HEALTH IN ALL POLICIES: REPORT ON PERSPECTIVES AND INTERSECTORAL ACTIONS IN THE WESTERN PACIFIC

Regional Report
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Health in all policies: report on perspectives and intersectoral actions in the Western Pacific


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### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>8GCHP</td>
<td>8th Global Conference on Health Promotion</td>
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<tr>
<td>AIPF</td>
<td>Asia Injury Prevention Foundation</td>
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<td>CSDH</td>
<td>Commission on Social Determinants of Health</td>
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<td>FCTC</td>
<td>Framework Convention on Tobacco Control</td>
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<td>HFK</td>
<td>Helmets for Kids</td>
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<td>HiAP</td>
<td>Health in All Policies</td>
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<td>HIA</td>
<td>Health impact assessment</td>
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<td>HLA</td>
<td>Health lens analysis</td>
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<td>ISA</td>
<td>Intersectoral action</td>
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<td>NCD</td>
<td>Noncommunicable disease</td>
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<td>NEC</td>
<td>National Emergency Committee</td>
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<td>NTSC</td>
<td>National Traffic Safety Committee</td>
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<tr>
<td>PIHOA</td>
<td>Pacific Islands Health Officers Association</td>
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<tr>
<td>RSVP</td>
<td>Reduce Smoking in Viet Nam Partnership</td>
</tr>
<tr>
<td>SASP</td>
<td>South Australia’s Strategic Plan</td>
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<tr>
<td>SPC</td>
<td>Secretariat of the Pacific Community</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>VINACOSH</td>
<td>Viet Nam Steering Committee on Smoking and Health</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive summary

Background

In 2008, the World Health Organization (WHO) Commission on Social Determinants of Health (CSDH) made global recommendations on what could be done to address the avoidable health inequities created by political, economic and social factors. Addressing the social determinants of health to reduce health inequities requires action within and across the health and non-health sectors whose mandate does not focus on population health, but who contribute substantially to the determinants of health. The 2010 Adelaide Statement on Health in All Policies operationalized intersectoral action (ISA) in the form of the Health in All Policies (HiAP) approach to address the social determinants of health, outlining governance arrangements to facilitate necessary ISA. The World Conference on the Social Determinants of Health held in Rio de Janeiro in 2011 (WHO, 2011) asked governments to share what they had been doing to address these issues following the recommendations made in the CSDH report (WHO, 2008). Equipping the health sector to work with other sectors to improve the impact of their policies on health is prioritized in the Rio Declaration on Social Determinants of Health (WHO, 2011), and in the World Health Assembly (WHA) Resolution on the Social Determinants of Health (WHA65.8, 2012). In June 2013, the 8th Global Conference on Health Promotion (8GCHP) in Helsinki focused on implementing HiAP and produced the Helsinki Statement. This report is part of a global assessment of HiAP, which contributed to preparations for the 8GCHP.

The way in which social, economic and environmental drivers of health inequities play out and the nature of the action taken to address health inequities varies greatly between different political, social and cultural contexts and regions. The report considers how the global concepts of ISA, and specifically those practices lending themselves to scaling up a HiAP approach, are operationalized in the diverse local contexts of the WHO Western Pacific Region. The WHO Western Pacific Region is home to almost a quarter of the global population (approximately 1.8 billion people) and stretches from Mongolia and China in the north and west, to New Zealand in the south, and French Polynesia in the east. There are 37 countries and areas in the Region.

The aim of the report is to explain what, why and how ISA and, where possible, HiAP approaches have been implemented to address the social determinants of health. The report aims to explore lessons applicable to working intersectorally on public policies, which lies at the heart of a HiAP approach. It describes what it takes to develop and implement ISA across the Region. It analyses the roles of different areas of government and health and non-health sectors in addressing health. Different types of intersectoral action are examined, including the extent of civil society's engagement, as well as the systems, processes and structures that have facilitated or hindered ISA.

The report is based on evidence obtained from the peer-reviewed and grey, or informally published, literature, expert knowledge from telephone interviews with senior policy-makers in health and non-health sectors, and detailed case studies of ISA in Australia, Palau and Viet Nam.

1 Intersectoral action has been defined broadly as “effectively implementing integrated work between different sectors” (WHO, 2013). HiAP is a specific approach to intersectoral action, defined as “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.” (WHO Working Definition prepared for the 8th Global Conference on Health Promotion, Helsinki, 2013, see also the draft WHO Health in All Policies Analytical Framework for Learning from Experiences [WHO, forthcoming]). It is hoped that this regional report and related products will contribute to the refinement of these concepts. While some experts highlight important differences in the two concepts, for the purpose of this report, intersectoral action/work is used to refer to a range of practices aimed at supporting working “together” with other sectors or having health impacts taken into consideration in the actions of other sectors. The HiAP approach as formulated in the WHO definition refers to a specific inclusion of the public policymaking and implementation process (throughout the policy cycle). Where points are relevant to both “Health in All Policies” (HiAP) and “intersectoral action” (ISA), reference is made to “ISA/HiAP”.

An environment conducive to intersectoral action on the social determinants of health

Policy challenges that require ISA
The need for action on a number of diseases and health risks caused by societal factors across the WHO Western Pacific Region were identified. As in other regions, the triple burden of communicable diseases, noncommunicable diseases (NCDs), and traffic-related injuries and deaths is creating major challenges for countries’ health and social systems. In many countries in the Region, respiratory diseases, reproductive health and HIV/AIDS run parallel with issues of tobacco control, obesity, illicit drug use, cardiovascular disease and cancer.

Political will to pursue ISA
There are different types of champions for ISA for health. They are influenced by different factors and have different roles to play. Senior policy-makers in health and non-health sectors who were interviewed highlighted that debates among politicians in the Region (for example, on NCDs) have influenced leadership in favour of ISA. Calls for intersectoral action from the highest levels of leadership have also proved very important, partly because they have reinforced the mandate for ISA/HiAP approaches. Demonstrating their own country’s alignment with international movements is important in building pride in action domestically. Membership of cross-country initiatives and participation in ministerial meetings has helped promote countries’ accountability for their actions in addressing issues related to social determinants, thereby promoting ISA within the country.

The evolution of ISA in the Western Pacific Region
The Western Pacific Region has a long history of developing the intersectoral policies and programmes approaches laid out in the Ottawa Charter for Health Promotion (creating supportive environments through healthy settings, building healthy public policies, developing personal skills, strengthening community action and reorienting health services). These mechanisms provide opportunities to reduce inequities, promote health and prevent risk factors. Similarly, the environmental health programme has been a driving force in the Region for ISA. More recently, noncommunicable diseases have proved to be an important convening point for ISA across the Western Pacific Region. The NCD crisis has rallied action in health and non-health sectors, not necessarily from a health perspective but because of its impact on society and the economy. Disease or health issues were identified as being entry points rather than issues of concern to non-health sectors. Governments have occasionally engaged in health issues to force ISA, but the reality is that the entry points are not always immediately or easily identified as health related (for example, related to globalization, poverty reduction and urbanization).

Building blocks for the development and implementation of intersectoral policies and programmes

Framing and hooks for intersectoral collaboration
Countries in the Region do not have a consistent terminology to describe action on the social determinants of health. Many of the countries identified actions that were not framed using the term “Health in All Policies” per se; most refer to ISA and others to multisectoral action. All policy-makers who were interviewed understood that all sectors affect health, but they repeatedly raised the issue of how this way of working should be framed. This was reflected in comments about not using health-dominant language, using existing structures and opportunities, and not introducing HiAP as if it were new. In particular, it was seen as important to identify how HiAP is different to and builds on what has previously been termed ISA. The health system is concerned with policies and programmes to do with health, and other sectors are not. However, these differences in core business do not necessarily mean that different sectors cannot, or are not, working together to improve policy development and outcomes. The co-benefits of working across sectors to promote health, and social and economic outcomes, is recognized and actively pursued in many countries in the Region.
Working across sectors or intersectorally can be facilitated by the development of institutional mandates for collaboration, which are supported at an operational level by agencies and stakeholders. Furthermore, it is important that the purpose and co-benefits of ISA/HiAP are made explicit, rather than collaboration being undertaken for collaboration’s sake – for example, collaborating to achieve broader social goals that contribute to the overall national policy agenda or collaborating to identify and limit potential health damage caused by non-health sector policies and actions, are in all sectors’ interests. In both examples, the incentives and mandates will be influenced by the prevailing policy and political context for action. Clarity of purpose in turn enables explicit explanation of roles and processes, thereby avoiding misunderstanding and improving collaboration. More systematic documentation of different examples will advance and clarify these issues.

Collaborative practices, including HiAP
Countries across the Region present many examples of different sectors working together in ways that affect health, but the ways in which the collaborative practices are articulated vary significantly. While such efforts may address the underlying determinants of health, collaboration is often not explicitly labelled as anything to do with health. In some cases it may be called multisectoral or intersectoral action for health, but it is rarely termed HiAP. When asked what they understood by HiAP, senior policy-makers from across the Region expressed different views. All the interviewees highlighted that it was important not to present a HiAP approach as an entirely new way of doing things.

Key stakeholders and their role in ISA
Successful intersectoral partnerships occur where health and other sectors are perceived as equal partners or members of partnerships. Many sectors and stakeholders have played a role in driving HiAP activities, including committees on food security and safety, and ministries of transport, housing, and education. Similarly, nongovernmental organizations, including faith-based organizations, have been instrumental in the development of intersectoral policies and programmes to address the social determinants of health. ISA has worked best when these organizations are considered equal partners (for example in terms of joint accountability). In a number of countries across the Western Pacific Region, the central government has played an important role in leading national policy reform and change supporting intersectoral collaboration related to specific health issues, especially NCDs. Importantly, in most cases where intersectoral collaboration across government took place, the intersectoral partnership either reported directly to the head of state (prime minister or president) or received commitment from the highest level of government. Much of ISA or HiAP activity reported among health ministries involved their adopting, endorsing and championing policies and plans that address the social determinants of health and health equity. The health sector often plays an important coordinating role as a member of ISA partnerships focusing on health-specific issues. For example, in Palau, the Minister for Health is leading across-government action on NCDs in collaboration with other appropriate ministries. Where the issue is non-health specific, the health sector is a supportive and/or collaborative partner rather than the coordinator. In the case of the Project for improving the mobility, safety and well-being of Aboriginal people in South Australia, the Health Lens Analysis (HLA) project is a joint initiative within SA Health (Aboriginal Health and Public Health branches), with the various agencies or sectors, e.g. planning, transport and infrastructure, the Attorney-General, the police, correctional services, education, employment, and science and technology. The provision of information and research (including baseline or monitoring data) is an area where the health sector is perceived as playing a vital role. In Viet Nam, the health sector’s role consists in monitoring and surveillance of the impact of legislation on the wearing of crash helmets.

Formal and informal structures to facilitate ISA/HiAP
Enablers and constraints are found at various structural levels, and range from the absence of policies supporting collaboration to the coordination of services across sectors. Links between the health sector and communities also play a role. In the absence of systemic support for ISA, structural factors combine with individual actors’ variables, such as leadership in the health sector, or health professionals’ own initiatives, to affect action.
ISA that addresses the social determinants of health and health equity

Policy-makers were asked if they thought the term “health equity” motivated different sectors to promote health or intersectoral work. Based on formal interviews, and the literature, it seems that the usefulness of the term varies among countries in the Region. Equity was rarely framed explicitly or as an expected outcome of work in a country unless it was related to a specific sector goal or target. For example, equity is a focus of the HLA project, where the differences in life expectancy between Aboriginal and non-Aboriginal people are a key area for attention across sectors.

This highlights three key issues: (a) equity is rarely an explicit goal; (b) where reducing or improving health inequities is explicitly mentioned, the goal is rarely specific, for example by referring to a broad slogan such as “closing the gap”; and (c) even where an explicit equity-related goal exists, the impact of the policy action/intervention is rarely evaluated. The latter may be because there has not been enough time to see cause, effect and impact, or to a lack of data. The differing uses and interpretations of terminology across sectors pose a challenge when using them as hooks to encourage ISA and a HiAP approach. This points to the need to have sharper, more widely understood indicators of progress with respect to reducing health inequities.

A number of social determinants of health are being addressed across the Region. The detailed case studies described innovative work in transport, but examples of ISA do exist on food policy and taxation, social housing, action on gender-based violence, and a broad array of health services. While the case study from Palau focuses on the use of emergency powers in relation to NCDs, it implicitly points to the need for action on globalization as a social determinant of health, and its significant impact on NCDs among Pacific island countries and areas. It highlights inequalities between and within countries, even though the United Nations Political Declaration on Noncommunicable Diseases does not explicitly focus on this issue. Some of the literature identifies NCDs as the second wave of negative impacts of colonization on the health of indigenous populations. However, as described previously, most of these analyses lack systematic focus in assessing the impact of ISA on equity.

Sustaining ISA/HiAP on the social determinants of health and health equity

Significant activity on ISA/HiAP is taking place in the Western Pacific Region in terms of scope, approaches and progress. However, the published evidence, interviews with senior policy-makers and country case studies clearly highlight that improvements are needed. An institutional mandate is being built for ISA to address the priority issues facing countries. But this alone is insufficient for success. Identifying co-benefits and common goals, orienting political and bureaucratic structures towards the social determinants of health, and building good relationship skills were consistently identified as key factors needed to initiate, sustain and improve ISA/HiAP work in countries across the Western Pacific Region. Some specifics are outlined below.

Terminology matters
The review found a range of different understandings and applications of ISA/HiAP across countries. Terminology needs clarification as does the definition of HiAP, particularly of how it is comparable to and different from intersectoral or multisectoral collaboration. Similarly, health equity is not understood in the same way across countries and sectors, and it is rarely an explicit goal. This poses challenges if health equity is used as a hook to encourage ISA and a HiAP approach. Developing some clarity about concepts and consensus on definitions could improve data collection and categorization, and knowledge exchange and practice. It could also strengthen capacity within the health and other sectors to undertake sustainable and effective intersectoral collaboration on the social determinants of health for improved health equity.
Focus on co-benefits and not just health goals

Making the sectoral co-benefits explicit and clear is vital for an effective HiAP approach. Policy-makers from across the Region noted that successful HiAP action entails a willingness to not be the expert and focus on the longer term goal (improved well-being) even where discussions are not framed in health language. Many examples of ISA/HiAP have traditionally focused efforts on identifying the leading sector because of the concern that progress would not be possible without a clear lead. The review from the Western Pacific Region suggests that having clear roles and responsibilities is often overlooked, even though it is more important to success than identifying leading sectors. This comes back to the importance of being clear about the purpose of collaboration. In country or policy contexts where resources are limited, other sectors may be suspicious or unwilling to engage if the purpose is not explicit or if the health sector is perceived to be trying to get other sectors to use their own resources to achieve health goals.

Understand competing agendas

Competing agendas and limited resources among health and other sectors need to be understood and navigated. Health reforms are ongoing in some countries in the Region. ISA/HiAP needs to be well integrated into this work and its contribution to health systems strengthening made clear. Otherwise, HiAP may take lower priority than other health issues and crises that are perceived as more immediate, particularly where HiAP is seen as a governance or administrative process rather than a tangible intervention. For example, an NCD crisis was declared among Pacific island countries and areas not because NCDs were not being addressed within the health sector. Rather, it was felt that NCDs and related risk factors were not being tackled fast enough because they were being demoted to non-urgent in contrast to issues such as avian influenza – hence the need to accelerate action by declaring a state of emergency.

Participatory governance

While much of the focus of this report is on policy-making and implementation, the interviews with policy-makers highlighted the importance of ongoing advocacy by civil society groups for action on the social determinants of health. Support and mechanisms to ensure the participation of civil society groups in policy-making are needed.

Knowledge and skills for intersectoral working

There are gaps in the published literature on action that addresses the social determinants of health and health equity across the Western Pacific Region. Most of the literature focuses on issues and outcomes rather than on the processes of ISA/HiAP, and the underlying contextual factors that increase its effectiveness and sustainability. Research is needed into policy development, implementation processes and the impact on equity. This requires investment in different research areas and capacity-building in the skills needed to do such research. Another reason for the gaps in the evidence base is that some activities are just not documented. Also, examples of action by other sectors are not documented in language that is identifiable as comprising ISA or HiAP. Similarly, the focus has often been on identifying examples of “good” or “best” practice of ISA/HiAP and equity. Presenting examples of action on ISA/HiAP rather than seeking to label them as good or best practices may facilitate a more useful discussion. The WHO database “ISACS” (Intersectoral action case study database), which is accessible through “ACTION: SDH” (www.actionsdh.org, and the WHO website) provides a useful starting point for collecting information, and identifying gaps in the data on the processes, and on the impact of existing and undocumented ISA/HiAP activity and interventions.

Lack of familiarity with a topic and associated evidence can prevent action on the issue. For example, understanding food security as an area for ISA has been hampered by health scientists’ lack of knowledge, and evidence on sustainability and affordability. Building an understanding of the social determinants of health among health and other professionals is therefore important. Capacity-building for health professionals in policy development and implementation processes is also needed. The South Australian model demonstrates the importance of having a technical process, the “health lens”, attached to ISA/HiAP. This enables consideration of the content of policy decisions, particularly its links to health, well-being and equity, and brings evidence to bear on those decisions.
Conclusions
Improving the health sector’s ability to implement HiAP is important to ensure universal health coverage, as many of the barriers to promoting health or preventing and treating ill-health and disease lie outside the direct remit of the health sector. This report illustrates that there is a strong foundation for action. In particular, issues like NCDs and transport, urban development and gender inequalities provide important convening points for ISA, and multisectoral and HiAP-related action in the Western Pacific Region. Also, building the institutional mandate for ISA and multisectoral collaboration to address priority issues facing countries is clearly a necessary – although insufficient – requirement for successful HiAP activity. The report also illustrates where there are potential gaps and a need for clarification and consensus building, for example, clearer articulation of what is meant by HiAP in contrast to ISA and multisectoral action. This knowledge can be used to equip those working in health and other sectors to undertake sustainable and effective intersectoral collaboration on the social determinants of health for improved health equity.
Introduction

In 2008, the WHO Commission on Social Determinants of Health (CSDH) made global recommendations on what could be done to address the avoidable health inequities created by political, economic and social factors (WHO, 2008). Addressing the social determinants of health and health equity requires action within and between the health and non-health sectors. The 2010 Adelaide Statement operationalized intersectoral action ISA in the form of the Health in All Policies (HiAP) approach to address the social determinants of health, outlining new governance arrangements to facilitate ISA (WHO & Government of South Australia, 2010). The World Conference on the Social Determinants of Health in October 2011 asked governments to share what they had been doing to address these issues since the recommendations of the WHO CSDH. Equipping the health sector to work with other sectors to improve the impact of their policies on health is prioritized in the Rio Declaration on Social Determinants of Health (WHO, 2013), and in the follow-up WHA resolution, WHA65.8. In June 2013, the 8th Global Conference on Health Promotion (8GCHP) in Helsinki focused on implementing HiAP, leading to the adoption of the Helsinki Statement on Health in All Policies (WHO & Finland Ministry of Social Affairs, 2013). In this context, WHO commissioned a review of regional practices of ISA and HiAP to support assessments of opportunities for and learning from practice on how to implement HiAP. This report is part of the broader review in three WHO regions: Africa, South-East Asia and the Western Pacific.

This report considers how the globalized concepts of ISA, and current understandings of the relatively new concept of HiAP, correspond to the diverse local contexts of the Western Pacific Region. The WHO Western Pacific Region is home to almost 25% of the world’s population (approximately 1.8 billion people). It stretches from Mongolia and China in the north and west, to New Zealand in the south, and French Polynesia in the east. There are 37 countries and areas in the WHO Western Pacific Region. The way in which the social drivers of health inequities play out and the degree to which action is taken to address health inequities varies greatly between different political, social and cultural contexts and regions. The report looks at HiAP and ISA examples to address health inequities from an exclusively Western Pacific perspective. The report considers how the global concepts of ISA, and specifically HiAP, are understood and operationalized in the diverse local contexts of the WHO Western Pacific Region, and identifies common issues that support or act as barriers to HiAP and ISA for health and health equity (WHO & Government of South Australia, 2010).

Outline of the report

Section 1: Describes the methods used to collate and synthesize the evidence relating to HiAP and ISA for health across the Region. We draw on peer-reviewed journal articles, the grey, or informally published, literature and expert knowledge obtained through telephone interviews with senior policy-makers from health and non-health sectors in five countries. Detailed case studies elucidate key lessons learnt for effective ISA/HiAP.

Section 2: Describes the regional environment and how conducive it is to ISA on the social determinants of health. Based on the published literature and telephone interviews with senior policy-makers, various problems or issues are identified as needing intersectoral action to rectify them. Various entry points through which to initiate intersectoral work are described, and the important role of a political will to pursue ISA/HiAP is discussed. We close with an overview of the evolution of ISA/HiAP across the Region.

2 Intersectoral action has been defined broadly as “effectively implementing integrated work between different sectors” (WHO, 2013). HiAP is a specific approach to intersectoral action, defined as “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.” (WHO Working Definition prepared for the 8th Global Conference on Health Promotion, Helsinki, 2013, see also the draft WHO Health in All Policies Analytical Framework for Learning from Experiences (WHO, forthcoming)). It is hoped that this regional report and related products will contribute to the refinement of these concepts. While some experts highlight important differences in the two concepts, for the purpose of this report, intersectoral action/work is used to refer to a range of practices aimed at supporting working “together” with other sectors or having health impacts taken into consideration in the actions of other sectors. The HiAP approach as formulated in the WHO definition refers to a specific inclusion of the public policy-making and implementation process (throughout the policy cycle). Where points are relevant to both the terms “Health in All Policies” (HiAP) and “intersectoral action” (ISA), reference is made to “ISA/HiAP.”
Section 3: Describes what it takes to develop and implement ISA across the Region with the issues of language and framing featuring strongly. The importance of having a health sector that endorses an agenda on the social determinants of health for bringing non-health sectors along on the ISA journey is discussed. Ways of doing ISA are described, including the roles of different parts of government and civil society engagement, and the structures to facilitate or hinder ISA.

Section 4: Focuses on the issue of equity, and describes the design of ISA that has equity as an explicit target or outcome, and the main approaches used to address equity.

Section 5: Describes what is needed to build and sustain ISA/HiAP. Structural barriers and facilitators of ISA/HiAP are discussed, as are the knowledge and skills needed, and ways of measuring success. Lastly, we describe the central elements of effective ISA/HiAP based on the analysis of the case studies.
SECTION 1
ASSEMBLING THE EVIDENCE

The report is informed by: (1) a systematic review of peer-reviewed journal articles and grey, or informally published, literature related to concepts, actions and cases on how ISA is or could be implemented, (2) interviews with senior policy-makers and practitioners involved in ISA in countries across the Region; and (3) a review and analysis of grey and peer-reviewed literature to elaborate detailed examples identified through the first two processes, and to highlight key aspects of relevance to ISA and HiAP.

The literature search (both peer-reviewed and grey literature) was undertaken using search criteria describing intersectoral collaboration and governance, health and well-being, and country experiences specific to the countries covered in the three WHO regions of this review: Africa, South-East Asia and the Western Pacific. The search and review method is described in a separate paper that is available on request.

1.1 The published evidence

There were 87 peer-reviewed journal papers requested for extraction on the basis of an abstract and titles review. A review of these papers by the report authors identified 38 papers that were relevant. Forty-one papers were not considered applicable, because, for example, they were not specific to the Region or did not include any information on ISA/HiAP – they were about individuals and health problems), or were letters to the editor or editorials with quite limited information on ISA and HiAP activity. Eight further articles could not be obtained in the period needed. The evidence presented in this report is therefore based on 38 full articles, two abstracts and a prior scoping review by Shankardass et al. (2012). The number of articles per country ranged from one to three (see Table 1). The evidence was not equally distributed in all parts of the Region, possibly because some of it did not exist or was not published. Fourteen papers from Cambodia, China, Hong Kong (China), Malaysia, Mongolia and the Republic of Korea were identified as relevant from the database of grey literature provided by WHO.

There are a number of limitations concerning the papers derived from the search strategy. Most articles described potential topic areas for ISA and principles rather than the practice of ISA (especially those mentioning multiple countries). Several seemed relevant in a tangential way only. For example, those from Australia included only one paper looking at rural placements for medical students, and another at the role of a university department in assisting rural communities to obtain financial rural health grants for local projects; one from New Zealand dealt with the economic and climatic impact of having people ride bicycles rather
than drive cars for short distances (with barely a mention of health impacts). There was little explicit discussion of the intersection between primary health care and ISA in the identified peer-reviewed and grey literature. The literature that was identified referred to primary health care and health-service development in New Zealand (Glensor, 2004), medical education (McNair et al., 2001) and rural health capacity-building in Australia (McDonald et al., 2002) and the localized New Zealand primary health-care model of care (Glensor, 2004).

Another area of significant ISA activity not captured in the primary literature review was the use of health impact assessments. This omission is an important lesson for future updates of regional reviews and the associated search strategy used. Health impact assessments (HIAs) occur across the Region but have been particularly prominent in Australia (Harris & Spickett, 2011) and New Zealand (Cunningham et al., 2010). It is a structured step-by-step process for predicting the effects of a policy in order to make recommendations to improve the policy, as well as providing a space for dialogue and communication between stakeholders (Harris, Kemp & Sainsbury, 2012). HIAs have also been used in Australia, New Zealand and other countries across the Region as part of the assessment of development projects, either as stand-alone assessments or part of broader environmental assessments (Harris-Roxas et al., 2012). The projects range in size and nature but are often enormous in terms of their scope for influencing health and equity, and are all inherently intersectoral in the way they are conducted and approached (Harris et al., 2009). Both types of HIA activity have been extensively documented and evaluated in the literature (Kemm, 2012), providing valuable lessons for HiAP practice globally.

1.2 Telephone interviews with policy-makers

Six in-depth telephone interviews were conducted with senior policy-makers in health and non-health sectors to gain a better understanding of the mechanisms that facilitate the initiation of intersectoral initiatives, as well as the mechanisms that give or could give sustainability to intersectoral work, including structures of government, levels of decentralization, and the relationships and power between different sectors of government. The name, organization and country for each interviewee are listed in Appendix 1 along with the list of interview questions. Four of the six interviewees were senior policy-makers in either national or provincial-level health departments. Two interviewees were from non-health sectors, one at the national government level and the other at the regional/provincial level. Quotes are dispersed throughout the report with the interviewee’s initials and surname.

**Detailed examples of action and case studies**

During the first two steps, particularly the interviews with policy-makers, five examples of action were identified that were further elaborated through a
review of existing published and grey literature, and followed-up with policymakers. Given the limited published information and time constraints, three case studies were developed. Each uses the same structure, including the level of action, sectors involved, relevance to HiAP, issues addressed, overview of the activities and processes, associated monitoring and evaluation, overview of the country context, and limitations and assumptions. The three detailed case studies include:

1. the Health lens analysis (HLA) of Aboriginal mobility, road safety and well-being in South Australia’s HiAP;
2. declaring a state of emergency on noncommunicable diseases (NCDs) in Palau; and
3. formulation, implementation and monitoring of the helmet law in Viet Nam.

The case studies were chosen to reflect the breadth of experiences on ISA for health in the Western Pacific Region. Each case study also involved background desk research, complemented by information from authors, reviewers and other experts.

Since NCDs have proven to be an important convening point for recent ISA action in the Western Pacific Region, additional examples were included analysing intersectoral coordination and mechanisms used in Fiji, Malaysia and Mongolia.

This exercise also built on two previous related exercises. The first is the 2011 HealthGAEN report on health equity in the Asia Pacific region, which included a systematic review of examples of action to address the social and environmental determinants of health across the Asia Pacific region (HealthGAEN, 2011). The report identified many examples in countries in the Western Pacific Region tackling the wider determinants of health in the areas of urbanization, work, social protection, trade, environment and macroeconomic policy.

The second exercise was a series of case studies and background papers commissioned by WHO for the World Conference on Social Determinants of Health in Rio de Janeiro, Brazil, in 2011. The goal of these papers was to highlight country experiences in implementing action on social determinants of health. Several papers focused on examples from countries in the Western Pacific Region, including Australia (South Australia), Cambodia, Kiribati, Solomon Islands and Viet Nam. As well as action at a country level, examples of joint processes and coordination initiatives such as United Nations–Government Joint Programme on Gender Equality were identified.

The examples of ISA from these two exercises are not included here in any detail because (a) they are already well documented; or (b) they are the focus of another related exercise. For example, the WHO Centre for Health Development in Kobe, Japan, is developing detailed examples of ISA with regard to urbanization. Therefore, it is recommended that this report be read against this wider backdrop of activity. An earlier draft of this report was shared with WHO staff at regional and country level and, through them, with relevant national counterparts to cross-check and complement information contained therein. In the remainder of the report, we draw on the various types of evidence to describe and understand how ISA is being used across the Region, and to identify the barriers and facilitators of such approaches.
2.1 Problems identified as needing intersectoral action

Target problems and issues identified for specific countries are shown in Table 2. Newer issues for developing countries in the Region that were identified as requiring ISA include tobacco control, asbestos-related diseases, obesity and imported foods, breast cancer, drugs and HIV/AIDS. Articles also identified the need and problem of maintaining mosquito control as the incidence of malaria reduces in some countries.

<table>
<thead>
<tr>
<th>Target problem</th>
<th>No. of articles</th>
<th>Country/area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse of women (services for)</td>
<td>1</td>
<td>Malaysia</td>
</tr>
<tr>
<td>Alcohol</td>
<td>1</td>
<td>Malaysia</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>1</td>
<td>Lao People’s Democratic Republic</td>
</tr>
<tr>
<td>Cancer</td>
<td>2</td>
<td>Multiple/Federated States of Micronesia</td>
</tr>
<tr>
<td>Child abuse surveillance</td>
<td>1</td>
<td>Multiple</td>
</tr>
<tr>
<td>Chronic disease (economics)</td>
<td>1</td>
<td>Vanuatu</td>
</tr>
<tr>
<td>Drug policy</td>
<td>1</td>
<td>Malaysia</td>
</tr>
<tr>
<td>Government policy</td>
<td>1</td>
<td>Malaysia</td>
</tr>
<tr>
<td>Health policy</td>
<td>1</td>
<td>Fijil</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>2</td>
<td>Malaysia/Kiribati</td>
</tr>
<tr>
<td>Malaria prevention</td>
<td>2</td>
<td>Philippines/Vanuatu</td>
</tr>
<tr>
<td>Maternal mental health</td>
<td>1</td>
<td>Viet Nam</td>
</tr>
<tr>
<td>Mental health</td>
<td>1</td>
<td>Hong Kong (China)</td>
</tr>
<tr>
<td>Myopia</td>
<td>1</td>
<td>Singapore</td>
</tr>
<tr>
<td>Natural disasters</td>
<td>1</td>
<td>Multiple</td>
</tr>
<tr>
<td>Nutrition</td>
<td>2</td>
<td>Multiple</td>
</tr>
<tr>
<td>Obesity (via soft drink taxes)</td>
<td>1</td>
<td>Pacific island countries and areas</td>
</tr>
<tr>
<td>Parasites</td>
<td>1</td>
<td>China</td>
</tr>
<tr>
<td>Primary care</td>
<td>3</td>
<td>Multiple</td>
</tr>
<tr>
<td>Public health education</td>
<td>1</td>
<td>Multiple</td>
</tr>
<tr>
<td>Renal disease (treatment)</td>
<td>1</td>
<td>Hong Kong (China)</td>
</tr>
<tr>
<td>Respiratory diseases</td>
<td>1</td>
<td>Multiple</td>
</tr>
<tr>
<td>Schizophrenia (educating relatives)</td>
<td>1</td>
<td>Hong Kong (China)</td>
</tr>
<tr>
<td>School health (and sanitation)</td>
<td>1</td>
<td>Philippines</td>
</tr>
<tr>
<td>Sexual health</td>
<td>1</td>
<td>Multiple</td>
</tr>
<tr>
<td>Technological development</td>
<td>1</td>
<td>Multiple</td>
</tr>
<tr>
<td>Tobacco</td>
<td>1</td>
<td>Lao People's Democratic Republic</td>
</tr>
<tr>
<td>Transport and climate change</td>
<td>1</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Women’s health</td>
<td>1</td>
<td>Multiple</td>
</tr>
</tbody>
</table>
Issues in multiple sectors include natural disasters, nutrition, public health education, respiratory diseases, sexual health, technological development and women’s health.

The assessment of the grey literature identified various activities focusing on NCDs, mainly in the health sector (Omar & Mustapha, 2012; Varghese, 2011). Outside health-oriented issues, the grey literature suggests various issues that could be entry points for ISA. In China, concerns for agricultural biodiversity were a catalyst for ISA (Qingwen et al., 2009). In Hong Kong (China) various issues emerged including the ageing public sector workforce (Hong Kong [China], 2010), a shift to democratic local governance (Chan & Chan, 2005), and a move towards a low-carbon economy (Tsang et al., 2011).

In Japan, broad issues ranged from regional development policy from the 1980s to 2000s (Kitagawa, 2008), to the social determinants of health (Kondo, 2011), and the work of the WHO Centre for Health Development on ISA for health equity in urban policies (WHO, 2009) to unhealthy working conditions (IOHA, 2011). Globalization and policy change (Kim, 2011) and a specific healthy city (Gumi City Public Health Center, 2010) are issues identified in the Republic of Korea. Finally, in Mongolia,
an article on the health benefits of livestock vaccination was provided (Roth et al., 2003).

2.2 Entry points for intersectoral action

Both the grey literature and the interviews identified the importance of the current NCD crisis as a major entry point for ISA. A central argument in the NCD crisis is the unaffordability of providing universal access to chronic medication and related medical services as people live longer, therefore implying health promotion and prevention in deterrence from symptoms to active disease as a cost-saving measure. Entry points were obesity and cancer, as well as child abuse surveillance, natural disasters, nutrition, public health education, sexual health, technological development (genomics) and women’s health.

2.3 Political will to pursue intersectoral collaboration for health

The importance of a government’s political will to enable ISA is emphasized in several articles (Yadav, 2001; Yip & Anderson, 2007). It was also reflected in the responses from the telephone interviews with senior policy-makers. When asked if they thought that debates of politicians in the Region had influenced leadership in favour of HiAP work, they confirmed the importance of calls for ISA by regional intergovernmental organizations. They thought that these could help to reinforce the mandate for ISA/HiAP approaches in the home country. Being able to demonstrate that their own country was aligned with international movements was important to build pride in action domestically. Membership of cross-country initiatives and participation in ministerial meetings may encourage governments to be accountable for their actions on social determinants, therefore promoting HiAP action within the country.

In South Australia, certainly having a number of other countries talking about it, with other governments embracing it, shows the momentum that it’s building. The fact that the United Nations is talking about multisectoral action through the high-level NCD meeting in 2011 is important for the central government here in South Australia. It shows that we are doing something innovative, that it is worthwhile, and that we are not out there on our own. It helps keep the ideas resonating in Australia. South Australia is considered to be amongst a good group, holding our level NCD meeting in 2011 is important for the central government here in South Australia. It shows that we are doing something innovative, that it is worthwhile, and that we are not out there on our own. It helps keep the ideas resonating in Australia. South Australia is considered to be amongst a good group, holding our heads well in that international context. (C. Williams)

This has been quite important for us. Most of us work on the statements and recommendations from the Pacific Island Ministers for Health Forum. Fiji is now mainly using the Healthy Islands Declaration from 1996. At the same time, the Pacific islands have declared an NCD crisis, and moving onto mental health. Leadership and guidance (from the other countries) is helpful not only for our Minister but for guiding our policy and programmes. (I. Tukana)

The top officials, presidents of governments in Micronesia, got together, and under the leadership of the President of Palau, came up with a very important environment and conservation protection initiative called The Micronesian Challenge. The President got everyone in Palau to agree to conserve 30% of our coastal areas and 20% of our terrestrial areas for environmental protection and conservation, for future generations. And then he got together with the other executives and challenged them to agree to do the same. They initially signed the Micronesian Challenge, and they will do the same in the Marshall Islands, Micronesia, Guam, and Northern Mariana Islands. Politically, this has happened and has been done right. (C. Otto)

This year in Samoa, we will be answering to all health ministers at the Pacific Islands Minister of Health meeting. Papua New Guinea … will need to respond to the health ministers about what we have done for the determinants of health. (P. Dakulala)

Within countries, the interviewees reported that political leadership and engagement around ISA was very important. Most of the leadership has been at the national level (or state level in the case of South Australia).

We had very good work by the politicians when I was in the Senate in Palau. The beer makers in this area – the biggest beer sold here is Budweiser, which comes from a US brewery in Guam. For their marketing they started labelling their cans “Bud Nation Palau”, “Bud Nation Guam”, etc. The Association of Pacific Island Legislators wrote to Budweiser requesting that they stop because we (the countries) had not given them the authority to use our name to promote their product, a product that has negative consequences for our young people. They stopped it. The politics and political support can be very important. (C. Otto)

In Fiji, the health minister, because he comes from the health sector, has been useful in driving this reorientation. In his term, he has set up a health policy unit that was not there before. And he has looked into the health network. The Ministry of Health is only the second that has a health policy unit, and he is moving towards a Health Commission to keep the collaboration. If it is at the ministerial level, it is the minister who has driven us towards that. We are fortunate that the leadership has been to our advantage, where a minister, rather than a political candidate, has an interest in health. There is some flexibility in terms of passing decrees now that we
do not have a parliament. We have never had so many policies passed through – the leadership was a big factor moving forward policy and encouraging intersectoral policies. (I. Tukana)

Papua New Guinea has a Vision 2050, which is set at the highest level, our Prime Minister. Direction was to get all of the different sectors to respond to how we can deal with our country becoming a healthy working country by 2050. That involved churches, governments, business, and so all of that was made about Seven pillars. All of those pillars have had an influence in terms of the social determinants of health. Each sector has a sectoral plan to address the national strategic plan and vision. (P. Dakulala)

We have been very fortunate at the state-level, as we have maintained good support for HiAP at all levels of the bureaucracy. Even when the people within bureaucracy have changed, we have maintained that support. Because we do not have a big budget, we are really just a team of people, there is that level of support. (C. Williams)

The HiAP strategies in South Australia were initiated by the Premier at the time. I think that tied to this is the ongoing search across government for greater responsiveness at the local level, and greater emphasis on intersectoral work. The more flexible we can be at the local level, the better we cater to local communities, the more we use joined-up approaches, and the better the outcome for citizens. (B. Semmens)

Interviewees mentioned competing agendas, priorities and paradigms within countries as issues that affected political leadership at the various levels of the different sectors. In some instances, the values and personal views of political leaders either explicitly or implicitly prevented or diluted ISA/HiAP work and impacted negatively on healthy public policy.
The evolution of intersectoral action for health across the Region

Using the evidence available, it was not possible to conduct a complete chronology of ISA and HiAP across the Region. However, ISA has been undertaken for many years through various activities promoting health, including the establishment of health-promoting foundations, boards or councils. Similarly, environmental health programmes have been a strong driving force for ISA. Furthermore, from the mid-1990s, a range of policy and programme development has been underway in the Pacific island countries and areas that were informed by the Healthy Islands vision and approach (WHO Regional Office for the Western Pacific, 1995). However, it is clear that for intersectoral approaches on NCDs, the 2011 United Nations High-level Meeting on the Prevention and Control of Non-communicable Diseases provided an important convening point for all countries in the Region, accelerating activities from about 2010 onwards (see Table 3).

The key milestones presented in the table summarize recent activities but do not reflect the work that took place in the early part of this century. Since 2000, there has been a substantial increase in the number of countries developing NCD-specific policies, which most likely had its roots in the World Health Assembly endorsement of a global strategy on NCDs (Rani et al., 2012). Similarly, although the helmet law came into effect in Viet Nam at the end of 2007, the multisectoral National Traffic Safety Committee (NTSC) that leads this work

### Table 3. Summary of Intersectoral Action/Health in All Policies Across the Western Pacific Region, 2010–2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>April: Pacific Islands Health Officers Association (PIHOA) resolution declaring NCD crisis (PIHOA, 2010:5)</td>
</tr>
<tr>
<td></td>
<td>June: Pacific NCD forum with a report detailing ISA in countries in the Western Pacific Region (Secretariat of the Pacific Island Communities &amp; WHO, 2010)</td>
</tr>
<tr>
<td></td>
<td>December: Endorsement of the PIHOA resolution by the Association of Pacific Island Legislatures (APIL, 2010)</td>
</tr>
<tr>
<td></td>
<td>Ongoing preparatory work in Palau and Pacific island countries as follow up to the PIHOA declaration</td>
</tr>
<tr>
<td></td>
<td>Fiji – From Womb to Tomb with a Double Edged Sword. Everybody’s Business, the NCD Strategic Plan 2010–2014 (Fiji Ministry of Health, 2010)</td>
</tr>
<tr>
<td>2011</td>
<td>February: Nadi Statement on the NCD crisis in Pacific island countries and areas (WHO Regional Office for the Western Pacific, 2011a)</td>
</tr>
<tr>
<td></td>
<td>May: Palau declaration of a NCD emergency by the President (Palau Office of the President, 2011)</td>
</tr>
<tr>
<td></td>
<td>Minister of Health, Palau, requests Chair of National Emergency Committee (NEC) to trigger meeting of NEC</td>
</tr>
<tr>
<td></td>
<td>June: Honiara Communiqué on the Pacific NCD Crisis by the Ministers of Health for the Pacific Island Countries and Areas (WHO Regional Office for the Western Pacific, 2011b)</td>
</tr>
<tr>
<td></td>
<td>PIHOA technical working group on NCDs established and met in second half 2011 (Durand, 2013)</td>
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<tr>
<td></td>
<td>September: United Nations high-level meeting and declaration on NCDs</td>
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<tr>
<td></td>
<td>October: NEC meeting with Ministry of Health staff in Palau to plan the way forward</td>
</tr>
<tr>
<td></td>
<td>WHO Regional Committee for the Western Pacific Resolution (RC62.R2) on NCDs</td>
</tr>
<tr>
<td></td>
<td>November: PIHOA 51st meeting with special focus on NCDs (PIHOA, 2011a; PIHOA, 2011b)</td>
</tr>
<tr>
<td>2012</td>
<td>January: first national summit on NCDs in Palau and Hazard Mitigation Sub-Committee of the NEC is tasked with ensuring the outcomes of the summit are developed</td>
</tr>
<tr>
<td></td>
<td>April: draft NCD Strategic Plan developed by the Hazard Mitigation Sub-Committee of the NEC in Palau including proposed lead and support roles of different sectors</td>
</tr>
<tr>
<td></td>
<td>June: WHO Western Pacific regional meeting on national multisectoral plans for NCD prevention and control (Malaysia) (WHO Regional Office for the Western Pacific, 2012)</td>
</tr>
</tbody>
</table>
has been active since 1997, and related legislation was developed prior to 2007 (Passmore et al., 2010a; 2010b). Another example is the establishment in 2002 of the National Council for Public Health in Mongolia led by the Prime Minister with ministerial-level representation from health, education, justice, infrastructure, food and agriculture, environment, foreign affairs and defence, as well as the National Statistical Office, the Health Sciences University of Mongolia and the Ulaanbaatar City Government (Rani et al., 2012; Bolormaa et al., 2007).
SECTION 3
BUILDING BLOCKS FOR THE DEVELOPMENT AND IMPLEMENTATION OF INTERSECTORAL ACTION ON THE SOCIAL DETERMINANTS OF HEALTH AND HEALTH EQUITY

Informed by the evidence review and telephone interviews, this section is organized according to a number of important ISA issues to be addressed when considering whether ISA on the social determinants of health and health equity, and specifically HiAP, has been taking place across the Region, and what factors have facilitated or hindered that action.

3.1 Framing issues and hooks for multisectoral engagement

The vision of health and its importance for multisectoral engagement

The vision of health does play a role in encouraging or inhibiting ISA/HiAP. For example, the health sector in Malaysia began intersectoral policy engagement in 1971 by linking it to the New Economic Policy (Abdul Khalid bin Sahan, 1988). The policy concentrated on the eradication of poverty and the restructuring of society. The health sector focused on the poor and other disadvantaged groups (especially rural communities and the urban poor). Disease as a population health issue was also an important entry point for the health sector (e.g. infectious diseases and malnutrition), but specifically sanitary conditions, and the health of the mother and child. The inequitable distribution of health resources and facilities was a third focus for the health sector.

In the Viet Nam case study, the incentive for introducing the helmet law does not appear to have been primarily or solely to tackle a health issue per se. The focus of the overall decree is to improve road safety and provide traffic alleviation – both of which have positive health benefits if implemented effectively. However, other commentators on injury prevention have noted that it “…provides a powerful way of illustrating the health impacts of intervening on the social determinants. Intervening in this way can and frequently does yield cross-cutting benefits for a range of health and other outcomes.” (Roberts & Meddings, 2010:244).

However, as the literature reviewed highlights, the entry point for ISA frequently focuses on diseases, for example in relation to sexually transmitted infections (Brewis, 1992), HIV/AIDS (Narayanan et al., 2011), chronic respiratory disease (Varela, 2012), and vectorborne diseases (specifically, malaria and dengue) (Van de Berg et al., 2012). Another clear entry point is hospital service delivery
for complex problems such as violence against women (Colombini et al., 2012). Moreover, developing an integrated primary health-care service also requires that the conditions in which health is created be addressed, and advocating for equity or social justice (Glensor, 2004). More recently, it has been noted that Malaysia has been concentrating public health activity on traditional diseases surveillance and government regulation (Allotey et al., 2011).

In terms of tackling NCDs, the Fijian, Malaysian and Palauan national strategies place health in a much broader context. The overall goals are to have populations that are largely free from NCDs and the main risk factors for NCDs – for example, the Fijian plan uses a definition of health that goes beyond absence of disease. Both the Fijian and Palauan approaches are informed by the Pacific Framework for Prevention and Control of NCDs where underlying socioeconomic, cultural, political and environmental determinants of health (globalization, urbanization and population ageing) are identified as the major causes of NCDs. Consequently, policy responses should put a significant amount of resources into structural policy changes, followed by lifestyle changes and clinical services (Fiji Ministry of Health, 2010).

In Fiji, the Ministry of Health is noted as having supported the Ottawa Charter, enabling health promotion efforts at different levels (Roberts & Kuridrani, 2007). This is reflected in the NCD strategy which emphasizes multisectoral collaboration and partnership, advocacy, policy and regulatory interventions (environment) as well as clinical interventions (Fiji Ministry of Health, 2010). A primary health-care strategy in New Zealand is reported to be shifting government priorities towards reducing health inequities (Glensor, 2004).

The vision of health in South Australia is more broadly expressed, making health more of a by-product of mutual collaboration and working with other sectors (see Box 4).

This is consistent with the South Australian model for HiAP, which is inextricably linked with the goals of the SASP – where health is seen as central to achieving the objectives of the plan. HiAP principles recognize health as a human right, a vital resource for everyday life, and a key factor for sustainability. Moreover, health is seen as an outcome of a wide range of factors necessitating an integrated and collaborative approach across all sectors (Government of South Australia & SA Health, 2007). Furthermore, the HLA of Aboriginal mobility, safety and well-being, is informed by a conceptual framework (see Figure 1 below), which illustrates a broad vision of health and highlights how limited mobility hinders autonomy, access to services, education, recreation, work, identity (a driver’s licence is one of the major forms of personal identification in Australia, for example, to open a bank account), and opportunities (employment prospects).

**FIGURE 1. ABORIGINAL MOBILITY, DRIVER’S LICENCE AND WELL-BEING**


**BOX 4. VISION OF HEALTH IN SOUTH AUSTRALIA**

South Australia: a better place to live.

- Health is part of our lives – it helps us achieve all that we want.
- Our health is protected and improved when we work together to develop better neighbourhoods and communities.
- People can be healthier when they have the chance to live healthier lives.

determinants of health helped engage non-health sectors in ISA, all interviewees noted that this made a significant difference to the engagement.

A shift to a promotion agenda, to social determinants, tied in with what is a more proactive community engagement strategy, such as community health, where I think that does flourish in health systems it certainly adds a lot of opportunities to interconnect with other agencies like education. (B. Semmens)

I am not sure. For us what has really worked, and what has encouraged people, is that the curative agenda is not coping, and that the health system is buckling under the weight of health-care costs and the number of people needing services. People are turning towards promotion and determinants as a way of trying to stop that. Other sectors are interested in participating in HiAP because they have a negative view about the fact that the health-care system is preventing them from pursuing their goals because it is taking all of the money and taking over the agenda. (C. Williams)

Yes, it has been helpful. Instead of focusing on curative, the ministry has shifted to promotion; the shift has happened. Yes, it has helped connect across sectors, in some issues. You can say that it is not the focus of the Ministry of Housing, but Ministry of Housing pushes the issues to various committees. They will promote these issues. … pushing the other ministries to … has been useful for pushing the agenda forwards. (S. Anuar Huseen)

In terms of NCDs, some key strategic documents (identified as part of the background work for the case studies) illustrate how some countries in the Western Pacific Region (Fiji, Malaysia and Palau) call for responses across government and society, and emphasize that this is “everybody’s business” (Malaysia Ministry of Health, 2010; Fiji Ministry of Health, 2010; PIHOA 2011b; Kuartei, 2011). It is not clear yet whether and how effectively this framing of what is essentially a call for a more intersectoral approach to health will be realized among other sectors, and if it will enable leverage to improve collaboration and change policy responses. The analysis of Thow et al. (2011) of soft drink taxes in Pacific island countries and areas illustrates the importance of framing and highlighting the sectoral co-benefits from ISA. They note that the reason for the tax can make a difference to its support and ongoing implementation, calling upon health promotion practitioners to justify taxes in terms of their contribution to health, while for the finance and trade ministry there may be a benefit in the form of additional revenue. The additional rationale of improved health can make an important difference to action.

### 3.2 Collaborative practices, including Health in All Policies

Countries across the Region articulate collaborative practices in different ways. Collaboration does not always have anything to do with health; it may be called multisectoral or ISA for health, and it is rarely articulated as HiAP. This is not surprising, as the first global move out of the European Region, where the term was used during the Finnish presidency of the European Union (2006), was in 2010.

#### Understanding HiAP

In order to understand how a HiAP approach was being developed or implemented in their country, policymakers interviewed were first asked to identify which of three definitions of HiAP resonated best in their country.

i. A strategy that allows the formulation of public policies in sectors different to the health, such that when these are in use, these policies can correct, improve or positively influence the determinants of health.

ii. A systematic approach to taking into account the impacts of public policies on health determinants, including health systems, in order to realize health-related rights, to seek synergy across sectors and to improve accountability for the impacts of policies, and ultimately population health and health equity.

iii. An initiative that focuses on influencing the health of the population and its determinants. A central element is cooperation between different relevant sectors, inside and outside the domain of public health on aspects of health. The common goal is to improve, promote or protect health.

Responses were mixed. The definition that most accurately described the HiAP approach in the Fijian context was the first one, whereas the last definition fell most closely in line with the meaning of HiAP in Palau.

It is basically that we would like to have health considered as an important issue in every sector, with the idea that eventually everything that’s done in each sector has a health outcome, a good health outcome. (C. Otto)
The second definition of HiAP resonated most closely with the education sector interviewee from South Australia, particularly the ideas of synergy across sectors and accountability.

I thought the one that was most connected to the work that we have done is the middle one. HiAP is, in my perspective, in its resonance with education, the synergy across sectors, and accountability, but ultimately positively impacting on population health and health equity. (B. Semmens)

The SA Health and Malaysian interviewees believed the third definition was closest to their perception of a HiAP approach, because it represented the balance required to facilitate HiAP work.

None of them are quite right. The one that probably is closest is the last one. I think that is because the way we are working is so much about influencing, where we work in collaboration and partnerships and do not really take the lead. The other thing – it is not necessarily the goal of other agencies, but the goal is to achieve public policy outcomes, and that goes about creating healthy sustainable communities. I would have something in there about public policy outcomes in that definition. Recognizing that the more I talk about it, we need to recognize that HiAP might have two arms: there are multiple ways of doing it. Perhaps we need to be clear about where we are approaching, what definition for the type of HiAP work we are doing. (C. Williams)

Ways of doing ISA/HiAP

The varying ways of understanding what is meant by HiAP as articulated in the telephone interviews helps to explain why all of the interviewees highlighted that it was important not to present a HiAP approach as an entirely new way of doing things. It was suggested that it should be presented as improving and adding value to existing approaches.

I think it is about joined-up approaches, and HiAP is just an example of a joined-up approach for government. They might want lots of other structures as well. Within health, I think it depends on the climate. Anything that is really new and out there is definitely not driving priority setting at the moment. Having said that, they are interested in looking at ways of trying to really halt the escalating health-care budget, which is of great concern to everyone. That would now be an issue for all of government. HiAP cannot demonstrate success in the short-term, it is a very long-term process. (C. Williams)

In Fiji, for example, HiAP work has been undertaken within existing structures, and efforts have been made to build on existing legislation to “add value to what they are doing”.

Yes, we seem to be working more on existing legislation and how we may add value to what they are doing. But also new opportunities – there are new ways of doing things. We are working on existing and hoping as we move on there will be new ideas and ways of doing things building on collaboration and agreement. (I. Tukana)

Among Pacific island countries and areas, there has been a long history of a broader approach to tackling health issues, particularly with regard to NCDs and related risk factors. For example the Yanuca Declaration (WHO Regional Office for the Western Pacific, 1995) sets out a vision for healthy islands: “… healthy islands should be places where: children are nurtured in body and mind; environments invite learning and leisure; people work and age with dignity; and ecological balance is a source of pride.” Health promotion and protection are identified as essential to the change process, and environmental health is the bridge to working with other health programmes and sectors (WHO Regional Office for the Western Pacific, 1995). In some of the texts linked to the PIHOA declaration and related country action, reference is made to the ongoing relevance of the Yanuca declaration. In Malaysia, the structures are in place to engage in intersectoral work, but it is not carried out under the name of HiAP and it ranges from intersectoral cooperation of services to coordination.

There appear to be two main ways of doing ISA across the Region – through coordination of service delivery or through the development of new policies or plans involving different sectors from the beginning.

For me, ISA in Malaysia has involved developing policies and plans. We have what we call the Economic Planning Group for each sector, or the EPG in short. We all take notice of the issues. The department involves building policies and plans, involving sectors from the beginning. The Economic Planning Group facilitates interagency planning groups across the government departments, it is connected to everything across the government departments. In Malaysia we have different management of committees. (S. Anuar Huseen)
Palau is very service-oriented government. The Government is the biggest employer in the nation. That means much of the services are given by the Government to the people – education, health, across the 10 ministries that we have. And so the Government do realize that there needs to be some emphasis on coordinating various services and programmes in order to realize the most effective and efficient delivery of services. There is also involvement of different sectors from the beginning. The Government is mindful of the need for the various sectors to be together to start policy development for various programmes. Even though this takes place the outcome is less than optimal. The reason I think that happens is even though people come together at the initial stage to discuss policies, very often from what I have seen, the people who come together do not really know/understand their own plans, the plans for their own sectors. Next to that, they do not seem to know how to integrate the strategies or approaches to make a meaningful whole in terms of policies or plans. (C. Otto)

3.3 Key stakeholders and their role in intersectoral action

Overall, the majority of articles identified in the review discuss the following key stakeholders: health-service activities, followed closely by communities, and then governments, nongovernmental initiatives and, finally, non-health sectors. Crucially, the detailed examples (Australia, Palau and Viet Nam) and the mini-case studies (Fiji, Malaysia and NCD processes within the Western Pacific) suggest a balance between the drivers of activity in the health sector and other agencies.

The NCD responses tended to be driven by the health sector, whereas responsibility for advancing work in South Australia and Viet Nam was either more cross-sectoral and driven by other agencies, or at the central level in collaboration with the health sector. The current reality of ISA/HiAP is that the health sector is usually primarily concerned with health-specific activities, and other sectors are not. However, these differences in core business do not mean that these sectors cannot or are not working together to improve policy development and outcomes.

**Highest level of government**

Central government plays an important role in leading national policy reform and change supporting intersectoral collaboration related to specific issues ranging from myopia (Kiat, 2005) to economic reform (Abdul Khalid bin Sahan, 1988; Uchimura & Jatting, 2009). The government can also facilitate HiAP by investing in research ranging from child protection (AlEissa et al., 2009) to molecular biology (Ebomoyi & Srinivasan, 2011). It is also noted as responsible for initiating a primary health-care strategy (Glensor, 2004). In Malaysia, for example, government economic reform became the entry point for health to collaborate intersectorally (Abdul Khalid bin Sahan, 1988). More recently, however, legislation in Malaysia has been used to divert attention away from inequities between groups (Allotey et al., 2011). In other countries, government regulation has encouraged quality in private pharmaceutical services (Stenson et al., 2001). In Fiji, government funding silos have been set up as barriers to ISA (Roberts & Kuridrani, 2007).

Additional information about the role of government came to light in the case studies. The introduction of the helmet law in Viet Nam was part of a longer term process driven by the National Traffic Safety Committee, which was chaired by the Ministry for Transport and reported to the Prime Minister. Passmore et al. (2010a; 2010b) noted that this ensured political commitment at the highest level. Furthermore national leaders supported public education efforts in the lead up to the legislation taking effect.

In South Australia, the governance and key drivers for HiAP come from government at the highest level. In the HLA of Aboriginal mobility, safety and well-being, for example, the health sector is strongly involved, but it is fundamentally a joint action between two units in SA Health along with other sectors, such as planning, transport and infrastructure, police, correctional services, and further education and training (Government of South Australia & SA Health, 2010a).

In Fiji and Palau, while the Minister of Health is leading action on noncommunicable diseases, action across government and society is upheld by a commitment from the Prime Minister or President. For example, the state of emergency decree in Palau was issued by the President and identifies the Minister of Health as taking the lead on this issue but working with other sectors. In this instance, the Minister for Health approached the Chair of the National Emergency Committee to initiate the required processes and mechanisms to accelerate action on the emergency.
In Fiji, the NCD action plan has as its slogan “everybody’s business” beginning with a message from the Prime Minister of Fiji:

Health is no longer the business of the Ministry of Health alone but everyone’s business. This strategic plan serves not only as a Public Health document but also a development plan to bring our greatest asset, the people of Fiji, into better health and welfare with quality living (Fiji Ministry of Health, 2010:4).

Ministries of health
At a policy level, ministries of health play an influential role in supporting HiAP. Successfully shifting policy to harm reduction in Malaysia ultimately became the responsibility of the Ministry of Health (Narayanan et al., 2011). Across jurisdictions, the Ministry of Health’s commitment to improving women’s health is also reported as essential (Yadav, 2001). The development of cross-sectoral advocacy coalitions in the Pacific has been a critical component in the taxing of soft drinks, and this type of effective agenda setting can be encouraged by active advocacy by the Ministry of Health (Thow et al., 2011).

As a nation, the only way that we can effectively fight this epidemic of NCD is a “whole-of-government” approach. Therein lies the biggest challenge facing the Ministry of Health: How do you get buy in from other government ministries and department? How can the Ministry of Health convince other government machineries that they have such important roles to play in influencing the behaviour of Malaysians in choosing healthy foods and in leading active lives? (Message from the Secretary-General, Malaysia Ministry of Health, 2010:6).

At local practice levels, ministries of health play a coordinating role in organizing meetings between sectors and communities focusing on disaster preparedness (Ferrier & Spickett, 2007). The Ministry of Health in Malaysia requested permission to form a state-level committee to monitor activities related to the health sector’s response to violence against women (Colombini et al., 2012). Ministries of health or equivalent agencies have also requested funded training and capacity-building initiatives (Colombini et al., 2012; McDonald et al., 2002).

A study by Rani et al. (2012) of governance in response to NCDs among selected low- and middle-income countries within the Western Pacific Region (Cambodia, Fiji, Malaysia, Mongolia and the Philippines) examined three dimensions – institutional arrangements for stewardship and programme management and implementation; policies/plans; and multisectoral coordination and partnerships. Over a 10-year period they found several positive trends, including a shift from specific NCD-based programmes (e.g. a programme for diabetes control) to integrated NCD programmes and approaches, and increasing inclusion of NCDs (and linked risk factors) in health sector plans. With regard to multisectoral collaboration on NCDs, four countries had a committee on NCDs (Cambodia, Fiji, Malaysia and Mongolia). The chair of the committee was the Minister of Health in Cambodia and Fiji, the Deputy Prime Minister in Malaysia and the Prime Minister in Mongolia (Rani et al., 2012).

In Palau, Executive Order No. 295 declaring a state of health emergency on NCDs ordered the Minister of Health to take immediate action. Notably, it called on all ministers and heads of national government agencies to assist the Minister of Health in tackling this national crisis, as necessary. The former Minister for Health, Dr Kuartei, then requested assistance from the chair of the NEC, chaired by the Vice President and Minister of Finance, to escalate the level of response to the emergency so as to activate the NEC. Most members of
the NEC, together with staff from the Ministry of Health, met in October 2011 to advance action on the emergency, and this led to the formation of a small task force to plan for the first national summit on NCDs in January 2012.

**Non-health ministries**

The literature is mostly concerned with sectors involved in implementation rather than policy development per se. Specific sectors identified as involved in partnerships are education (Benzian et al., 2012; Curtin & Nelson, 1999) and agriculture (Engberger et al., 2005). There are also partnership activities with financial institutions and lawmakers on taxes and regulations (Thow et al., 2011). Linking with economic units in government is also noted as an important driver for ISA (Abdul Khalid bin Sahan, 1988). At the service-delivery level, the health service often links with social services (Colombini et al., 2012). In addition, transport policy has been recognized as influencing health (Lindsay et al., 2011). The case from Viet Nam suggests that action on injury prevention is an important convening point for multisectoral action, particularly when framed in terms of transport or road safety policy.

The Ministry of Transport led the formulation and overall coordination of the helmet law in Viet Nam (see Box 5) (Passmore et al., 2010a; 2010b).

The background work for the case studies revealed that food security and rising global prices are a growing issue among Pacific island countries and areas. In a recent interview with a Melanesian Spearhead Group (January 2013), the interviewees noted the policy response of countries to encourage local buying and also incentives for local agricultural and food production. They also noted that regional trade liberalization and agreements:

> … represents an area for improvement of policy coordination within governments and between governments and regional bodies. Often trade officials that are developing tariff liberalization offers and negotiating commitments do not effectively consult those ministries and departments that are responsible for food production, for example, Ministries of Agriculture, Livestock and Fisheries. In this context, cheapening imported food substitutes can on occasion destroy domestic industry, particularly where small-scale producers are facing competition from large overseas suppliers. The links between national agriculture and trade policies and food security need to be more fully and clearly elaborated. For example, at present Vanuatu’s Corporate Plan for the Ministry of Agriculture, Quarantine, Fisheries and Forestry makes no explicit reference to food security goals. (Sikivouand & Merewalesi, 2013).

**Communities and nongovernmental public organizations**

The literature positions communities as being a necessary component of ISA (Roberts & Kuridrani, 2007; McDonald et al., 2002; Atkinson et al., 2010). Involving youth in a food nongovernmental organization in the Federated States of Micronesia was identified as an important strategy.

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**BOX 5. TRAVELLING SAFELY IN VIET NAM: A TRANSPORT-LED INITIATIVE**

Of the 33.2 million registered vehicles in Viet Nam in December 2010, 95% were motorized two-wheelers, and an estimated 59% of all road traffic fatalities were motorcyce riders (Nguyen et al., 2013). A Cochrane review has demonstrated that helmet use is effective in terms of reduced head injuries and fatalities (Liu et al, 2008; Nguyen et al., 2013; Pervin et al., 2009; Passmore et al., 2010a; 2010b). However, compliance with helmet use in low- and middle-income countries, where motorized two-wheelers are a cheap and accessible form of transport, is low. The National Traffic Safety Committee is led by the Ministry of Transport, reports to the Prime Minister and includes 15 ministries and agencies including transport, police, health and education. There is a Committee in all 63 provinces in Viet Nam. It has overall responsibility for ensuring the helmet law is cleared including collaborating and consulting with provincial networks to ensure nationwide implementation, and reporting both progress and any obstacles to the Prime Minister. The Committee also establishes partnerships with bilateral and multilateral agencies, nongovernmental organizations, e.g. the Asia Pacific Injury Foundation, and private companies e.g. FedEx, UPS, to facilitate international assistance in achieving the national road safety objectives. In terms of specific sectoral roles or contributions by government agencies the following ministries were responsible for:

- drafting the legislation – transport
- enforcing the legislation – public security
- hospital surveillance – health
- school-based safety programmes – education and training
- social marketing – culture and information (Passmore et al., 2010a; 2010b).
Community input is required in sex education programmes (Brewis, 1992). In Hong Kong (China), the need to educate and support families having to care for relatives with schizophrenia post-institutionalization is highlighted (Chien & Norman, 2003). Nongovernmental organizations play an important role as partners in HiAP and in coordinating ISA (Englberger et al., 2005). In Malaysia, women’s nongovernmental organizations have helped to put the issue of violence against women onto the policy agenda (Colombini et al., 2012). In Vanuatu, incorporating communities into the design of food and nutrition interventions including education (Dancause et al., 2011), and involving community representatives in the island food community nongovernmental organization has led to increased attention to new products from high-nutrient local foods (Englberger et al., 2005). Regional environmental health officers have supported local community organizations or cooperatives in developing water and sanitation projects (Ferrier & Spickett, 2007). In New Zealand, community members’ and trade unions’ input have made primary health care more accessible to people in social housing (Glensor, 2004). In Hong Kong (China), participation in patient support networks has overcome social isolation and consequent non-compliance of treatment for renal disease (Leung, 2003).

I really think that this is where we need to put a lot of emphasis, and a lot of capital into it. Because from my experience, civil society advocacy has been very important in terms of moving the agenda forward in terms of health. In Palau especially, tobacco – agent of change that has caused the tobacco change. We are the ones who have been working very hard and talking to legislators and providing workshops for them, helping them to understand what tobacco does to our communities. I think they really have a big role to play because they not only put the specific items on the agenda, they have a way of maintaining, sustaining that item – with a lot of passion, and a lot of effectiveness. I feel their role needs to be supported. I have been doing this, advocating for more support for civil society, with regards to their role of trying to implement the framework convention for tobacco control. Big case in point in Australia where civil society has pushed the government to take up that convention. (C. Otto)

It’s vital. Nongovernmental organizations have a strong influence in Malaysia; under the Ministry of Health they also have a Committee on Health Care. Under that Committee on Health Care they have so many issues discussed, and also so many nongovernmental organizations as members of the committee. They discuss a lot of issues; the nongovernmental organizations are seen as co-partners in health in the sector. (S. Anuar Huseen)

The importance of collaboration between government, nongovernmental organizations, particularly faith-based nongovernmental organizations and the community was raised.

At the community level in Papua New Guinea, the church has been the mobilizing factor that brought everyone together. They built on the approach; they cleaned the road, shaped the road to improve access to community, they went into agriculture, making gardens and changing coffee, made ponds for fish, and then they dealt with security issues, banking systems. That is not directly related to health, but it has come on board and there were dialogue and discussion with others. At the highest level, this discussion has been, depending on where the meeting was coming from – if it is related to health, there is the church health services, they meet on a regular basis for funding, budget. There are also avenues where different sectors get involved; the department of health and HIV/AIDS – it is technically embedded within the department, but the other part involves all other stakeholders in the national council. It is a multisectoral approach; all different stakeholders become involved in it, including all of the other government sectors. The business against the HIV/AIDS coalition is a big one. They have become a big focal point in terms of mobilising the community. (P. Dakulala)

Private sector

Linking to the private sector is also seen as an important HiAP/ISA strategy (Ebobomoyi & Srinivasan, 2011; McDonald et al., 2002). The Asia Injury Prevention Foundation (AIPF) is a non-profit organization registered in the United States of America. It creates public-private partnerships, develops mass media education and school curricula, and implements school-based helmet use and traffic safety education programmes to reduce the pervasive and devastating rate of road traffic crash injuries and fatalities in developing countries. It has been established in Viet Nam since 1999. The AIPF played a significant role in the public education and awareness raising aspects of the helmet law in Viet Nam. It has had a “Helmets for
kids” (HFK) programme in place since 2000, and currently implements the programme at 32 schools nationwide. As well as providing free helmets for children, the programme incorporates helmets into the school curricula – effectively making helmets part of school uniforms. It also undertakes teacher and student training, public, media and corporate awareness raising, creates partnerships, and carries out monitoring and surveillance (AIP Foundation 2013a; 2013b). In January 2013, the AIPF launched a HFK programme in four high-risk schools in Ho Chi Minh City sponsored by the UPS Foundation (business/private sector). The four schools are in close proximity to high-risk roads, and the helmets children normally wear are mostly of substandard quality (AIP Foundation, 2013a; 2013b). Furthermore, WHO, the United Nations Children’s Fund (UNICEF) and the AIPF have used the media and provided training workshops for senior officials and national legislators as part of a sustained campaign to improve the wearing of helmets among children and to counter the myths about the dangers of wearing them (Pervin et al. 2009). As part of their advocacy and legislative work, AIPF has contributed to the development of the Region’s first motorbike helmet standard for children (known as TCVN:6979-2001). Viet Nam is one of only three countries in the world to have introduced a child helmet standard (AIP Foundation, 2013a; 2013b).

Since early 2011, the Government of Fiji (through the Ministry of Health) has sought to encourage the food industry to voluntarily reformulate and re-label their products, warning that non-compliance would be subject to strong penalties. This was taken up by Pacific Periscope (a weekly newsletter and blog on trade around the Region) and reported as a health issue (Pacific Periscope, 2011a; 2011b). In January 2013, the Minister for Health in Fiji reported on overall health reforms in Fiji for the past three years, including active lobbying of manufacturers to address the NCD crisis through self-regulation, and the phased reduction of fat, sugar and salt. The Minister for Health noted that there has been only measured success to date. He highlighted the need to make locally bottled water an alternative for all Fijians, increasing taxation on internationally branded soft drinks, and rescinding cheap meat concessions to address harmful public health effects (Sharma, 2013). In the Pacific, the industry is seen as the key opposing advocacy coalition for taxing soft drinks (Thow et al., 2011).

We have what we call public-private partnership. Civil society organizations, faith-based organizations, and other nongovernmental organizations. Because of the NCD crisis, it civil society organizations] is become more important for us, becoming stronger. We are beginning to realize that it is the social determinants which are the issue, which we need to address for the NCD crisis in Fiji. (I. Tukana)

**Sectoral roles in ISA for health**

Successful intersectoral partnerships for health occur where health and other sectors are perceived as equal partners or members of partnerships (Van den Berg et al., 2012). The telephone interviewees were asked what, in their experience, leadership roles health had successfully held in the initial phases of intersectoral policy processes.

I think the health sector has provided leadership in three ways: 1) They have led the process in providing data that elucidates the relationship between the vector and the host, for example, that type of model; providing the data for people to think that way. 2) They have been able to elaborate on the relationship between policies and desired outcome – e.g. sanitation policies, the lack of sanitation with respect to eradication of mosquitoes – malaria, dengue. 3) They have been able to impress a certain sense of urgency about the need for policy-making. In other sectors, if you did not have money, or if you did not have food, you’d still have some time to work it out, but if you are sick, then you have very little time to work out the sickness. In this sense health has been able to provide some leadership in providing a sense of urgency for policy-making. (C. Otto)

I think leadership is not the right term. To some extent we certainly do provide the impetus and catalyst, but we are careful not to set ourselves up as leaders since that is something that shuts down interest and disengages sectors outside of health. We definitely do a lot of the initiation, facilitation, initial contacting and preliminary work. Once we get over the hurdle of that, the primary agent we are working with is likely to take leadership. We would never set ourselves up as leaders. Even within the health system, where you might think it would be less risky, people react aggressively or uncomfortably to the term; they think we are just teaching them what they already know. (C. Williams)

The Ministry of Health has got the potential to act as a catalyst; there are some programmes which are actually driven by the other ministries and we just play a more supportive role. We are becoming more and more of technical input, giving technical input to those industries. (P. Dakulala)

In the three case studies, the health sector’s role in intersectoral
collaboration was understood and implemented in three different ways. For the formulation, implementation and monitoring of the helmet law in Viet Nam (see detailed information in Box 5), the health sector’s role was in monitoring and surveillance of the health impacts of this work, specifically reviewing data for all road traffic injury patients with head injuries admitted to 20 provincial and central hospitals – three months before and three months after the law came into effect in December 2007 (Passmore et al., 2010a; 2010b). The NTSC, chaired by the Ministry of Transport, had overall responsibility for ensuring all details of the helmet law were cleared, including collaborating and consulting with provincial networks to ensure nationwide implementation and reporting both on progress and on any obstacles to the Prime Minister (Passmore et al., 2010a; 2010b).

In South Australia, HiAP has been developed with a view to better utilizing the social, economic and environmental levers to influence population health (Bucket et al., 2011). The idea is that other agencies use HiAP in partnership with SA Health as a mechanism for achieving their own goals, particularly the objectives and related targets of the SASP (Williams & Broderick, 2010). It is a process that is supported by both central government and the health sector. In the case of Aboriginal mobility, safety and well-being, the HLA project is a joint initiative in SA Health (Aboriginal Health and Public Health branches) with the following agencies/sectors: planning; transport and infrastructure; the Attorney General’s office; the police; correctional services; education; employment; and science and technology. As identified in the previous section, in Palau, across-government action is being led by the Minister for Health in collaboration with other ministries, as appropriate.

Malaysia’s National Policy and Plan for NCDs positions an NCD multisectoral plan – with a budget – within a National Health Plan but with attached coordination mechanisms to other ministries and partners. This is supported by a National Strategic Plan endorsed by Cabinet involving 10 different ministries including health (Omar & Mustapha, 2012). In Malaysia, many sectors have played a role in driving HiAP activities, such as the Committee on Food Security and Safety, the Ministry of Housing, and the Ministry of Education. Although health is not the primary focus of these committees, they discuss activities relevant to health.

Work is headed by different ministries under different committees. In these examples, within the committee the main focus is not actually on health, but they also discuss about activities related to health. These committees are chaired by those who are responsible for the main focus; e.g. food safety is chaired by the Ministry of Health. Issues of health in schools is also being discussed, but headed by the Ministry of Education. (S. Anuar Huseen)

The interviewee from the education sector noted that each sector has the capacity to drive HiAP activities, as evidenced by the success of joint health and education HiAP initiatives.

All government departments can have an impact on health outcomes. That has been validated to me through the HiAP programmes. But I know of a number of instances where health-promoting and health-focused, health-related activities have been the core relevance of [education] departmental thinking. There’s no reason it can’t be for every other department either. A previous Chief Executive really opened up a much more incisive conversation within the education community about child well-being. The literature again is very clear about the direct link between the well-being of a child and their educational outcomes. Therefore, this has been a long-standing conversation, based on the fact that the two, health and well-being, and educational outcomes are so closely tied. There is very little doubt in anyone’s mind that it is absolutely correct that a child’s well-being, the classroom environment, feeling connected to others, feeling connected to the teacher, is absolutely fundamental to educational success. (B. Semmens)

Yes, I do. I believe that we need to continue to think about the importance of environment in influencing behaviour. HiAP could be driven by Ministry of Infrastructure; policies for health enablers (paths, zoning for homes and businesses, etc.) could happen through forced behaviour modification. I also think that the Ministry/Sector of Finance could also provide some driving force in terms of policy for health, in the sense that many of the things that they consider to be economically important must first think of whether they are economically important for health, physical and community health, mental health, spiritual health. For example, the Palau Olympic Committee has been very aggressive in helping the Government; we have been working with them to develop policies for road, to share the road, to change the thinking of the road. We have very heavy traffic and it’s dangerous. We don’t have sidewalks so it’s hard for people who want to walk in the morning or evening to be safe. We have had some accidents and traffic mortality. Recently the National Olympic Committee and some commission have worked with the state
to put along the road to share the road, to teach people to be mindful of bicyclists, pedestrians, etc. There are also initiatives to create exercise stations across Koror to allow people more opportunities to do physical activities. (C. Otto)

Health professionals may play supporting roles by raising awareness of problems: for example, front-line nurses may raise awareness of conditions in housing estates and subsequently attempt to coordinate with other sectors to provide services to address them (Glenser, 2004). Health membership (among other interested parties) in an intersectoral nongovernmental organization addressing dietary and lifestyle-related problems is identified as integral but secondary to the agriculture sector (Englberger et al., 2005). Health-care professionals might also be aware of the broader issues around mental illness, but more training is required for health staff to see health as a holistic rather than physical treatment and care issue (Chien & Norman, 2003). Similarly, environmental health officers have a role to play in preventing exposure to natural disasters by raising awareness of the issues, conducting assessments, and encouraging environmental preparedness (Ferrier & Spickett, 2007). Environmental health professionals from government and nongovernmental organizations can help strengthen cooperation between communities, and engage with them routinely while planning other activities or projects that include vulnerability reduction strategies (Ferrier & Spickett, 2007). For example, three of the goals of the Mongolian National Environmental Health Programme 2006–2015 are concerned with improving information, legislation, fact-finding, surveillance and research in relation to effects of the environment on human health, and population education and awareness raising. An expected outcome was the increase in the participation of people in promotional activities and in the programme on environmental health (Government of Mongolia, 2005). In Australia, the health department has supported regional community grant writing by providing evidence, obtained from university databases and statistical data, to assist with submissions (McDonald et al., 2002).

In terms of health information for taking action on NCDs across government, the Malaysian National Strategic Plan for NCDs reflects an operationalization of existing knowledge and scientific evidence with regard to the country context (Malaysia Ministry of Health, 2010). It provides a basis for action and collaboration with other sectors.

3.4 Formal and informal structures to facilitate intersectoral action/Health in All Policies

Enablers and constraints function at various structural levels, such as the coordination of services across sectors to the absence of policies supporting collaboration. Links between the health sector and communities also play a role, often facilitated by health promotion foundations and tobacco control funds. Structural issues are also combined with personal variables, for example leadership within the health sector. In the absence of systemic support for ISA, initiatives undertaken by individual health professionals are crucial.

**System support at multiple levels**

Action to promote health across the levels identified in the Ottawa Charter is described in the literature as facilitating intersectoral cooperation in the management of myopia in Singapore (Kiat, 2005). Colombini et al. (2012) provide an example of how structural factors influence a coordinated

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**BOX 6. SUPPORTING THE GENERATION OF KNOWLEDGE ABOUT THE IMPACT OF THE HELMET LAW: VIET NAM**

Resolution 32 is a Government Decree of the Prime Minister in Viet Nam on a range of road safety and traffic alleviation measures, which came into effect in December 2007. As well as requiring all riders and passengers on all types of roads to wear helmets, the new regulation substantially increased fines (Passmore et al., 2010a; 2010b). The national helmet law was developed and implemented by the NTSC, which was established in 1997 and is present in each of Viet Nam’s 63 provinces (Passmore et al., 2010a; 2010b). Implementation of the law has been monitored on a number of fronts: behaviour change in terms of compliance with helmet wearing and correct helmet wearing, reduction in the prevalence of head injuries among road-traffic injury patients admitted to hospitals, and helmet wearing among children (Passmore et al., 2010a; 2010b; Nguyen et al., 2013; Pervin et al., 2009). The role of the Ministry of Health on the NTSC has been to support surveillance and the monitoring of the impact of the law. The Ministry (General Department for Preventive Medicine and Environment, Hanoi School of Public Health, and the Department of Planning, Viet Duc Hospital, Hanoi), together with the WHO Representative Office in Viet Nam, have been involved in all these follow-up studies to assess the impact of the law and use this information to further refine effectiveness, health impacts and outcomes.
response to violence against women – although their work largely deals with hospital services. They argue that this encompasses a multi-level approach requiring actions by different actors at different levels and sectors. Some challenges may be dependent on organizational or structural issues and, if ignored, may cause health responses to fail (Colombini et al., 2012). They provide a figure of the challenges faced at multiple levels (see Figure 2).

The literature together with the background work for the detailed case studies identified a range of usually formal mechanisms within the Western Pacific Region at national, regional and global levels to facilitate cross-sectoral engagement. Some key examples are described below.

1. In South Australia, a model for HiAP has been developed in order to better use the social, economic and environmental levers to influence population health (Bucket et al., 2011), which in turn contribute to achieving the overarching government vision for South Australia as articulated in the SASP. There has been a deliberate effort to position HiAP strategically as a central process of government, and with other agencies using HiAP in partnership with SA Health as a way of achieving their own goals, particularly the objectives and related targets of the SASP (Williams & Broderick, 2010). The implementation of HiAP is supported by the central Government, in partnership with the health sector. The main instrument for progressing HiAP is the HLA. For example, the HLA of Aboriginal mobility, safety and well-being, is a joint initiative and includes the following agencies: SA Health; Department of Planning, Transport and Infrastructure; the Attorney General's Department; South Australia Police; the Department for Correctional Services; and the Department of Further Education, Employment, Science and Technology. It has followed the steps of the HLA.

2. In Malaysia, the Cabinet Committee for a Health Promoting Environment, proposed in the National Strategic Plan for NCDs 2010–2014, was established in 2011 and is chaired by the Deputy Prime Minister. Its clear terms of reference are to determine policies that support positive behavioural changes towards healthy eating and living. Membership is at the ministerial level and from the following sectors: health; education; information; communication; arts and culture; rural and regional development; agriculture and agro-based industry; youth and sports; human resources; domestic trade; cooperatives and consumerism; housing and local government; and women, family and social affairs (Rani et al. 2012).

3. The NTSC in Viet Nam, which is described as multisectoral, is chaired by the Ministry of Transport and has been in place since 1997 (Passmore et al. 2010a; 2010b). The Viet Nam Committee for Smoking or Health (VINACOSH), a multisectoral and separate convening agency with
responsibility for leading efforts to develop tobacco policy in line with the WHO Framework Convention on Tobacco Control (FCTC) in Viet Nam, was established in 2001. In 2007, the Ministry of Health designated VINACOSH as an official, separate entity with its own budget, increasing its autonomy and empowering it to facilitate inter-ministerial work. It gave VINACOSH the power to convene other ministries directly. The Minister for Health chairs VINACOSH, the standing Vice-Chair is the Vice-Minister for Health and the Vice Chair is the Vice-Minister of Culture and Information. Members of the Committee from other sectors include the vice-ministers/chairs/secretaries of industry and trade, finance, education and training, Viet Nam Fatherland Front, Farmers’ Association, Women’s Union, Ho Chi Minh Communist Youth Union, the Culture and Ideology Committee, and Viet Nam’s Confederation of Labor (Stillman et al., 2013; VINACOSH, 2013).

4. Three examples of intersectoral processes for taking action on gender-based violence and inequalities were documented in three countries in the Western Pacific Region, e.g. Kiribati, the Solomon Islands and Viet Nam (Rasanathan & Bhushan, 2011a; 2011b; 2011c). In the case of Kiribati, the Ministry of Internal and Social Affairs conducted the Kiribati Family Health and Support Study in 2008 and established a Committee of Stakeholders to guide the research, support its planning and implementation, and provide a long-term sense of commitment and ownership. The overall process was undertaken with support from the Australian Government, the United Nations Population Fund (UNFPA) and the Secretariat of the Pacific Community (SPC). It drew on the methodology of the WHO Multi-country Study on Women’s Health and Domestic Violence against Women. The Committee consisted of: local and national government, including the Ministry of Internal and Social Affairs; the ministries of education, finance and economic development, health and medical services; the police; the Attorney General’s Office; 10 nongovernmental organizations, including women’s advocacy nongovernmental organizations and associations, crisis centres, the Kiribati Association of Nongovernmental Organizations (KAnongovernmental organization), Aia Maea Ainen Kiribati (AMAK, a semi-governmental umbrella organization for women’s associations in Kiribati), Alcoholic Awareness and Family Recovery, the Kiribati Women’s Advocacy Network, Tetokatarawa Old Men Association and the Kiribati Family Health Association; and international organizations such as the UNICEF, WHO, the Australian Agency for International Development and SPC (Rasanathan & Bhushan, 2011c).

These examples are supported by the comments from the interviews with policy-makers. When asked to comment on whether they thought formal structures (e.g. statutory inter-departmental review groups, parliamentary committees, legal instruments) were key drivers for intersectoral engagement, or if informal processes would also be effective, most interviewees thought that it was both. Interviewees highlighted the need for a useful approach, to support the agendas of collaborating actors, and to ensure that each actor gains from the engagement. Some also noted that while the structures in government can be helpful, they can also become a hindrance if not set up to accommodate the current needs.

I think the formal structures are important. I keep thinking that so much of our work has gone unheeded, not strengthened, because there has been lack of political will to assist in terms of developing the formal framework for our efforts. I think the long and short of it is that in my mind, there needs to be formal framework for our work. We keep saying that it requires political will, but I am of the mind that if there is a will for change, for modification to help policies for health at the highest level, then it will obtain a lot of mileage. The work of the grass roots and the work of civil society are important, but if we had the legal framework for a lot of our activities, we would gain a lot of mileage. (C. Otto)

I think you need a mandate to act. I think cross-sectoral committees can work. They need to be time-limited and follow an agenda. For more sustained, ongoing engagement, my experience is that formal processes and structures are nice, but do not often get acted on. There is plenty of legislation that doesn’t get implemented, millions of policies. I think you cannot rely on that (formal structures) alone – that will not work. It is about the approach, and it is about being useful. If other agencies find the approach useful, if it supports their agenda, and they get something out of the engagement that would not have received if they were not engaging, that is probably the most powerful thing. (C. Williams)

Formal structures can be effective. There have also been ad hoc committees been set up to make a decision on some health issues. We have a committee chaired by the Prime Minister, we call it the Economic Council. The focus of this committee is across all
ministries. The committee only involves a few key Ministers; they discuss and review all the issues as informal committee. Government decisions are based on formal structures, but informal structures can work in terms of ad hoc committees. (S. Anuar Huseen)

Financial support for intersectoral working

The interviewees were asked if they thought that the provision of direct financial support for activities related to implementing a HiAP approach was necessary to facilitate effective intersectoral engagement.

I guess a pragmatic answer to that one is that direct financial support for anything makes it more effective. In terms of schools, with limited budgets, and always wanting to be able to explore the possibility of accessing other budgets, the school principals would probably say yes. But I would have to say, that going on what I just said before, if this is an exercise in co-construction and intellectualising our work at a conceptual level, you do not need direct financial support for that; it is about people sitting down and thinking flexibly about what they can do better and what they can do with others. (B. Semmens)

When asked if they found it useful having people whose job was to facilitate ISA, hence indirect financial support, the education sector interviewee noted that this certainly helped ISA happen.

Yes, I think they do have to be there, and there has to be specific, what we call over here line-item for that, so that it does not get derailed by other initiatives. It has to be specific for HiAP work; if we just save some money for health, then that money can very easily be directed elsewhere. If you want the work to be strengthened across all sectors, to think about implementing policies for their sectors, I believe there has to be some support for it. (C. Otto)

I do think that there needs to be mutual commitment to working together. We always ask for people to identify someone whose core role it is to work with us, a resourcing commitment. Inevitably, if we do a piece of work, we share the cost of any research. Whenever we have paid for things, we’ve made sure that our partners contribute some funding. Sometimes it’s 50–50, sometimes it is 25–75 our way, sometimes its 25–75 their way; what is important is having the capacity for health people to do that coordination, that facilitation, to keep things moving along, to keep being the driver in a quiet way – that is essential. If we stop doing that, in most cases it would fall over. Financial support; making sure there is someone whose job it is to do it. (C. Williams)

Yes, I think that is an important thing to consider. But Fiji is moving towards promoting ISA by advocating if these partners of ours can allocate budget for health/health policy, rather than having a separate budget for a collaboration. We are looking for ways we can collaborate within the existing, how we can allocate certain percentage of the existing budget to help in the collaboration work. (I. Tukana)

The literature and background work for the case studies illustrated that funding can play an important facilitative role for ISA by supporting committee meetings and governance processes. For example, funding for the Reduce Smoking in Viet Nam Partnership (RSVP) was provided through an Atlantic Philanthropies grant to the Johns Hopkins Bloomberg School of Public Health Institute for Global Tobacco Control in partnership with the intersectoral committee responsible for smoking and health in Viet Nam, VINACOSH. This funding led to an increase in VINACOSH’s capacity, enabling an expansion of activities and an enhancement of their ability to garner more funding from other donors. The continued efforts of VINACOSH are funded by external sources; no funds are currently received directly from the Ministry of Health or other government agencies (Stillman et al., 2013). Health promotion foundations, often funded by tobacco control funds, provide indirect financial support for ISA.

People – initiative, interests and leadership

People play an important role in supporting ISA, which is intertwined with structural and organizational factors. Leadership is essential to influence new ways of working (Abdul Khalid bin Sahan, 1988; Colombini et al., 2012; Glensor, 2004; Benzian et al., 2012). Training people in positions of responsibility and authority to advocate for policy change was identified as having been successful (Allotey et al., 2011). Politically connected champions can play a crucial role in progressing issues (Narayanan et al., 2011). Individual initiatives in the absence of structural support were also seen as critical (Colombini et al., 2012). One article suggests that they are the most important facilitator for ISA (Abdul Khalid bin Sahan, 1988).
The objective of this section is to describe the characterization of equity and social determinants in HiAP and ISA across the Western Pacific Region.

4.1 Does ‘health equity’ encourage intersectoral action

When policy-makers were asked if they thought the term health equity motivated different sectors to promote health or work intersectorally, their opinions varied between countries in the Region. The differing use and interpretation of terminology across sectors poses a challenge when trying to use it as a hook to encourage ISA and a HiAP approach. For example, in Papua New Guinea, the importance of health equity lies not in the language itself but in the action, and the way politicians and those in different sectors perceive it. In Fiji, the term health equity is considered useful, as it is in line with the country’s shift from a disease focus to a health focus.

I find the term useful. I think they are more comfortable with it. Up until now, we have felt that the other partners tend to look at the Ministry of Health as a disease type of entity, so when we discuss it in terms of health equity, they [other partners] seem to buy into it more. There is a shift from a disease focus to a health focus, and now to a wellness sort of context. When you talk in that type of language, they seem to buy into it more. (I. Tukana)

In Malaysia, health equity is not the primary driver for intersectoral work, unless it falls under specific goals or targets of the agency.

I can say it is not the main, big focus. Across ministries and agencies from different sectors, only a few have health components or health aspects in their day-to-day work. Under the Committee of Health, they have a Committee on Food and Food Safety, for example, and a few other ministries like agriculture (in relation to food and food safety), the Ministry of Trade, concern and the issue of food. For me, it [health equity] is not the key motivation for different sectors to participate unless they have some specific goals or targets. The Ministry of Housing, for example, their main focus is housing. But it does not mean they do not take into account the health aspect of building a house. (S. Anuar Huseen)

4.2 In practice: equity as an explicit target/outcome of intersectoral action/Health in All Policies

Equity was reported as an explicit target for activities in the primary health-care programme in New Zealand (Glensor, 2004), ISA in Malaysia (Abdul Khalid bin Sahan, 1988), disaster preparedness (Ferrier & Spickett, 2007), and women’s health (Yadav, 2011), reproductive health (Altotey et al., 2011) education and school health (Benzian et al., 24
2012; Curtin & Nelson, 1999), cancer disparities (Ka’opua & Holden, 2010, fiscal decentralization (Uchimura & Ja-tting, 2009), and breast health (Yip & Anderson, 2007). However, the influence of ISA on equity in outcomes did not appear to have been evaluated.

Equity was not mentioned in the telephone interviews as an explicit target. Similarly, in the detailed case studies developed for this project, equity was rarely framed explicitly or as an expected outcome of the work – with the exception of the HLA of Aboriginal mobility, safety and well-being in South Australia. A core principle of the South Australian approach to HiAP is recognizing that the social determinants of health are not equally distributed among population groups in South Australia and therefore HiAP is about closing the health gap, particularly for Aboriginal people (Government of South Australia & SA Health, 2007). The HLA of Aboriginal mobility, safety and well-being from South Australia highlights that, where equity is an explicit target, the focus is on collaboration between and across several sectors to tackle the unequal distribution of social determinants (e.g. limited mobility options) and consequent inequalities in life opportunities, health and well-being among Aboriginal people (e.g. higher rates of mortality and morbidity from traffic accidents – road death rates are three and a half times higher than non-Aboriginal people).

However, more often than not, reference was made to vulnerable groups, which were defined in terms of age groups or life stages (e.g. babies, children, mothers to be and older people). In the state-of-emergency approach applied by Pacific island countries and areas, reference is made to indigenous peoples in some of the declarations (APIL, 2010). Also sex/being a man is identified as a non-modifiable or biological determinant in the NCD work for Palau (Kuartei, 2011). In the Viet Nam case, the intervention is population-based without explicit mention of equity. However, the majority of users of motorized two-wheeler transport are people on low incomes, and much of the social marketing and awareness raising has been targeted at changing parental attitudes, knowledge and practices about the safety of children (particularly children under the age of seven) wearing a helmet. Furthermore, in the lead up to the law coming into effect on 15 December 2007, 50 000 helmets were distributed to low-income families nationwide (Passmore et al., 2010a; 2010b). However, the process or criteria for distribution of these helmets (i.e. how low-income was defined) is not known, and the law was not framed in terms of equity.

While equity does not appear to be an explicit target of the helmet law in Viet Nam, there is an implicit focus on equity through the distribution of 50 000 free helmets to low-income families in advance of implementation of the law (Passmore et al., 2010a; 2010b). A review of the global evidence on road traffic deaths identified that about 90% of deaths are in low-
and middle-income countries, the poor get hurt more often than the rich, and the differentials in progress in reducing road traffic fatality rates between high-income countries and low- and middle-income countries reflect a steep inequity between countries (Roberts & Meddings, 2010). After the country enacted a motorcycle helmet law in 2007, the helmet-wearing rate jumped from below 30% to over 95%. This change alone was estimated to have saved more than 1500 lives and prevented almost 2500 serious injuries (WHO & GRSP, 2012). In terms of early child development, the risk of serious head injury and its impact on life chances can be reduced by increasing the number of people wearing helmets from an early age. In Viet Nam, the motorcycle is the primary mode of transportation, and children are the most vulnerable passengers while riding with their parents because of the widespread lack of helmet use. Annually, traffic accidents kill 4200 children in Viet Nam alone (AIP Foundation, 2013a; 2013b). The issue of the cost of purchasing a helmet for school children has therefore been addressed as part of the programme. This is continued through the ongoing AIPF HFK programme (Pervin et al., 2009; AIP Foundation, 2013a; 2013b). However, the impact across income groups in Viet Nam is not known. Another equity issue warranting further attention in respect of the law is that of gender equity, as men have been identified as having a much higher risk of injury (Roberts & Meddings, 2010). Finally, the work on road safety in Viet Nam may go some way to addressing inequities between low- and middle-income countries as they have much higher rates of road injury (fatalities and serious injuries) from two-wheeler motorized vehicles.
5.1 Structural barriers and facilitators

Various barriers and facilitators of ISA and HiAP were identified in the published literature. Siloed structures and funding for specific sectoral activities were reported as the main barrier (McNair et al., 2001; Roberts & Kuridrani, 2007; Benzian et al., 2012). The ability to see and coordinate activities beyond these silos and take a holistic view of the issues is required from government policy level down to service delivery (Chien & Norman, 2003; Glensor, 2004; Englberger et al., 2005; Colombini et al., 2012).

Facilitators were mainly identified in relation to developing and sustaining partnerships: identifying a clear strategy (Glensor, 2004) and enabling principles can facilitate partnerships (Benzian et al., 2012). The infrastructure and sustainable financing mechanisms available through health promotion foundations are also key facilitators of ISA. At a policy level, ISA partnerships require good quality information, and the selection of strategies, priorities and interventions that are relevant to the country. They also require continued high-level political commitment backed by both adequate resources and local community participation (Tee, 2001).

In the interviews, policy-makers were asked what they considered as short-term key barriers and facilitators to initiating HiAP initiatives. Institutionalized inertia was identified as a barrier to the initiation of policy across all government agencies. To overcome it, they noted the importance of promoting creative ways of thinking and working.

All government agencies forever run up against the limitations of individuals and groups to better understand how they could shape their organizations in different ways. All institutionalized inertia is something that is a worldwide issue. And I put it down to, not the apportioning of blame, but simply our intellectual capacity to think differently about our work. That is a universal worldwide challenge, always is. There is institutionalized inertia. I think part of promoting HiAP is partly about promoting the ability and methodology of looking at what others do, and also promoting the ability to have a dialogue with your community about what their needs are. That is as much a dispositional thing as anything else. (B. Semmens)

A number of the people interviewed believed that there was a lack of knowledge on a HiAP approach, its necessity, and its potential outcomes. Demonstrating the importance of health and a HiAP to other sectors will be an important step in facilitating HiAP initiatives. While the term “social determinants of health” may not be needed per se, at
least the concept and evidence base derived from social epidemiology needs to be integrated into the thinking used across all public policy sectors. Once a basic understanding has taken root, the messages related to the need for a HiAP approach will be taken on board at the highest decision-making levels. However, the tendency to prioritize economic growth (rather than distribution), and the associated theory that short-term economic gains (at the expense of short-term health and well-being losses for some parts of the population) will emerge into longer term gains for all, threatens such initiatives.

The main challenge is to make the non-health sectors aware of the importance of health in all policies. Why do we need to consider health, especially in housing policies? It depends on issues keeping the eye of the ministry. The Ministry of Education has certain goals; the Ministry will go for their goals and pursue them first. We had lots of committees with specific roles and objectives. We have our goal – Mission 2020 – we want to achieve high-income country status by 2020. All efforts are geared towards the achievement of that goal. (S. Anuar Huseen)

Come back to the definitions: that language must be on the tongue; it must be part of their business in all of the sectors. There is a need to continue to bring that message so it is taken on board at the highest level, where decisions are made: where resources go, etc. One of the questions that has come up at the World Health Assembly in Geneva is, where do you put the focal point for health? It should be up at the highest place where decisions are made. I was listening to the Prime Minister give the speech, and I am very excited about the type of statement he is making, because he is making connections between infrastructure and how it will affect health. If you recall in Manila, we had this fish bone analysis. In the fish bone analysis, we put in three points that we had to do. The first one was to find a focal point in the Department of Health; that’s been looked at and addressed, hopefully that will happen, at the policy level. The second point was to get to our ministers and leaders who make decisions; that is a task that will be ongoing. The third point: getting more knowledge, getting the evidence. What we are calling social determinants of health now, when we go back, I think we have been doing a lot of it together. Papua New Guinea is in the health sector and others are about integration, doing things together. We need to come back to the integrated approach. At the end of the day, I think the whole approach and what will happen is down at the ground level. The message is taken on board, and they build it up, they will have a snowball effect for the whole country. (P. Dakulala)

Two most important barriers are: (i) lack of knowledge/understanding of what HiAP is and why it is necessary and what the outcomes would be; (ii) political will to prioritize health over economic profits. Important facilitators: (i) the current national efforts to curb NCDs, because unabated deaths due to NCDs is actually a national security issue for the nation of Palau with such a small population (20 000); (ii) the requirement for sectors to get together to develop a national plan to combat NCD provides a good preview of what intersectoral HiAP might be. (C. Otto)

Different people have different approaches and engage in different levels in partnership – you cannot control that. Some people actively block you. Just because of their style and approach, they can make it difficult to achieve things, slow things down. Some policy people are much happier to share and work collaboratively, others are more likely to stay in control and maintain their power base. (C. Williams)

In the long term, continued support from WHO was identified as being necessary to facilitate HiAP work. It was also felt that where HiAP work is being carried out at the highest level, it is crucial to create a strong foundation at the ground level. The NCD epidemic was perceived to serve as the main entry point for social determinants of health, partly because it validated the idea that the issue cannot be tackled from the disease perspective alone and enabled a focus on the role of different sectors in addressing the several determinants of NCDs. The lack of a specific framework or mandate for HiAP policies was considered a significant barrier to the long-term sustainability of such initiatives. Importantly though, the mandate has to include some added value beyond HiAP. For example, in the case of South Australia, the SASP provided an important convening point, and HiAP integrated what are essentially shared goals and targets for the state.

For the long run, the key barrier to ensuring sustainability of policy initiatives between sectors is lack of specific framework/mandate for policy initiatives which would leave sustainability dependent on sector management or political will and ministerial, congressional level (budget). (C. Otto)

A challenge for HiAP will be the ability to demonstrate impact. To sustain
initiatives, it will be necessary to demonstrate positive health outcomes within the constantly changing political climate. Evidence-based data demonstrating the positive impact of HiAP on health and other sectoral goals would facilitate its long-term success.

Key facilitator in the long run is evidence based on data that HiAP benefits the overall developmental objectives of health and the nation as a whole. (C. Otto)

Being able to demonstrate that we make a difference. Part of the challenge is just the challenge of policy making itself. There are plenty of policies that are made that are never implemented, for a variety of reasons, and HiAP will suffer from that, as all policies do. The difficulty in that is whether it was part of the process, if the policy was wrong, or if the context in which that policy was pulled together and then environment changed and it wasn’t possible anymore. (C. Williams)

5.2 Knowledge and skills for Health in All Policies/intersectoral action

The review of the evidence and the interviews with policy-makers did not identify any regular, dedicated programmes aiming to build policy-makers’ and public health professionals’ HiAP/ISA capacity. There are Australian programmes to train medical students in rural health and community collaboration (McNair et al., 2001), but these do not focus on the social determinants of health. In Pacific island countries and areas, a meeting with academics about academia’s response to the NCD crisis in the Region held in September 2011, the issue of capacity for policy action was noted:

Much of control of NCDs lies outside health. It was therefore important not to have courses in issues such as nutrition only, but also in areas such as policy development, advocacy etc. There is a need to move towards more training around health promoting interventions (green prescription versus white prescription). (Snowdon, 2011:5).

The interviewees identified that a crucial capability needed to enable the success of HiAP implementation was to embed sustainable change. It is necessary to clearly define the end goal, to use an evidence-based approach, and to allocate resources so that change is sustainable. From a leadership perspective, it is necessary to establish a dialogue with the people who will bring about change, to maintain a sense of ownership, and involve the local community, so that they remain open to the initiative and recognize the practical benefits. Capacity-building and resource development were recognized as being beneficial prior to the broad implementation of HiAP.

I think what’s worked best in terms of the HiAP work that we have done in recent years is tying it to the social determinants of health, no doubt, because the social determinants of health, I would say, are almost completely compatible with the social determinants of education quality. I think that, instinctively, the education sector understands that. I think we have gotten better at understanding how it looks in practice. We have moved from a philosophical approach to a more pragmatic approach. I think the other thing that is really an absolutely fundamental capacity, not only in education and health but working with those two in particular, is the ability to embed sustainable change. People have skills in those areas and people have skills in terms of being able to understand the possibilities of shared business, but it actually has to do itself in some kind of change. This requires being absolutely clear about your end goal is. It is about absolutely being, from a leadership perspective, about co-constructing the, establishing a dialogue with both the people who are going to bring about the change (so their ownership is high) but also with the local community (so that their openness to the initiative is high and they can see the practical benefits for themselves) — you have to be able to establish those dialogues. I am locating that in the school context, but I think it works in any organization. The other thing I would stay, and education will come at this from a slightly different angle, is having an evidence-based approach to that — that is fundamental. (B. Semmens)

Tobacco legislation also needs the other sectors’ involvement. Getting the funds from the treasury to create the health promotion fund; need to set up an endowment fund, to discuss ways to deal with this for tobacco legislation and also for other NCDs. They have to take on board whether it is health promotion, or what sort of funding mechanism. We have to convince the whole sector, the key ones involved with money. For example, a tax on tobacco — how much — we want to get this money into the endowment so it is used for these purposes. Big corporate companies are taking on social responsibilities by forming foundations, for example linking up with the Global Fund. (P. Dakulala)

I think there needs to be more people like us who have this framework of HiAP as an important key motivation for policies and plans, to drive this forward. Because of that, I think there needs to be some capacity-building in this area, so that when we talk about HiAP they know what it means: the definition, what it takes, why there is urgency for it. I think capacity-building is the first one, and I think there needs to be resources to develop some basic framework with each sector or across the board that will provide maybe a sort of a protocol or a template for people to use in dealing with the issue. (C. Otto)
The development of effective health diplomacy will facilitate collaboration and is crucial in improving the ability to determine, and articulate the path between policy and health, and well-being. Population health research is valued for its ability to quickly pull together evidence and effectively plan programmes. These skills are necessary to drive HiAP but all actors should be prepared to listen and learn.

I think for the health personnel, it is really important to have good health diplomacy, to understand when to push and when to sit back in terms of when to encourage collaboration. I think it is really important that there is a resource where people can make connections and draw the pathways between policies and how it links to health and well-being through the determinants, and being able to articulate that. We are valued because we are able to pull evidence together that is very accessible quite quickly, because we are able to view evidence and draw on evidence (population health research) and also be good programme planners. A good population approach is certainly essential to drive that, but done in a way where there is a lot of listening. It means being prepared to be told that we do not know things, being prepared not to be the expert. Sometimes, we will go to a meeting and we will know what the answer is, we would like to tell people what the answer is, but we keep quiet. After more investigation and talking to people we can figure out we were wrong anyway. We have to be quiet, listen, and take the time to be patient and tenacious – these are qualities about people. I spent a lot of time trying to work across sectors to get others to do things that I wanted them to do about health equity or quality of life. And people, you know, I could not get them to change unless we reframed things. It is about framing them in a way that is good for them. People are always interested in what is good for them. Over a long period of time, you learn to reframe things and not to argue the specific population health point. While that was something that through that process I have come with, that has become much more entrenched in our work. We encourage out team to spend a lot of time listening. (C. Williams)

To facilitate the implementation of HiAP policies, interviewees noted the importance of shifting the health focus in a country towards prevention. However, in medical schools, students still receive disease-based and curative-based learning. The importance of the social determinants of health needs to be promoted, which will require further local evidence.

I would think that my challenge in the Ministry of Health is the shifting of the responsibility to the other factors [social determinants of health], with the ultimate objectives of us handling the curative part, which is just 30% of the whole scenario of NCD. That is the challenge at the moment. At the same time, they are moving towards specialty, which is really expensive. Our problem in Fiji is that our schools are still producing disease-based and curative-based products: this is a major hindrance. We still have graduates from the School of Medicine who are practising curative-based care. We have challenges in the school, but it is becoming clear to Fiji that social determinants are the way to go and we need to provide evidence. (I. Tukana)

5.3 Measuring success

All of the examples of ISA and HiAP reviewed across the Western Pacific Region provide important lessons for countries everywhere. Many different measures of success have been used in the various countries. In this report, we deliberately do not describe the policies and programmes as example of good practice as this would imply that there have been systematic process, impact and outcome evaluations. Nonetheless, the examples from Palau, South Australia and Viet Nam provide useful lessons when considering the effectiveness of ISA for health.

Declaring a state of emergency on NCDs in Palau: This case study is of interest because the Palau declaration is part of a wider policy and social change process among Pacific island
countries and areas to use emergency powers (which are normally reserved for discrete events and immediate crises) to make international and regional decision-makers and stakeholders (including international donors) pay attention to what is defined as a slow-moving health catastrophe. In April 2010, at its 48th meeting, the Pacific Islands Health Officers Association (PIHOA) passed a resolution declaring a regional state of health emergency on NCDs and called for all countries within PIHOA to make a similar declaration at national level. The PIHOA and affiliated countries used the September 2011 United Nations High-level Meeting on the Prevention and Control of NCDs (and associated preparatory meetings, e.g. Moscow) as a focus for action and as a way of generating a sense of urgency, particularly among political stakeholders, to act on a well-recognized but largely unaddressed problem. It is of interest to policy-makers as an example of how political will and processes can be used to generate action and change, as well as an example of global policy-making for HiAP.

The text of the 2010 PIHOA resolution reflects members’ frustration at the inadequacy of existing policy responses and particularly the mismatch between recognition of the size and extent of the problem at political/policy levels and the available funding at local, national and international levels for tackling the agreed NCD epidemic (PIHOA, 2010:5). Palau, in the WHO Western Pacific Region, was one of the first countries to take follow-up action and declare a state of emergency at the national level. The former Minister for Health in Palau and also President of PIHOA, Stevenson Kuartei, has been a key proponent in advancing this issue – both nationally and regionally. The PIHOA, Palau and related declarations underline the need for a response across government and society, and in some instances underline the importance of tackling the social determinants of NCDs (Palau Office of the President, 2011; PIHOA, 2010:5; APIL 2010; WHO Regional Office for the Western Pacific, 2011a; Kuartei, 2011; WHO Regional Office for the Western Pacific, 2011c). Finally, it is also a useful case study because of the health equity issues arising from NCDs among indigenous populations such as in Palau and other Pacific island countries and areas as a result of colonization.

For Palau, success and evaluation needs to be considered in two ways. The first is about the impact of the approach used in declaring a state of emergency to galvanize stakeholders and resources to act. The second is about the longer term vision of sustained action on NCDs. The draft NCD action plan developed by the NEC has yet to be finalized and endorsed by Government. It proposes an approach for monitoring and evaluation of both the state of emergency and the NCD action plan and goals. For example, it proposes that the Hazard Mitigation Sub-Committee meet annually to assess progress. It also proposes that, at the end of the fifth year, the Ministry of Health should undertake a comprehensive evaluation of the national response to assess if it is progressing in the right direction and identify any fine-tuning that might be required. As part of this proposed approach, if the evaluation suggests that NCDs are decreasing, then a recommendation might be made to the President to end the state of emergency. For overall monitoring of NCDs, the plan proposes that the Ministry of Health uses the STEP survey to evaluate the effectiveness.

With regard to the process, the PIHOA resolution can be viewed as an important springboard for much of the subsequent activity, bringing a sense of urgency to policy action and making use of many of the opportunities at international, regional and national levels to better tackle NCDs. A key lesson is the effectiveness of the state-of-emergency approach in getting NCDs considered and addressed as a multisectoral concern, for example, the development of a draft NCD plan of action by the NEC with leadership and roles for certain issues shared across different sectors, as well as increased awareness of the problem of NCDs in Palau. Sustaining the momentum for NCDs as an emergency issue could however prove challenging, both in terms of the regulatory and governance mechanisms available for tackling emergencies, and in terms of stakeholders’ and other sectors’ interest. The state of emergency could potentially last 15 years.

HLA of Aboriginal mobility, safety and well-being, South Australia: This case study is of interest for two main reasons. First, it outlines how the emphasis on partnership(s)
with other sectors in the South Australian model to tackle the social determinants of health enables other sectors to achieve their goals and indirectly achieve health goals. This addresses the challenge of health “imperialism” normally associated with ISA or HiAP (Williams & Broderick, 2010). Second, the HLA project with its focus on improving the mobility, safety and well-being of Aboriginal people in South Australia (Government of South Australia & SA Health, 2010a) illustrates the principle of equity, one of the principles underpinning the South Australian HiAP approach: “Recognizes that the impacts of health determinants are not equally distributed among population groups in South Australia and aims at closing the health gap, in particular for Aboriginal peoples” (Government of South Australia & SA Health, 2007).

This case study describes the implementation of HiAP and the steps undertaken as part of a HLA focusing on road safety for Aboriginal people. The health perspective is central to the HiAP model. It is a process that analyses and explores the links between the public policy area of focus and the health and well-being of the population, and examines the contribution of a healthier population to achieving the related SASP target. In this HLA, the collaborative HiAP process looked at SASP targets for: (1) Aboriginal healthy life expectancy – lowering morbidity and mortality rates of Aboriginal South Australians; and (2) Aboriginal well-being – improving the overall well-being of Aboriginal South Australians.

Mobility is an important determinant of health – people need to travel for work, education, health care, family, recreation or social reasons. People living in both urban and rural areas need a range of accessible and appropriate mobility options. Limited transport and mobility options therefore can have significant social and economic costs to society and governments. The HIA focuses on increasing the number of Aboriginal people in South Australia, who obtain and retain a current driver’s licence. The need for such a project is the result of a combination of factors including a policy that increases the requirements for people to obtain a licence. This measure, which was intended to increase the safety of the community, has had the unintended effect of creating a system that makes it extremely difficult for Aboriginal people to successfully obtain a licence. Thus, people drive without a licence causing an increase in the rates of mortality, morbidity and conviction for driving-related offences. The case study illustrates how making a driver’s licence more accessible through a culturally appropriate system and support can contribute significantly to mobility, road safety and ultimately health and well-being.

The concept of success espoused in the South Australian model for HiAP is largely that of effective collaboration and partnership across agencies. This comes through in the impact and process evaluation undertaken for some of the completed HLAs and through a recent overall evaluation of HiAP in South Australia. The evaluation of the South Australian model was commissioned by SA Health and undertaken by researchers from the South Australian Community Health Research Unit at Flinders University. The evaluation was designed in conjunction with the HiAP unit staff, but its activities were undertaken independently. Key stakeholders were interviewed (individually and in groups), including project and policy staff, middle managers, executives and university researchers. The evaluation focused on project development and impacts, how the steps in the HLA process worked in practice, and whether participants considered their specific HLA objectives
had been achieved (Lawless et al., 2012).

It was found that policy-makers had increased their understanding of the impact of their work on population health and health equity. The design of the HLA, particularly the fourth step of navigating the progress of recommendations through to the decision-making process, made a difference to policy change. The HLA process facilitated the exchange of evidence and provided an opportunity to examine inter-relationships between health and other sectoral agendas. Greater understanding and stronger partnerships between health and other government departments, and a positive disposition towards the ongoing use of the HLA in future policy work had been noted. Additionally, the deliberate focus on mutual benefit in the South Australian model of HiAP, and the supportive rather than leading role of SA Health seems to be contributing to the overall success of the approach (Lawless et al., 2012). As part of a more comprehensive five-year evaluation funded by the National Health and Medical Research Council, a detailed assessment of the policy impacts of HLAs (most likely including the Aboriginal Road Safety HLA), and the mechanisms that lead to these impacts will be undertaken (Lawless et al., 2012).

Success in terms of the HLA of mobility, safety and well-being for Aboriginal people in South Australia can be derived from the aims of the project to collaboratively identify ways of increasing Aboriginal healthy life expectancy. The project is improving road safety by increasing safe mobility options, and focusing on licensing drivers and diversionary programmes that support Aboriginal people to obtain and retain their driver’s licences (Government of South Australia & SA Health, 2010a)). The HLA has concentrated on how to directly support the achievement of two SASP targets: (1) Target 2.5 Aboriginal healthy life expectancy: lower the morbidity and mortality rates of Aboriginal South Australians; and (2) Target 6.1 Aboriginal well-being: improve the overall well-being of Aboriginal South Australians. This HLA also provides the opportunity to consider the connections with related additional SASP targets including closing the gap between Aboriginal and non-Aboriginal unemployment rates annually, reducing overall road fatalities and reducing overall serious road traffic injuries (Government of South Australia & SA Health, 2010a).

Improving road safety for passengers and drivers in Viet Nam: This case study is of interest in terms of effective ISA and HiAP because the lead government agency responsible is the Ministry of Transport, and the formulation, implementation and monitoring of the legislation is the result of the work of the multisectoral National Traffic Safety Committee in place since 1997. In terms of HiAP, the incentive for action does not appear to have been primarily or solely to tackle a health issue per se. Instead, the focus of the overall decree is to improve road safety and alleviate traffic congestion – both of which have positive health benefits if implemented effectively. In addition, “... injury prevention provides a powerful way of illustrating the health impacts of intervening on the social determinants. Intervening in this way can and frequently does yield cross-cutting benefits for a range of health and other outcomes.” (Roberts & Meddings, 2010:244.) Furthermore, this example is taken from a lower middle-income country setting, and makes an important contribution to improving the evidence base on reducing injury through action on the social determinants of health, which is usually drawn from high-income settings (Roberts & Meddings, 2010).

Of the 33.2 million registered vehicles in Viet Nam in December 2010, 95% were motorized two-wheelers. An estimated 59% of all road traffic fatalities are motorcycle riders (Nguyen et al., 2013). A Cochrane review has demonstrated that helmet use is effective in terms of reducing head injuries and fatalities (Liu et al, 2008; Nguyen et al., 2013; Pervin et al., 2009; Passmore et al., 2010a; 2010b). However, compliance with helmet use in low- and medium-income countries, where the use of motorized two-wheelers is a cheap and accessible form of transport, is low. This case is of interest to policy-makers as an example of evidence-informed policy development and implementation. Throughout the process of development and implementation in Viet Nam, attention has been paid to the main barriers to effective implementation of helmet use including: lack of availability and quality of helmets suited to the climate, loopholes in the
legislation, and beliefs (based on anecdotal knowledge) about the impact of helmet use, particularly on young children (up to seven years old) (Passmore et al., 2010a; 2010b). It also potentially reflects an important lesson learnt about tackling the social determinants of health: that of managing policy change which includes approaches that work around the barriers, ensuring strong political and sound legislative work, research and collaboration with media, and forging operational or strategic alliances (Blas, 2011).

Finally, the example is of interest because information from the three surveys and follow-up processes as part of ongoing monitoring is provided. To some extent, this has been used to adjust the programme, for example by removing loopholes with regards to the correct fastening of helmets, and to inform future policy changes, for example by increasing financial sanctions.

In the case of Viet Nam, success is understood in terms of impact through changed behaviours and a reduction in road injuries (fatalities and serious head injuries). Three studies have been undertaken examining the impact of the legislation including: (1) drivers’ and passengers’ compliance with the legislation and behavioural change; (2) the number of patients admitted to hospital with head injuries caused by road traffic injury; and (3) children (0–14 years). The first was an observational cross-sectional study on a random sample of 38 roads in three provinces in Viet Nam. It provided pre- and post-intervention data for a total of 665,228 motorcycle riders and passengers observed between November 2007 and February 2011. Before the law was introduced correct helmet wearing averaged 40.1%. This figure rose to 92.5% after the introduction of the legislation, although with significant differences between travel times and locations. Despite the limitations of the study (e.g. the observation sites may not have been representative of the road network and observations were only made during fine weather), a significant positive impact was noted. This improvement was largely sustained in subsequent observations over the next two and a half years (Nguyen et al., 2013).

In terms of health impacts, Office of the WHO representative in Viet Nam, the Ministry of Health and the Department of Planning in Viet Duc Hospital undertook a study of all road traffic injury patients with head injuries admitted to 20 provincial and central hospitals three months before and three months after the law came into effect in December 2007. They found a 16% reduction in risk of road traffic head injuries and an 18% reduction in the risk of road traffic deaths (Passmore et al., 2010a; 2010b).

A third study assessed the impact of the helmet law on children (0–14 years), given that they are less likely to wear helmets than adults, and given public perceptions about the harm wearing helmets can do to children. For this study, roadside and random population surveys were undertaken in Hanoi, Ho Chi Minh City, Can Tho and Da Nang cities during April 2008. A total of 4,189 respondents were surveyed with equal distribution between sexes and three age groups; approximately 44% of the respondents were travelling with children. A total of 18,734 roadside observations were made with observers estimating the age of children and noting the use of helmets among children aged seven or younger, eight to 14, and 15 and older. There were significant variations in helmet use between adults and children – adults from 90%–99% across the four cities, and children from 15%–53% across age groups. With children, there was substantial variation, with 15%–53% below the age of seven wearing a helmet and from 38%–53% for children aged eight to 14 years.

In the population surveys, an average of 82% of surveyed parents agreed that helmets were safe for children from two to 14 years, and 61% believed that children should wear them when travelling on a motorcycle. Yet, the observations do not support this belief, suggesting that the population surveys may reflect a socially desirable response that is not supported by actual behaviour. Parents were questioned about their reasons for not making their child wear a motorcycle helmet. Their responses included concerns about the risk of neck injury from the weight of the helmet, the fact that an accident was unlikely, the cost of the helmet, among others. For all three age groups, the risk of neck injury was consistently named as the primary reason, but the
percentage decreased with increasing age of the child (67.1% for children below the age of six months, 60.3% for children of six to 24 months, and 46% for children aged from two to 14). Cost, however, was not a significant reason across the three age groups. This highlights the need for ongoing advocacy and awareness-raising campaigns on road safety and the use of helmets for children to counter the myth about neck injury (Pervin et al., 2009). A concerted and sustained effort has been made to dispel this myth, including increasing the use of the media and providing training workshops for senior officials and national legislators. A key challenge in measuring the impact on children is that age-disaggregated data have only been available since May 2008 (Pervin et al., 2009).

Other examples of interest from the Western Pacific Region and identified both through the interviews and search of the grey literature and warranting further attention include:

- the PIHOA process of declaring a state of emergency on NCDs including activities in other countries such as Samoa (PIHOA, 2010; APIL, 2010; Talanei.com, 2012; WHO Regional Office for the Western Pacific, 2011a; Secretariat of the Pacific Community & WHO, 2010; WHO Regional Office for the Western Pacific, 2011b; NCD Alliance, 2010; Pacific News Centre, 2011);
- three examples (Kiribati, Solomon Islands, Viet Nam) on tackling gender-based violence as a social determinant of health (Rasanathan & Bhushan, 2011a; 2011b; 2011c);
- efforts by the WHO Regional Office for the Western Pacific to convene and provide technical assistance to countries taking multisectoral action on NCD prevention and control (WHO Regional Office for the Western Pacific, 2012); and
- capacity-building for implementation of the FCTC in Viet Nam (Stillman et al., 2013).

Together, these examples from the WHO Western Pacific Region highlight different ways of operationalizing the concepts of ISA, and specifically those practices lending themselves to scaling up a HiAP approach. The three detailed examples above, combined with information from the literature search and interviews that have informed this report, provide an overview of what it takes to develop and implement ISA across the Region to address the social determinants of health as well as potential lessons applicable to working intersectorally on public policies in the Region and beyond.
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Annex

ANNEX 1. TELEPHONE INTERVIEWEES AND PROJECT QUESTIONNAIRE, HEALTH IN ALL POLICIES IN THE WESTERN PACIFIC REGION

<table>
<thead>
<tr>
<th>Interviewee Name</th>
<th>Organisation</th>
<th>Country</th>
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<tbody>
<tr>
<td>Ms Carmel Williams</td>
<td>Manager, Health in All Policies, Public Health, South Australia Health, Government of South Australia</td>
<td>Australia</td>
</tr>
<tr>
<td>Mr Brendyn Semmens</td>
<td>Regional Director, Western Adelaide Region, South Australian Department of Education and Child Development</td>
<td>Australia</td>
</tr>
<tr>
<td>Dr Isimeli Tukana</td>
<td>National Advisor for Non-Communicable Disease, Head of the Wellness Unit, Ministry of Health</td>
<td>Fiji</td>
</tr>
<tr>
<td>Mr Saiful Anuar Huseen</td>
<td>Director, Social Services Section, Economic Planning Unit, Prime Minister’s Department</td>
<td>Malaysia</td>
</tr>
<tr>
<td>Dr Caleb Otto</td>
<td>Former Chairman of Health &amp; Education, The Senate</td>
<td>Palau</td>
</tr>
<tr>
<td>Dr Paison Dakulala</td>
<td>Deputy Secretary National Health Services Standard, National Department of Health</td>
<td>Papua New Guinea</td>
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Telephone interview questions

1. Which definition resonates more for your regional and country context? Why?

   “ISA for Health is

   … a strategy that allows the formulation of public policies in sectors different to the health, such that when these are in use, these policies, can correct, improve or positively influence the determinants of health

   … a systematic approach to taking into account the impacts of public policies on health determinants, including health systems, in order to realize health-related rights, to seek synergy across sectors and to improve accountability for the impacts of policies, and ultimately population health and health equity.

   … an initiative that focuses on influencing the health of the population and its determinants. A central element is cooperation between different relevant sectors inside and outside the domain of public health regarding aspects of health. The common goal is to improve, promote or protect health.”

2. What aspects of intersectoral work have had more emphasis in the experiences you know better:
   (a) coordinating service delivery (school, workplace)
   (b) coordinating evaluation of policies or plans
   (c) developing new policies/plans involving different sectors from the beginning?
       Please give examples.

3. Do you think the call for improving “health equity” is a key motivation for different sectors to participate in policies to promote health or work intersectorally? Why?

4. In your experience, what leadership roles has health successfully held in the initial phases of intersectoral policy processes? Do you think that ISA for Health activities can be driven by other sectors of government? Why?

5. What do you think about the role of civil society organizations whose advocacy helps to put specific
topics on the agenda? In your experience, has civil society participation had a weak or strong influence?

6. Do you think that debates of politicians in the Region (outside the country) have influenced leadership in favour of ISA for Health work? Please give (an) example(s).

7. Do you think that formal structures to control cross-sectoral commitments to health (e.g. statutory inter-departmental review groups, parliamentary committees, legal instruments) are key drivers for intersectoral engagement? Or can informal processes also be effective? How?

8. Do you think that priority-setting is facilitated if health does not present an “ISA for Health” approach as an entirely new way of doing things i.e. does working with existing structures matter? Why?

9. Do you think that the provision of direct financial support for activities related to implementing an ISA for Health approach (e.g. shared budgets) must be present to facilitate effective intersectoral engagement? Why?

10. How does cooperation and political will in different levels of the health sector (e.g. local, national) influence the promotion of ISA for Health in your view?

11. Within the health sector, do you think that shifting from a curative agenda to a promotion and social determinants agenda could influence favourably the participation of others sectors in ISA for Health? Why?

12. Which specific technical and practical capacities will the implementation of ISA for Health require the government to develop within health and across sectors?

13. In the short run, what are key barriers and facilitators to initiating ISA for Health initiatives?

14. In the long run, what are key barriers and facilitators to ensuring sustainability of policy initiatives between sectors?

15. Is there anything we have not asked you that you would like to mention?