - 5.5.1.2.2. Merge Steps 2 and 3;
 - 5.5.1.2.3. Combine 2, 4 and 5 into ‘engagement strategy, include 6 and 9 as examples of tools of engagement strategy;
 - 5.5.1.2.4. Merge Steps 4 and 5 (and perhaps step 9, too) and use the typology development by Solar et al (2009)⁶ as a model;
 - 5.5.1.2.5. Engagement is a separate step.
- 5.5.1.3. Some groups suggested to include additional elements:
- 5.5.1.3.1. ‘Building capacity’ should be added as separate step;
 - 5.5.1.3.2. Emphasize ‘programme development and implementation’;
 - 5.5.1.3.3. Add ‘share and celebrate successes.

5.6. In the **plenary discussion** that followed, a number of comments and clarifications were made:

- 5.6.1. Regarding the facilitators and challenges to engage other sectors, the book ‘HiAP: Seizing opportunities, implementing policies book (Ministry of Social Affairs and Health, Finland, 2013)’ offers more information in the concluding chapter;
- 5.6.2. There was a suggestion to provide a list of the preconditions or prerequisites that would make it easier to initiate and implement HiAP or ISA. These preconditions could be shown in a phase diagram as one of the first phases. However, these conditions should be illustrated with caution. For example, in previous experiences from Finland, some of the countries were so behind in fulfilling these preconditions that they could not start anything;
- 5.6.3. Regarding the issue on ethical arguments, it was mentioned by some participants that these were non-negotiable arguments that we must support;

⁶ Solar, O., Valentine, N., Rice, M., & Albrecht, D. (2009): *Moving forward to equity in health: what kind of intersectoral action is needed? An approach to an intersectoral typology*. Partnership and Intersectoral Action Conference Working Document for the 7th Global Conference on Health Promotion, “Promoting Health and Development: Closing the Implementation Gap”, Nairobi, Kenya, 26-30 October 2009.

- 5.6.4. There were some additional comments made regarding the issue on economic arguments to convince other sectors to engage;
- 5.6.4.1. Sometimes the ISA for health can be cost-consuming. Being public about the positive and negative costs was recommended when engaging other sectors;
- 5.6.4.2. Additionally, it is challenging to produce economic arguments because prevention is cost-saving in the long-term, and when it is successful;
- 5.6.4.3. There is a need to conduct research to assess the social return of investment on health.
- 5.6.5. It was noted that in all four groups suggested cooperation rather than placing the health sector to lead the ISA process;
- 5.6.6. It was also noted that healthy competition, celebrating and sharing success are strong incentives but not discussed widely in previous discussion on ISA.

6. Group work session 3: Review of ISA booklet part 2 – governance structures, community participation, and monitoring and evaluation

- 6.1. An **introduction to the group work session 3** was made by Dr Megumi Kano (WKC):
- 6.1.1. Dr Kano presented a review of the steps on implementing and evaluation, including the pre-meeting online survey results and the key finding from the synthesis report.
- 6.2. Participants were remained in the same groups as in group work session 2.
- 6.3. The questions and main points of group discussions were as follows :
- 6.3.1. What are the key governance structures that should be described in more detail? Examples?**
- 6.3.1.1. It would be difficult to adequately describe the complex arrangements in a concise document. There are many documents that give information on this. Refer to McQueen et al. (2012)⁷ or Adelaide Statement on HiAP (2010)⁸ for more detailed information on governance for ISA;
- 6.3.1.2. Consider changing the term ‘structures’ in the current document to ‘tools/instruments/mechanisms’ as this describes the contents of the Step better;
- 6.3.1.3. Effective governance principles for ISA were suggested as follows:

⁷ McQueen, D., Wismar, M., Lin, V., Jones, C., & Davies, M. (Eds.) (2012): *Intersectoral governance for Health in All Policies: structures, actions and experiences* Copenhagen, Denmark: European Observatory on Health Systems and Policies & World Health Organization.

⁸ WHO. (2010): *Adelaide Statement on Health in All Policies: moving towards a shared governance for health and well-being*.

- 6.3.1.3.1. Shared governance between central agencies (mandate) and key partners is important. The primary driver should not be the health sector/professionals;
- 6.3.1.3.2. Reporting requirements should be clarified and progress should be measured;
- 6.3.1.3.3. Utilize and leverage existing arrangements;
- 6.3.1.3.4. Ensure transparency (i.e. plans are publicly accessible) and accountability;
- 6.3.1.3.5. Ensure community engagement in decision-making.
- 6.3.1.4. Keep in mind that governance structures are dependent on the level of government at which the ISA is operating, and is highly influenced by the context and culture norms of each country;
- 6.3.1.5. Establishing governance structures may occur at different phases. For example, in a top-down approach, governance structures are established earlier, whereas in a bottom-up approach, they are established at later phases;
- 6.3.1.6. The role of laws is underrated and should be emphasized. Laws provide the mandate and specify the operational terms of the ISA. For example, in the case of Thailand, the National Health Act is used as a tool for initiating ISA and specifies that the prime minister is the chair of the National Health Commission.
- 6.3.1.7. Provide concrete examples of the different types of governance structures and commonly used intersectoral governance structures such as steering committee and task force would be helpful. For example, tease out the coordinating mechanisms from the 16 cases in the background report. Show who the stakeholders are and what their roles are in the governance structures;
- 6.3.1.8. Cautions –keep the structures simple, and avoid adding another layer of bureaucracy.

6.3.2. What are effective strategies for enhancing and/or sustaining community participation that should be described in more detail? Examples?

- 6.3.2.1. Principles for community participation should be included in the ISA booklet. Some suggestions for these were:
 - 6.3.2.1.1. Engage community from the start;
 - 6.3.2.1.2. Make sure to involve the least heard community, ensure representativeness, make sure community participation goes beyond the 'loudest voice';
 - 6.3.2.1.3. Inclusiveness, equitable engagement;
 - 6.3.2.1.4. Empowering community with information and evidence before and throughout the feedback process;

- 6.3.2.1.5. Transparency and open access to information.
- 6.3.2.2. Effective strategies for community participation were suggested:
 - 6.3.2.2.1. Surveys (baseline surveys and needs assessment);
 - 6.3.2.2.2. Community events and town hall meetings;
 - 6.3.2.2.3. Use of local media;
 - 6.3.2.2.4. Election agenda;
 - 6.3.2.2.5. Brainstorming workshops and focus groups;
 - 6.3.2.2.6. Involving key political leaders and sectoral authorities;
 - 6.3.2.2.7. Involving intergenerational stakeholders;
 - 6.3.2.2.8. Involving community in the evaluation, e.g. community-based participatory research;
 - 6.3.2.2.9. Pilot projects.
- 6.3.2.3. It was mentioned that models of community participation including Arnstein's ladder of participation (Arnstein, 1969)⁹ and others should be referred to. The aim for community participation should be clarified;
- 6.3.2.4. Community participation should not be left as a voluntary action. Delineate, specify, regulate, and structure the representation and participation of the civil society;
- 6.3.2.5. Cover the issue of conflict of interest;
- 6.3.2.6. There are differences between community participation in the national and local levels of governments. Community participation is more challenging at the national level. In the local level, community level planning can be a way;
- 6.3.2.7. Cases on community participation from Kenya, Nepal, India and Brazil were mentioned in the groups.

6.3.3. *Should there be some discussion about the role of the private sector; if so, what and how?*

- 6.3.3.1. The private sector is part of the landscape and can often provide solutions. However, there are challenges such as conflict of interest. When discussing about the role of the private sector, recognize and address potential conflict of interest. Involvement of private sectors requires risk management;

⁹ Arnstein, S. (1969): *A ladder of citizen participation*. Journal of the American Planning Association 35 (4), 216–224.

- 6.3.3.2. Use cross-border international legislations to monitor the private sector. It was also mentioned that WHO HQ is developing a guidance for private sector involvement;
- 6.3.3.3. Acknowledge the different types of actors in the private sector such as social enterprises, for-profit companies, and those for communication. And assess the added value of the private sector, case by case;
- 6.3.3.4. The role and appropriateness of private sector participation will vary depending on the issue, task or goal;
 - 6.3.3.4.1. In the case of issue-specific ISA, such as NCD-related risk factors, the private sector (e.g. food industry) may need to be included;
 - 6.3.3.4.2. In some cases, private sector engagement is positive, e.g. private health care services to ensure equitable access to quality care and private corporate social responsibility;
 - 6.3.3.4.3. Private sector participation is highly recommended for initiatives such as healthy workplaces, healthy markets, age-friendly businesses, family-friendly employer, etc.
- 6.3.3.5. Consider using the term non-state actors(NSA) instead of private sector;
- 6.3.3.6. Guidelines on private donations and private sector's role in policy implementation;
- 6.3.3.7. Consult with the private sector to create incentives for their engagement;
- 6.3.3.8. In general, the private sector should be addressed in the ISA booklet, and should be recognized that this is a very complicated and emerging issue.

6.3.4. Are there existing guidance and resources on monitoring and evaluation of ISA processes which the booklet could reference?

- 6.3.4.1. Existing guidelines and resources include:
 - 6.3.4.1.1. South Australia is developing an evaluation methodology;
 - 6.3.4.1.2. CRICH economic assessment of HiAP¹⁰;
 - 6.3.4.1.3. The Fiocruz Foundation of Brazil is developing a matrix to evaluate ISA;
 - 6.3.4.1.4. The California HiAP Guide provides a list of questions to think about in the monitoring and evaluation chapter.
- 6.3.4.2. Develop and provide indicators to measure the process, impact and outcome;

¹⁰ Bayoumi, A. (2011): *Economic Assessment of Health in All Policies: A Discussion Brief*. Centre for Research on Inner City Health (CRICH) in the Keenan Research Centre of the Li Ka Shing Knowledge Institute of St. Michael's Hospital.

6.3.4.3. There are existing tools for monitoring and evaluation that could be modified for ISA:

6.3.4.3.1. Stakeholder evaluation models;

6.3.4.3.2. Partnership evaluations, studies, tools available;

6.3.4.3.3. Studies on Public-Private Partnerships.

6.3.4.4. A variety of strategies, methods, and sources of data that can be used for monitoring and evaluation ISA were suggested:

6.3.4.4.1. Observational, qualitative methods;

6.3.4.4.2. Records of meetings;

6.3.4.4.3. National health profiles;

6.3.4.4.4. Assembly reports (Thailand).

6.3.4.5. Need to involve academia for monitoring and evaluation;

6.3.4.6. Focus on transparency, accountability.

6.4. In the **plenary discussion** that followed, additional comments were made:

6.4.1. The following comments and observations were made on the co-leadership and leading role in the ISA:

6.4.1.1. The health sector was advised not to take the leading role or be notional leaders, but act as facilitators, translators, mediators, and drivers;

6.4.1.2. In many cases, the health sector explicitly asks the other sectors to take the lead, but the other sectors refuse;

6.4.1.3. The leading role should be based on the issue at hand.

6.4.2. Some comments highlighted regarding private sector participation and conflict of interest:

6.4.2.1. When talking about private sectors, a clear distinction between for-profit and non-profit should be made. There are private sectors who have a vested interest in selling products that have health impacts, which require a very different approach than those can unambiguously support health goals;

6.4.2.2. It was also emphasized that a uniform approach is not appropriate in addressing private sector issues. The context of private sector participation varies among countries;

6.4.2.3. Corporate social responsibility was mentioned as an opportunity for private sector participation.

6.4.3. Regulation of private sector activities that affect health was emphasized, and it was recommended that cross-border regulations should be highlighted in the revised

document. This is important because what is enforced in one part of the world should be enforced to some point in other countries as well;

6.4.4. It was also mentioned that while the general consensus is to keep the revised document simple, it should be remembered that developing countries with less experience and different governance structures need guidance on tools.

7. Other recommendations for the revision of the ISA booklet

7.1. In the **final plenary discussion**, the participants re-emphasized the key messages and offered additional recommendations for the revision of the ISA booklet:

7.1.1. It was confirmed that there is an overall consensus on need for multiple products on ISA. A one-pager document is needed for the higher-level policy-makers and a more detailed guidance document with links to additional resources for the technical-level staff;

7.1.1.1. It was emphasized that a one-pager flyer is crucially needed and urged that it should not be abandoned for resource reasons. Participants offered to contribute to the development of the one-pager.

7.1.2. Many suggestions were given on how the revised document could be differentiated from the other resources. The main argument involved clarifying the target audience of the revised document;

7.1.2.1. One participant suggested for the revised version to target local and state level governments;

7.1.2.2. Another participant suggested targeting the non-health sector. However, it was also noted that there should be caution in targeting the non-health sector as they have different approach and language and would require a different framing. To produce such a document would require more expertise.

7.1.3. Participants highlighted and requested alignment with the WHO HiAP Framework for Country Action and urged more coherence within the WHO in the area of ISA and HiAP;

7.1.3.1. A point was made on introducing ISA as a modality or process that builds towards HiAP;

7.1.3.2. Instead of using terms such as ISA or HiAP, using generic terms such as “working together” or “crossing borders” was suggested as a way to overcome this issue;

7.1.3.3. If the WHO HiAP Framework for Country Action is more focusing on national-level policymakers, then the revised ISA booklet could target local and state level policymakers;

7.1.3.4. It was also suggested to reduce the number of steps and components in these documents.

- 7.1.4. The need for systematic dissemination plans to promote the utilization of the revised document was discussed and the following suggestions were made;
- 7.1.4.1. A launch event to announce the publication of the ISA booklet should be planned;
 - 7.1.4.2. Platforms internal to WHO can be used. For example, the World Health Assembly and the Regional Committees can be events where the ISA booklet can be introduced to high-level policymakers;
 - 7.1.4.3. Translation into other languages was emphasized. Many Member States do not find the English version useful as a guidance tool. Therefore the ISA booklet should be available in multiple languages;
 - 7.1.4.4. Websites are important tools for dissemination. It was suggested that WHO Country Office websites and WKC partner websites are used for this purpose;
 - 7.1.4.5. Key events and conferences such as the WKC Global Forum are good opportunities to disseminate the product;
 - 7.1.4.6. Capacity building opportunities such as webinars, online seminars or 2-hour lectures can be conducted;
 - 7.1.4.7. Endorsement from other UN agencies was suggested as a way to promote exposure, especially to the non-health sectors. The non-health sectors can gain access to the document through their respective UN agencies. Providing links to the documents in the other UN agencies' websites was recommended.
- 7.1.5. It was noted that a guidance document itself is not sufficient for initiating and implementing ISA. There is much literature available, but supplementary mentoring is required to capture and understand the nuances and tactics for ISA. Systematic mentoring and training programmes would be helpful;
- 7.1.5.1. A peer-to-peer mentoring system is helpful for health departments to start ISA. In this case, adequate staffing, resources and systematic infrastructures are needed to accelerate such a system;
 - 7.1.5.2. Participants urged the WHO to take the lead in developing mentoring and training programmes for technical assistance.
- 7.1.6. Regarding the issue of monitoring the utilisation of the document, the following recommendations were made:
- 7.1.6.1. Provide a voluntary report-back mechanism on the website where the link to the document is available;
 - 7.1.6.2. Include the utilization of the ISA booklet to one of the existing WHO reporting mechanisms;
 - 7.1.6.3. Refer to the developed indicators for assessing progress on ISA. For example, the NCD Action Framework has some process indicators for intersectoral action;

7.1.6.4. Include a suggested citation in the inside cover of the document. This would suggest citation of the document is encouraged to its users. Frequency of the citation can then be used as a way to monitor its use.

7.1.7. Furthermore, many participants expressed interest in contributing in the revision process;

7.1.8. WKC response to the comments and recommendations were as follows;

7.1.8.1. It was acknowledged that multiple products should be developed for the different target audiences. However, the target audience was not agreed during the expert consultation. Targeting non-health sectors would not be feasible for the time being;

7.1.8.2. Alignment with the WHO HiAP Framework for Country Action is a critical task;

7.1.8.3. A need for mentorship programmes was acknowledged, however developing something concrete would be difficult at this stage;

7.1.8.4. It was mentioned that the Urban Health Portal could be a channel for dissemination;

7.1.8.5. WKC asked the meeting participants to continue participating in the revision process;

7.1.8.5.1. A comprehensive report of the expert consultation meeting will be drafted and sent to the participants for review by the end of June;

7.1.8.5.2. The key arguments will be reviewed and plans for the revision will be developed.

7.2. The meeting was closed with closing remarks by Dr Hoda Rashad and Mr Alex Ross.

8. Next steps

8.1. Synthesize the results from the group work and plenary discussions;

8.2. Consult with meeting participants on the final synthesis report;

8.3. Decide on the target audience ;

8.4. Develop dissemination plan, monitoring and evaluation plan;

8.5. Begin development of the next version of the ISA booklet;

8.6. Review the revised version with WHO officials, experts and key stakeholders;

8.7. Finalize the revised ISA booklet;

8.8. Launch.

9. Annex 1: List of Participants

Dr Shiva Adhikari, Associate Professor, Economics (Health), Tribhuvan University, Kathmandu, Nepal

Professor Marco Akerman, Professor, Policy and Management, School of Public Health, University of São Paulo, São Paulo, Brazil

Ms Pilar Campos, Head of Service of the Health Promotion Area, Ministry of Health, Social Services and Equality, Madrid, Spain

Ms Julia Caplan, Program Director, Public Health Institute, Health in All Policies (HiAP) Task Force, Office of Health Equity, California Department of Public Health, United States of America

Ms Grace Chan, Chief Officer (Elderly Service), Service Development, Hong Kong Council of Social Service, Wanchai, Hong Kong, China, Hong Kong SAR

Dr Ling Chew, Director, Research & Strategic Planning, Health Promotion Board, Singapore

Mr Jon Dawson, Senior Consultants, Jon Dawson Associates, Chester, Cheshire, United Kingdom

Professor Billie Giles-Corti, Director, McCaughey VicHealth Centre for Community Wellbeing, University of Melbourne, Carlton, Victoria, Australia

Dr Pamela Juma, Research Fellow, Health Systems and Challenges, African Population and Health Research Center, Nairobi, Kenya

Mr Jeongmuk Kang, Project Officer, Programme Management Department, ICLEI Korea Office, Suwon-si, Republic of Korea

Dr Kirsten Langeveld, Researcher, Department of Public Health, University of Amsterdam, Academic Medical Center, Amsterdam, The Netherlands

Dr Karen Lee, Global Healthy Built Environment Consultant, New York, United States of America

Ms Carmel Williams, Manager, Strategic Partnerships, Public Health, Department of Health, Government of South Australia, Adelaide, South Australia, Australia

Ms Kirsten Myrup, Health Manager, Social, Health and Employment, Varde Municipality, Varde, Denmark

Dr Eeva Ollila, Ministerial Adviser, Department for Promotion of Welfare and Health, Ministry of Social Affairs and Health, Helsinki, Finland

Professor Hoda Rashad, Professor and Director, Social Research Center, American University in Cairo, Cairo, Egypt

Dr Sirina Pavarolarvidya, President of National Health Assembly Organizing Committee, National Health Commission Office, Nonthaburi, Thailand

Dr Tipicha Posayanonda, Assistant to Director, Technical Development and Knowledge Management Department, National Health Commission Office, Nonthaburi, Thailand

Dr Vandana Prasad, Joint Convenor, Peoples Health Movement-India / Public Health Resource Network, Noida, Uttar Pradesh, India

Dr Kaoruko Seino, Senior Lecturer, International Health, Tokyo Medical and Dental University, Tokyo, Japan

Professor Ketan Shankardass, Assistant Professor, Psychology, Wilfrid Laurier University, Waterloo, Ontario, Canada & Centre for Research on Inner City Health at St. Michael's Hospital, Toronto, Ontario, Canada

Ms Nana Soetantri, Transport Specialist, Regional and Sustainable Development Department / Sustainable Infrastructure Division, Asian Development Bank, Mandaluyong City, Metro Manila, Philippines

WHO HQ & Regional Offices

Dr Kwok Cho Tang, Coordinator, Health Promotion Unit, Prevention of Noncommunicable Diseases, WHO Headquarters, Geneva, Switzerland

Dr Kira Fortune, Regional Adviser, Determinants of Health, Special Program on Sustainable Development and Health Equity, WHO Regional Office for the Americas/Pan American Sanitary Bureau, Washington, D.C., United States of America

Dr Faten Ben Abdelaziz, Regional Adviser, Health Education and Promotion, WHO Regional Office for the Eastern Mediterranean, Cairo, Egypt

Dr Suvajee Good, Programme Coordinator-Health Promotion & Social Determinants of Health Focal point, WHO Regional Office for the South-East Asia, New Delhi, India

Dr Anjana Bhushan, Technical Officer, DHS/HCF, WHO Regional Office for the Western Pacific, Manila, Philippines

Dr Ki-Hyun Hahm, Technical Officer, DHP/NHP, WHO Regional Office for the Western Pacific, Manila, Philippines

WHO Kobe Centre (WKC)

Mr Alex Ross, Director

Ms Suvi Huikuri, Technical Officer, Urban Health (UH)

Dr Megumi Kano, Technical Officer, UH

Ms Jinhee Kim, Consultant, UH

Ms Min Hyun Maeng, Volunteer, UH

Mr Amit Prasad, Technical Officer, UH

Ms Riikka Rantala, Technical Officer, UH

Ms Lotte Van Der Weijst, Intern, UH

10. Annex 2: Programme

Day ONE: Thursday, 29 May		Chair <i>Hoda Rashad</i> , The American University in Cairo
0900 – 0915	Welcome remarks	Alex Ross WHO Kobe Centre
0915 – 0930	Introduction of participants	
0930 – 1015	“Intersectoral Action on Health, a path for policy-makers to implement effective and sustainable action on health” Including Q&A/ Plenary	Riikka Rantala WHO Kobe Centre
1015 – 1030	<i>Coffee break</i>	
1030 – 1130	Recent studies and guidance on ISA/HiAP:	
	HiAP Framework for Country Action	Kwok-Cho Tang, WHO HQ
	South Australia and WHO HiAP training manuals	Carmel Williams, Dept. of Health and Ageing, South Australia
	Systematic scoping reviews of HiAP and other ISA for health equity	Ketan Shankardass, CRICH, Canada
	California Health in All Policies guide for state and local governments	Julia Caplan, Public Health Institute, California
1130 – 1220	Plenary discussion	
1220 – 1230	Group photo	
1230 – 1400	<i>Lunch break</i>	
1400 – 1430	Synthesis: Review of 16 WHO case studies using the ISA booklet as a framework	Jinhee Kim WHO Kobe Centre
1430 – 1500	Plenary	
1500 – 1515	Group work session 1: Linking recent evidence and guidance to the ISA booklet Presentation: Introduction to group work	Amit Prasad WHO Kobe Centre
1515 – 1530	<i>Coffee break</i>	
1530 – 1630	Group discussion	
1630 – 1730	Group report-back	
1730 – 1745	Plenary discussion and closing of Day One	Chair

Day TWO: Friday, 30 May		Chair <i>Hoda Rashad</i>
0900 – 0915	Recap of Day One	Chair
0915 – 1015	ISA/HiAP experiences	
	National government ISA/HiAP: Experiences from Finland	Eeva Ollila, Ministry of Social Affairs and Health of Finland
	Local government ISA: the case of Bhaktapur, Nepal	Shiva Adhikari, Institute for Nepal Environment and Health System Development
	Engaging the civil society in ISA	Vandana Prasad, People's Health Movement
	Q&A	
1015 – 1030	Group work session 2: Review of ISA booklet part 1 – key elements related to assessment and engagement of other sectors, and developing a strategy	Suvi Huikuri WHO Kobe Centre
	Presentation: Introduction to group work	
1030 – 1045	<i>Coffee break</i>	
1045 – 1200	Group discussion	
1200 – 1300	Group report-back	
1300 – 1415	<i>Lunch break</i>	
1415 – 1430	Group work session 3: Review of ISA booklet part 2 – governance structures, community participation, and monitoring and evaluation	Megumi Kano WHO Kobe Centre
	Presentation: Introduction to group work	
1430 – 1545	Group discussion (<i>coffee break included</i>)	
1545 – 1645	Group report-back	
1645 – 1745	Discussion on other recommendations for the revision of the ISA booklet Format of new version of the ISA booklet Strategies for dissemination	Chair
1745	Closing of the meeting	

11. Annex 3: 10 steps for ISA

