SUMMARY **of the Experiences of the Americas**

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8th Global Conference on Health Promotion HELSINKI 2013

Rockefeller Foundation
Innovation for the Next 100 Years

Pan American Health Organization
World Health Organization

The 8th Global Conference on Health Promotion 2013, Helsinki, Finland, 10 to 14 of June

Dr. Clarissa Etienne
Director
Pan American Health Organization

Dr Jose R. Teruel
Assistant Director a.i.
Pan American Health Organization

Dr Luiz Augusto Galvão
Manager
Sustainable Development and Environmental Health (SDE)
Pan American Health Organization/ World Health Organization

Dr Sofíaleticia Morales Garza
Health Promotion and Social Determinants Coordinator
Pan American Health Organization / World Health Organization

Rosana Martinelli
Consultant
Pan American Health Organization

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FOREWORD

By now there is wide consensus around the fact that no sector of government can thrive and reach its goals without the participation of other sectors. Health in All Policies stresses a *whole of government approach*. Working together and across sectors is not only more effective, but also a pre-requisite to further improve the health and well-being of our communities at the national, regional and global level.

The path towards universal health coverage and to securing the well-being of communities cannot be addressed by the health sector alone. It needs coordinated action by and between sectors of government, by health professionals and other social and economic sectors and groups, by voluntary organizations, by local authorities, by industry and by the media and society at large. Inter-sectorial action is a sine qua non to be successful in reducing the health equity gap. In this respect, the UNGA Special Meeting on NCD's reaffirmation on multi-sectoral approaches has been a catalyst in many countries to move forward in the implementation of strategies of Health in All Policies.

Inter-sectoriality is not a new concept for the health sector. The 1978 ***Alma Ata Declaration*** fully recognized that a multi-sectoral approach was essential for Health for All. This concept has been revisited on multiple occasions. One such moment is the issuing of the ***1986 Ottawa Charter*** which referred to health promotion as *"the process of enabling people to increase control over, and to improve, their health, focuses on achieving equity in health, emphasizing that health promotion is not just the responsibility of the health sector, but goes beyond health lifestyles to wellbeing".*

A new advocacy is needed to crystallize a paradigm shift that supports more inclusive governance. The health sector will need re-tooling and leadership reform to build the capacities to accompany the meaningful interaction with other sectors. In the post-2015 development agenda, Health in all Policies will be as critical as it is today. Our challenge is to frame global problems not only by stressing the importance of health as a driver of change across all social and economic circumstances, but also the political impact of social and economic development on health. If we frame the challenges for sustainable development by involving all sectors of society working together in an aligned and synergistic way, we are more likely to succeed in creating a future that is equitable, healthy and productive.

As we move towards 2015, we have a unique opportunity to influence the global dialogue on strategies that effectively reduce the inequity gap and ensure well-being for all members of society, within a sustainable development construct that places human development at the center.

PAHO has recently established a Special Program on Health Equity and Sustainable Development at the level of the Assistant Director, which groups together the Social Determinants, Health Promotion, the unfinished agenda of the MDGs, and the post-2015 agenda. The Program will work with Member States in building the capacities for the successful implementation of whole of government approaches.

Let us continue our efforts and determination to securing societies free of inequities, where people have access to healthy environments and modify social determinants to live long, dignified, healthy, and productive lives.

Dr. Clarissa Etienne
Director of the Pan American Health Organization

Experiences of the Americas

"This publication includes 25 cases from 15 countries, including one presented by the government Andalucía, Spain. Not all of them are equally strong as examples of Health in All Policies, nor respond to all the established criteria, but each one of them has important aspects to be considered in the National Framework for Action of Health in All Policies. They were selected and presented by the Ministries of Health of the region. For these reasons, these cases are organized in alphabetical order by country, as no hierarchy was established with regards to their qualifications in the order they are presented below."

Experiences of the Americas

Health in All Policies

based on experiences from the Americas

The Pan-American Health Organization (PAHO) – along with the Ministries of Health of the region and PAHO's national offices - designed an instrument for gathering and systematizing national, state and local experiences on intersectoral work. A template was developed that enabled the identification of the initiatives being carried out that would reflect the concept of **Health in All Policies**. The following criteria to classify the cases identified were developed, based on the existing literature:

1. The initiative demonstrates political support at the highest level (it was launched by the President of the country or its equivalent at subnational level).
2. It has as formal intersectoral structure that operates the program.
3. A specific budget is allocated to operate the initiative.
4. There is an explicit commitment from other sectors to be part of this initiative.
5. There is an explicit commitment to reduce inequity in health.
6. There is scientific evidence on the impact of the program.
7. It includes mechanisms for participation, as well as for social and community empowerment, that enhances ownership and sustainability of the program.

Based on these criteria and the work from the ministries of health, 25 cases from 15 countries were gathered and systematized[1]. A program from the government of Andalucía, Spain, was included, although it does not come from the region of the Americas, given the merits and the value of the example. While not all cases presented responded to all the criteria, the majority of them showed collaboration and work among different sectors and addressed health challenges from areas outside the traditional scope of health. Most of the experiences shared were national and state cases, but there were some very valid local and municipal experiences worthy of analysis. It is important to highlight the political will at the highest level of the national experiences presented, but also to mention efforts undertaken in the municipal or local territory; as this is a space for integration and synergy of policies, actions and knowledge of the social actors that enables a collaborative work among different sectors.

1. Rosana Martinelli, PAHO consultant and the SDE Team coordinated by Sofialeticia Morales analyzed and systematized the 25 cases presented by 15 member States.

Health in All Policies implies and requires intersectoral efforts, moving beyond the field traditionally defined as the domain of health sector, in order to address issues that impact health. The broad history and experience in the region on the implementation of strategies for primary care makes it necessary to reaffirm the importance of intersectoral work in achieving universal access to health. ***"Success in reducing health inequities will require ensuring that the broad focus of primary health care and the social determinants is kept foremost in policy - instead of the common historical experience of efforts being limited to a part of the health sector[2]"***. This explains why 52% of the experiences presented included Primary Care in Health in its design and implementation.

The adaptation developed by Solar Valentinen 2009[3] of the work on integration of policies from Nethereland E Meijers[4] was taken as a starting point, in order to establish the type or level of intersectoral work in the cases analyzed:

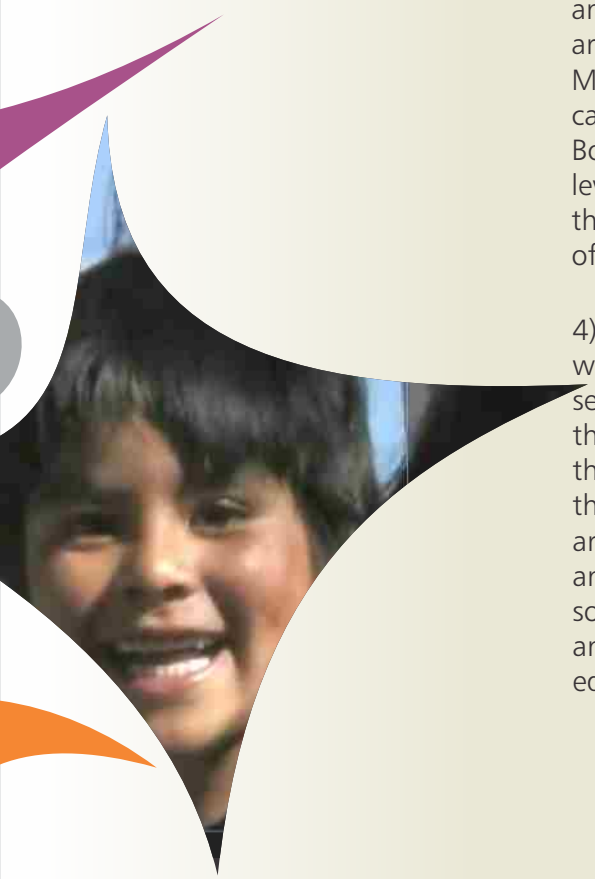
1) The first level of intersectoral work is the **Exchange of Information**, understanding that in a first stage, each sector shares information available on a specific problem or initiative to develop, in order to build a common language and start working together. Some of the cases presented have this level of intersectoriality. An example of this is the case presented from Bolivia "Points for Life" (Puntos Vida).

2) The second level of intersectoral work is **Cooperation**, where the different sectors, based on the information previously shared, establish a cooperation strategy to resolve a given problem or to work together towards an initiative that requires a joint solution. Generally, cooperative actions occur at the implementation phase, and do not have a shared budget. Most of the cases presented have this level of intersectoriality. An example of such is the work lead by the General Attorney's Office of the state of Chihuahua, in Mexico. It tackled violence prevention by coordinating different sectors and actors. The case presented by El Salvador, which describes a developing initiative that establishes an Intersectoral Political and Technical Commission on Health is also an example of cooperation and coordination. The Political Commission is headed by the Minister of Health, and is comprised by more than 35 governmental and civil society agencies. The Technical Commission is formed by technical representatives of public, private and cooperation institutions and organizations.

2. J Epidemiol Community Health .2009. Primary Health Care and the Social Determinants of Health: Essential and Complementary Approaches for Reducing Inequities in Health K Rasanathan[1],E Villar[1], Don Matheson[2], Carissa Etienne[1],T Evans[1]

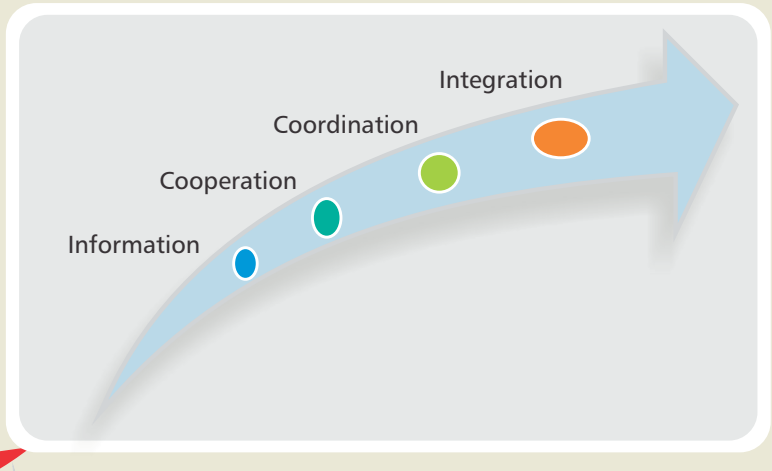
3. Moving Forward to Equity In Health What kind of intersectoral action is needed? An approach to an intersectoral typology. Partnership and Intersectoral Action Conference Working Document7th Global Conference on Health Promotion, "Promoting Health and Development: Closing the Implementation Gap", Nairobi, Kenya, 26-30 October 2009.

4. **Policy integration: what does it mean and how can it be achieved? A multi-disciplinary review 2004** Evert Meijers, Dominic Stead Conference Berlin .



3) The third level of intersectoral work is **Coordination,** where all involved actors from different sectors not only exchange relevant information produced by each one of them, but also develop cooperation strategies to solve the problem or advance on a shared solution, establishing strategies and mechanisms for inter-institutional coordination. Generally, budgets are shared and there is a shared design and/or implementation process. Many of the cases gathered have this level of intersectoriality. Among the cases presented by member states, it is important to highlight the case of Bolsa Familia and Brazil without Poverty (Brasil sim Miseria), where a high level of coordination can be observed. There are also local experiences with this level of intersectoriality, such as the Network of Healthy Municipalities of Pernambuco, also in Brazil.

4) The fourth level of intersectoriality is **Integration** of all involved sectors, where the drafting of a new policy that integrates the work of various sectors can be identified. It also establishes its own budget that integrates the different sectors. Few of the cases presented can be identified as having this degree of intersectoriality. An example of this is the National Plan for the Good Living of Ecuador, which becomes the instrument used to articulate public policies with management and investment at national and subnational level. It is built on the basis of the search for equality and social justice, and on the recognition, value and dialogue among all people and their cultures, know-hows and lifestyles, with the goal of reducing equity gaps and satisfying basic needs of the population.



Parallel to this work of actively searching for cases of Health in All Policies in the Americas and the systematization process, PAHO, with support from the Rockefeller Foundation, and aligned with the World Health Organization, is carrying out an investigation on the intersectoral work in the region and the connotation with the terminology "health in al policies", aware that this is a concept developed in Europe under the leadership of Finland. For that reason, it is important to define the type and level of intersectoral work as well as the concept of "health in all policies" based on the experience within our region.

The first step was the acknowledgement that in spite of the fact that intersectoriality is a commitment expressed since Alma Ata (1978) and the Ottawa Charter (1986), and is also mentioned in almost all public health programs, its impact on health has not been documented or systematized thus far. Neither is there a theory on which to build a framework for analysis on the effectiveness of intersectoral action in the different programs, or to identify which type of intersectoral work has characterized the actions taken for prevention and mitigation of communicable and non-communicable diseases. There is also no background on the type and level of intersectoral work that should be developed to respond to social determination and advance in the reduction of inequities.

For this reason, it was necessary to carry out an investigation in order to build a reference framework that would allow us to analyze the different types of intersectoral work on health, and based on this research, determine which is the Health in All Policies profile that responds to our regional reality (inter-America and Ibero-American regions).

The following step was a literature review on the work done in and on our region, and published in scientific magazines with unrestrictive circulation. The search was also broaden to include all published articles in English, Spanish and Portuguese since the Ottawa Charter (1986)[5]. Grey literature was also reviewed to ensure that current articles were also considered, even when they were not yet published in scientific magazines but did reflect the kind of initiatives and experiences that would help us characterize the kind of intersectoriality in the Americans, as opposed to the kind of intersectoral work developed in other regions of the world.

The identified literature was later grouped into two sections, one related to articles that contributed to deepen the understanding of the regional concept of "health in all policies" and another on articles that reflected experiences or cases of intersectoral work.

5. Sandra Rehiner and Ana Lucia Ruggiero carried out this face and togheter with SDE team developed the HiAP toolkit: PAHO toolkit: http://www.paho.org/hiap/

With the support of a team of researchers[6], three hypothesis were identified for the analysis of the intersectoral work in our region:

1) There is an alignment between the intensity of the intersectoral work and the purpose a program or a public policy seeks.

An example of this would be when a country proposes tackling a specific case to reduce the incidence of a disease, for example dengue or cholera, through intersectoral work, which can be developed in order to share information and coordinate actions to respond to the key goal of reducing the incidence of these diseases in a specific population at risk.

2) There are variables related to the organizational structure, management, evaluation and financing of the intersectoral work, which impact the kind of intersectorialtiy developed and on the results it produces.

An example of this is the criteria established to identify cases of Health in All Policies where it is clear that the political will at the highest level shows a shared commitment among all sectors (integrated management). Planning and implementation of the initiative, the administrative and functioning structure, and the financing are conceived from the beginning as integrated processes conducive to the reduction of inequities in health.

3) There is a correlation between the type of intersectoral work and the predominant focus on the health sector associated with the public health approach, both within the heath sector as well as other sectors.

For this reason, it is important to identify the vision of the concept of health and society that defines or shapes the type of intersectoral work developed, as well as identify which interventions are given priority. In this way, a case that has as an objective the reduction of a specific disease, will require intersectoral information sharing action, as well as cooperation.

A case targeting prevention and development of health promotion strategies will additionally require greater coordination, not only information sharing or cooperation. Only those initiatives or policies that seek to impact social production of health, that is, the determination and social determinants reflected in other sectors, will seek interventions to reduce inequalities, especially inequalities in health.

6. Under the leadership of Orielle Solar, Lucero Rodriguez, Raul Mercer and Sofialeticia Morales

Health promotion and social determinants authorities from 30 member states participated in the Regional Planning Meeting for the 8th Global Conference on Health Promotion, held in Brasilia, with the support and leadership of the Ministry Of Health of Brazil on February 25-27, 2013. They analyzed the Framework for National Action for Health in All Policies, and, based on the proposed definition provided by the WHO, they developed a definition that would be operational for the region:

Health in All Policies (HiAP) is a state strategy which redirects public policy and implies coordinated planning among different sectors and levels of government for decision making. It is centered in equity and guarantees the right to health, generates synergies to advance on the wellbeing of the population in a sustained and sustainable manner.

The Region of the Americas highlights that HiAP:

* *HiAP is not simply a group of multisectoral or intersectoral actions, but a deliberate decision of systematically evaluate the impact of integrated policies and actions on health and people's wellbeing. HiAP is not only a technical matter, but rather and more importantly, it requires the political commitment at the highest level.*

* *HiAP does not impose a health agenda on other sectors, but it is rather a mechanism to promote a balance among different sectors, with the goal of avoiding overlapping of strategies and strengthening their actions.*

* *Civil society participation in the decision making process and allocation of resources is vital to ensure ownership and legitimacy of HiAP. For that reason, the government must promote participation of all individuals, making special effort to include groups traditionally marginalized and living in disadvantaged conditions.*

Brasilia, Brazil, February 25-27, 2013

The cases presented in this report showcase different approaches to Health in All Policies that can effectively impact the health and wellbeing of the population by working with other sectors. These are promising examples that advance the goal of the state that, in partnership with relevant organizations, develops public policies that efficiently deliver services to its citizens maximizing its resources while addressing the persistent inequalities in health.

Sofíaleticia Morales Garza
Health Promotion and Social Determinants of Health Coordinator.
PAHO/WHO

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HEALTH IN ALL POLICIES IN THE AMERICAS

The 8th Global Conference on Health Promotion 2013,
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Bolivia systematize two cases, one of them reflects a local development example and health among communities" y debe de decir "Bolivia systematize two cases, one of them reflects a local development and health example among communities from three countries un the Guarani region of the Great South American Chaco. It reflects the experience from the Bolivian perspective and it emphasizes the appropriation process within the community, where the conditions of the community are seen as social determinants of health. Political will is present at national, subnational and community level, but it is circumscribed within the health sector, and it has a ***cooperation intersectoral approach***. The second example is an information and communication experience in health, "Puntos Vida", where awareness is raised on the possibility of reducing risks for Non-Communicable Diseases. This is done by involving inhabitants as co-participants and taking charge of their own health. Nonetheless, this does not show the same level of co-responsibility seen in other examples, and in the best case this is a case of ***intersectoriality at the information*** level.

TCC faces voices and places in the Bolivian Chaco

The Bolivian Chaco region participated between 2009 and 2011 inter-American initiative faces, voices and places, promoted by the Pan-American Health Organization. This initiative supports average-income countries to close the inequality gaps in their poorer localities. It also seeks to strengthen the construction of citizenship with a rights based and shared responsibilities approach. It promotes intersectoral and interagency action, contributing to fulfill the MDGs. Along with the implementation of community activities; it also develops a training plan on health, environment, food security, and health and nutrition surveillance. This project was designed based upon a study developed in the border region of Argentina, Brazil and Paraguay, which call for a stronger local coordination in order to design joint strategies for health programs, so that public health measures can affect the whole population. In a joint collaboration between national and local agencies, an inter sectoral action is plan is developed with active local participation. PAHO provided technical cooperation for the implementation of actions in Maternal and Child Health, Malnutrition, Neglected Infectious Diseases (like prevention of Chagas disease, STH control and prevention of rabies in dogs), improve water quality and access to food security by implementing coops and orchards.

TCC faces voices and places in the Bolivian Chaco

Although it does not meet all the criteria to be considered as an example of health in all policies, it is important to highlight that:

Although it does not have the highest political commitment, it has support from the health sector both at the national level from the Ministry of Health and Sports as well as local authorities.

Although a specific structure was not established, an intersectoral effort at the local level was put in place to implement national policies, along with a strong support from international cooperation.

Other sectors along with health participate in this initiative The national Ministry of Health and Sports supported these actions. The Departmental Health Services Office (SEDES) of Santa Cruz developed education, prevention and diagnostics actions through its maternal and child health program, as well as initiatives in malnutrition, fight of the Chagas disease and other programs. The university Gabriel René Moreno (UAGRM) conducted de-worming against in schools, with consent of the autonomous Government of Santa Cruz. Other institutions provided technical support for the implementation of family orchards and raising poultry. The Charagua municipality with the technical cooperation of PAHO conducted the monitoring of water quality.

Although it lacks its own budget, this project was funded by PAHO/WHO. National counterparts contributed with their human resources.

It seeks to reduce inequality. This is the basis of the faces, voices and places initiative, when identifying communities in which interventions are made. This project included addressing the needs of indigenous populations.

It is based on inter sectoral work. This endeavor required interaction between health, food safety and animal health at the local level, with coordination at the departmental level and national supervision.

It develops public policies that impact on health by improving coordination and work with the local community on issues of care and health promotion. As result of this initiative, technical teams at SEDES have considered leading departmental and national level actions to improve inter and intra- institutional coordination, in order to make more effective delivery of health services.

It has scientific based evidence of its results. SEDES reports positive results with regards to this initiative. The community addressed became visible to health and departmental authorities in health, highlighting its basic health needs and sanitation to reduce the morbidity and mortality. There was an increased awareness of the community on the importance of its active role. Be empowered women through the creation of a cooperative for the production of food of poultry origin. For example, there were improvements in the number of families raising poultry production, and school age children were treated for parasites.

Social participation is crucial for this program. In order to identify the needs for food, health and sanitation, participatory diagnostics were undertaken. The implementation of actions was carried out in close coordination with the Community authorities respecting their traditions and culure.

Points of Life
Puntos Vida

The strategy Puntos Vida was established in order to provide an information service to the community on risk factors such as smoking, alcohol abuse, eating habits, overweight and sedentary lifestyle. To do this, small informative, mobile tents were set up in different locations and areas with high population turnout such as bus terminals. In the tents, blood pressure test were taken, as well as weight control, body mass index and information on NCDs was provided for free. This initiative started in La Paz, and now has more than 60 tents set up throughout the country, including rural areas.

Although it does not meet all the criteria to be considered as an example of health in all policies, it is important to highlight that:

Although it does not have the highest political commitment outside the health sector, the initiative was promoted by the Ministry of Health, and coordinated by the NGO Club de Leones. It was supported by the Departmental Health Services Offices (SEDES).

Although it does not have its own structure, the Club de Leones presented the initiative to the authorities of the SEDES of La Paz, who incorporated it into their work plans, expanding it to nine departments/states throughout the country.

It is not evident that other sectors along with health participate in this initiative. However, there are several actors involved within the health sector and other actors are also convoked to assist, such as the Bolivian police. Club de Leones were the initial leader of this endeavor. Universities, SEDES, the Ministry of Health, scientific societies and other social agencies subsequently joined.

It has its own funding. Resources (for logistics) from agencies of international cooperation (such as PAHO) were provided. Club de Leones and universities provided their personnel to provide services in the tents and for printed materials. SEDES and the Ministry of Health committed financial resources and secured the availability of tents and other logistical aspects, according to their possibilities at the SEDES.

It seeks to reduce inequality. The initiative targets population segments of urban and some rural areas where there is a generalized lack on information on health care. Mobile tents were placed in public spaces around underserved areas.

Although it is not supported on inter sectoral work, some Departments established inter-agency committees (Cochabamba and Santa Cruz, are examples) to support the initiative. In other Departments, the Puntos Vida depend on SEDES exclusively or the Bolivian police.

It does not develop public policies that impact on. Changes in policies cannot be observed, although the initiative of Club de Leones has been incorporated into the work plans of many SEDES.

Although no scientific based evidence of its results is offered, monitoring actions were carried out. Preliminary results are related to both the demands from institutions as well as the community demand. In places where the tents were set up, long lines of people were formed, in order to receive information and primary care. Additional resources for a national evaluation are required to carry out a thorough evaluation.

Social participation. No active participation except for the active role in approaching the tents to receive information and primary care

Brazil systematized 8 cases. One of them "Bolsa Famila", fulfills all the criteria established for Health in All Policies examples. It represents a case of ***intersectoral work at the coordination level***. "The National Tobacco control" is an example of building consensus with other sectors to develop a national policy. There are five examples that show the importance of developing networks at the sub-national level. These are: "The Health in School Program in Florianopolis"; "the Pernambuco Healthy Municipalities Network"; the Road Safety Network implemented in five cities in Brazil under the "Life in the Transit" program; and the articulation of the Networks "Illuminar" and the Network of care for people in situation of Violence (NPVA). All of them are examples of ***coordination*** with other sectors to implement health in all policies. "In the Radio Waves" is an example of empowering the community in taken care of their health by discussing specific issues through radio programming, although the intersectoriality is only present ***at the level of exchange of information***. At the municipal level one of the most solid programs with high level of political will at the local level and intersectoral work at the level of ***coordination*** is the PAVS Green and Healthy Environment Program.

Bolsa Familia Program (BFP)

The Program aims to reduce poverty through direct monetary transfers to families, combating hunger and promoting food security. It also seeks to reduce the intergenerational aspects of poverty through support to families in order to comply with conditionalities attached to those transfers. It also provides support to promote and improve their access public services networks of health, social welfare, education, and social assistance. Finally it supports capacity development of families through coordination with complementary programs.

The BFP fulfills the requirements to be considered an example of Health in All Policies because:

It has the highest political commitment both at presidential and legislative levels, with the adoption of the 2004 law that created the Program. The Ministry of Social Development and Fight Against Hunger (MDS) receives the mandate to implement the program at all levels of government (national, federal, and municipal), and in coordination with relevant national ministries.

It has its own structure. The Management Council of the BFP (CGPBF in Spanish) is a collegiate body of deliberative character within the MDS which formulates and integrates public policies, defines guidelines, standards and procedures; and supports initiatives of institutionalization of policies that strengthen beneficiary families. The CGPBF is composed by heads of social development, education, health, planning, and Civil House, among others. It is also open to participation of representatives of federal, state and municipal administrations; as well as to the private sector and NGOs. Since 2009, an intergovernmental and inter-sectoral management of conditionalities Forum was established (with representatives from SENARC, MDS, Social assistance, continuing education, literacy and diversity, healthcare).

Other sectors along with health participate in this initiative. All the sectors involved supervise the compliance of specific conditionalities relevant to their responsibilities, through national ministries, state and municipal agencies (social assistance, education and health). The Program receives additional support from the private sector and NGOs on specific actions.

It has its own budget. Financing secured by article 195 of the Constitution, which established that policies developed to support social security should be financed with resources from the 3 levels of Government. Additionally, the Decree No. 1605/95 ensures resources for social assistance programs, in addition to contributions from the private sector and NGOs.

It seeks to reduce inequality. The program serves families in extreme poverty in order to increase their human capital and improve their opportunities of development - addressing inequalities in income through money transfers. Human and social capital is promoted through compliance with education and health conditionalities, as well as the promotion of information to access to public services.

It is based on inter sectoral work through regular and specific meetings of the CGPBF. Working groups are also established in the process to meet and discuss issues, conditionalities, and/or specific indicators.

It develops public policies that impact on health. After 6 years of implementation, the Program identified the need to strengthen the component of comprehensive health of families including addressing health of men and elder people, not considered initially. In addition, as a result of the BFP, areas of the Ministry of health were redefined to focus on the reduction of inequities in health (including principles, programs, policies, projects, strategies, instruments and actions).

It has scientific based evidence of its results. Multiple studies and evaluations of process and impact have been developed, both external and internal. The results have also allowed the adaptation and adjustment of the BFP. The initiative has proven impact in reduction of poverty and inequality, and contributed to the fulfillment of the MDGs. Some results highlighted: increase in clinical consultations of pregnant women; increase in births to term by 14.1%; improvement in infant nutrition (39.6% better than non-beneficiary families); decrease of infant mortality by 47.6% during the past 10 years; decrease in fertility rate (from 2.38 to 1.90); reduction from 13.5% to 6.8% in the deficit of height per age group; improvements in maternal schooling, purchasing power, basic health care, access to vaccinations. In 2012, 13.4 million families) were served, each one receiving on average 120,66 reais. (1.624.325.445,00 reais in total, representing 0.46% of GDP).

Social participation, although limited in the design, development and implementation of policies, there is social accountability of the program, through public sector and civil society representatives in the evaluation process. Additionally, participation of beneficiary families is required through shared responsibilities in order to comply with the conditionalities.

Pernambuco Healthy Municipalities Network

This initiative is built upon the framework of the initiative promoted by PAHO of healthy municipalities. Each municipality is committed to adopt a "healthy action" or a "healthy municipality plan" and having promoters of health trained by the University. The Government is in charge of the diffusion of the network (among 23 municipalities), offers technical courses on demand, mobilizes action and develops participatory health plans. The University promotes specific courses for healthy municipal promoters. There is a social actor, a healthy municipality promoter, trained to ensure sustainability of the intervention. He is addressed as the “inter sectoral agent” in the territory. The focus of the Network is to reduce inequalities in health - equity, social justice, cooperation and perception of happiness - and looks to add, give visibility and empower intersectoral health actions in the municipalities that are members of this network.

It fulfills the requirements to be considered an example of Health in All Policies because:

It has the highest political commitment of the Government of the State of Pernambuco (which takes over the responsibility of coordinating the network after initial phase developed as part of an international cooperation initiative).

It has own structure. The General Management Committee is formed by members of the University of Pernambuco, the State's Ministry of Planning and Management (SEPLAG) and municipal representatives (two local managers and civil society members). SEPLAG coordinates an inter sectoral Commission of all the Secretaries of State.

Other sectors along with health participate in this initiative. This initiative convokes municipal communities, local management representatives, municipal health promoters (volunteers with intersectoral training). The Federal University of Pernambuco, SEPLAG and the Intersectoral Commission also participate in this initiative, as well as government sectors of social action, health in schools, health agencies, art, and planning.

It has its own budget. Funding for annual meetings of municipal directors and for routine visits and monitoring of the technical local actions are Included in the multi-year budget plan of the State. The University has resources for systematic monitoring and the municipalities make additional contributions as needed.

It seeks to reduce inequality. The network has a strong gender component as one of the conditions of vulnerability in the State, and hence promotes empowerment through training to prevent domestic violence, learning crafts, creation of cooperatives, etc.

It is based on inter sectoral work. The Network, through the articulation and promotion of healthy public policies, seeks to involve in its management all sectoral secretariats, in order to promote public policies that are demanded by the citizenry. The meetings of the network also provide visibility and intersectoral interaction. The General Management Committee of the Network is being reactivated with municipal representatives. The holistic approach is present at the state and municipal levels.

It develops public policies that impact on health. As result of the work of the network, there are different focal points in each municipality for different sectors. The dialogue made by the University and SEPLAG (intersectoral representation) facilitates this dynamic. For example, the development and implementation of municipal master plans today based on health promotion of health as a cross-sectoral approach, so these plans were named General Participatory Health Plans.

It has scientific based evidence of its results. Qualitative assessments on the quality of life are carried out to verify the health of the people, as well as assessments of social capital. Evaluation of practice of the municipal health promoter (2008) defines this initiative as innovative, intersectoral, and with demonstrated actions and competences. Other assessments are in process on the institutionalization of strategy.

Social participation. All the process is built on active social participation. A social capital assessment was done to start the integration process of the population, which derived in the design of the municipal health promoters (with certification and support from universities). Social participation active since the start of the facilitators.

National Tobacco Control Policy

The general objective of this program is to reduce tobacco consumption and smoking prevalence, in order to lower the rates of morbidity and mortality related to tobacco in Brazil. Its specific objectives are to: reduce initiation into smoking, reduce access to tobacco products, provide protection against environmental risks of smoke, reduce social barriers that make it harder to quit smoking, increase access and availability of treatments to stop smoking, control and monitor tobacco products in the country (from its content and emissions to their promotion and marketing strategies); and monitor consumer trends, effects on health, the economy and the environment, as well as the strategies of the industry. Brazil ratified the WHO Framework Convention on Tobacco Control in 2005, requiring the country to pass laws to restrict tobacco.

It fulfills the requirements to be considered an example of Health in All Policies because:

It has the highest political commitment, where its implementation is entrusted to the Ministry of Health and the National Cancer Institute, following the presidential commitment to address the challenge.

It has its own structure. The National Cancer Institute is the Executive Secretary of the National Commission for implementation of the Convention for the control of tobacco (CONICQ) and is presided over by the Minister of health. CONICQ has 18 areas of Government represented at its maximum level (ministries of health, Foreign Affairs, finance, planning, agriculture, justice, education, labor and employment, foreign trade, agricultural development, communications, environment, science and technology, Civil House, Secretariat for women, drugs, advocacy, health surveillance Secretariat).

Other sectors along with health participate in this initiative. All sectors that are part of CONICQ are involved. Finance develops tax policy, and combat the illegal tobacco market. The Ministry of Justice focuses on illicit drugs. Agrarian Development develops programs for national diversification of farming areas. The national health surveillance agency issues regulations of contents of tobacco products. The National Cancer Institute, along with the secretariats of health state and municipal, implements treatment to quit smoking, educational actions and awareness.

It has its own budget. Funding is provided through the national budget for implementation of the International Convention. Additionally, all members of CONICQ contribute to its funding.

It seeks to reduce inequality. While serving the entire population smoker and non-smoker, there are specific actions for children and adolescents, and women.

It is based on inter sectoral work. Through CONICQ, advice is given to the Brazilian Government in policy decisions for compliance with the Convention to control tobacco and its commercialization, which demand the articulation of an intersectoral agenda to meet the Convention criteria.

It develops public policies that impact on health. With the ratification of the Convention on Tobacco Control in 2005, the government issued a decree in 2006 giving the mandate to make it operational. Actions included an increase in taxes on cigarettes with the intention of reducing consumption among young people.

The program provides scientific based evidence of its results. surveillance assessments are performed: VIGITEL monitors the frequency and distribution of risk and protective factors for NCD in all the capitals of the 26 Brazilian States and the Federal District through telephone interviews to the adult population; Special smoking surveys (Petab) are developed as an overview on the use of tobacco products in children under 15 years; the International (CTI) Tobacco Control policy evaluation project is the first international study on consumption, evaluation and impact of implemented policies were performed during the second half of 2012. Outcomes are reported regularly through publications by the Ministry of Health.

Social participation. Citizen participation mechanisms have been used in the design, implementation, and evaluation of the policy. Participating agencies promote continuing education to health professionals and offer seminars open to civil society on the main topics included in the Convention, as well as sensitization and awareness to public managers.

PAVS – Green and healthy Environment Program:

building integrated public policies in the city of São Paulo

The PAVS program seeks to incorporate environmental issues on the holistic approach to health promotion and improvement of the quality of life of the population developed within the Healthy Family Program (PSF) in the municipality of São Paulo. It is based on strengthening the inter-sectoral management of social policies at the local level, including training and enhancing qualifications of about 7000 community agents of health and social protection, promoting the development of community projects that take into account local strengths and needs.

PAVS – Green and healthy Environment Program: building integrated public policies in the city of São Paulo

PAVS fulfills many of the requirements to be considered an example of Health in All Policies because:

Although it does not have the highest political commitment, it was strongly supported and led by the Municipal Secretariat of Health of São Paulo.

It has own structure. The initiative of this project originated from the Municipal Secretariat of Green and Environment, and its development was coordinated by a national and international series of institutions: Ministry of health, PAHO, UNEP, University of São Paulo, FLACSO, FIOCRUZ, Municipal Secretariats of Environment, Health, and Social Assistance and Development affairs and twelve partners of the Municipal Secretariat of Health enrolled in the National Program of Family´s Health (PSF). For its implementation, during the first phase it was established a Board of Directors with representatives of several of these institutions. In this moment the coordination of the program (it is not a project anymore) is under the rule of Municipal Secretariat of Health.

Other sectors along with health participate in this initiative. Secretariats of Health, Environment, Education and Social Assistance of the municipality work together in this initiative - which is framed within the National Program of Family´s Health (PSF). It is also supported by the Secretary of Urban Infrastructure, Services (waste management and other utilities), and SubPrefectures.

It has its own budget. Financial resources were provided by SVMA, Ministry of Health/Municipal Secretariat of Health and UNEP for planning and training phase. It currently receives funds from the Municipality, in the framework of the PSF.

It seeks to reduce inequality. São Paulo has big challenges in terms of social exclusion and inequalities which impact urban and human development. As part of the PSF, this strategy serves in contexts of high vulnerability.

It is based on inter sectoral work. The initiative was created to address the lack of articulation among different policies and build an environmental management strategy involving the community in order to complement the work of the PSF program in an intersectoral way, enforcing the perspective of health promotion and to raise awareness in the population on environmental issues that can improve their health.

Though it doesn't develop public policies that impact on health, PAVS seeks to raise awareness in the population on environmental issues that can improve their health.

It has scientific based evidence of its results. PAVS has its own outcome indicators. Changes in behavior can be observed since some families incorporated new practices of environmental health in their daily lives, such as growing their vegetables in private orchards and gardens, improved their eating habits - among other things. More than 1400 projects with this approach on environmental health have been developed, some of the concluded while many are being developed.

Social participation. Associations of neighbors, merchants and entrepreneurs participate in the activity, as well as NGOs linked to the environment. They play important roles in identification, support and execution of evaluation processes within the program. Socio-environmental projects are developed with the information gathered from territorial surveys developed by health agents, who perform participatory diagnostics involving the community.

Health in School Program

Initiative that, through a Social Determinants of Health Approach, seeks to modify the school curriculum addressing various issues of health in a cross-cutting way. These issues include hygiene, alcoholism, sexual education, etc. Skills and training (workshops, seminars, forums, and discussions) are available to educators, as well as teenagers and their parents, in order to act as multiplying factors among peers, so that they may become health promoters in their communities.

It fulfills many of the requirements to be considered an example of Health in All Policies because:

It does not have the highest political commitment at local level, where the program is coordinated by the Municipal Secretariat of health and education in Florianopolis without a higher local authority being involved outside these sectoral leaders.

It has its own structure. An Inter-institutional working group (GTI was established) with the secretariats of education from the state and the municipality, as well as the Municipal Health Secretariat. In the initial phase of implementation, each health at school unit has an articulator of the program at the school and a health center.

Other sectors along with health participate in this initiative. This is a joint effort with the education sector.

It has its own budget Funding from the federal state is provided, with additional contributions of the secretaries involved – who offers stimulus for education and health professionals.

It seeks to reduce inequality by promoting free and universal access to the health of groups in situations of vulnerability, serving 100% of children in basic education.

It is based on inter sectoral work. Is a joint inter-sectoral policy. The Secretariat of social welfare, addresses cases of learning difficulties as result of domestic violence or neglect. An implementation workshop is offered for the school community to develop a joint health agenda on issues such as health care, promotion and lifelong learning, to be implemented during the school year.

It develops public policies that impact on health. The Secretariat of health included in its school care policy addressing visual health as result of this experience. The area of education improved the school feeding program by adding the ban on sale of non-healthy lunches in schools.

Although there is no scientific based evidence of its results, an indicator of compliance with the health agenda at the school was developed to follow up on the initiative (No. of students who participate in primary care in health).

Social participation. Two annual forums are performed with youth participation to foster their activism. Workshops and meetings in schools are developed to promote local community involvement (associations of parents, unions, local boards of health, and others).

The intersectorality as a strategy for reducing morbidity from traffic accidents

Life in the transit is a national initiative implemented in 2010 by the Ministry of Health with support from PAHO in 5 cities of Brazil. It included the development of actions to promote health and a culture of peace in public road, as well as training, awareness seminars and actions to prevent injuries and deaths from traffic accidents. It created opportunities for collaboration and coordination with other sectors, and developing intersectoral actions. In Belo Horizonte three workshops were conducted with relevant actors for data analysis, construction and approval of an Action Plan, which was later implemented. The participation of federal, State and municipal governments was promoted, articulating joint measures and focusing on collaborative work to identify risk factors for traffic accidents. As result of this, groups were established to address specific population sectors ("Jovem Condutor", "Rider", "Pesdestre", "Associação alcool e Direção" "Speed").

The initiative fulfills many of the requirements to be considered an example of Health in All Policies because:

It has the highest political commitment. It has the support of the National Ministry of Health. At the local level the Ministry of Health of the cities are involved, as well as the Transit Company for Belo Horizonte, Minas Gerais (BHTRANS).

It has its own structure. The strategy was coordinated by a National Committee of Mobilization for the Health, Safety and Peace in the Public Road. Representatives from the Ministries of: Health, cities/urban development, justice, transport and education are part of the Committee. Its function is to make a diagnosis to promote joint and cross-sectoral strategies on the matter. At the local level, the inter-institutional Commission with participation of the Secretariat of Health, BHTRANS, Education, DETRAN, Municipal Guard, Municipal Council of health, among others. The Intersectoral Commission for Control and Prevention of Traffic Accidents was created in 2004 with the participation of the Executive power, universities, and civil society, among others.

Other sectors along with health participate in this initiative. At municipal level joint actions are carried out with education in the public schools - incorporating driving education plans in schools. The Municipal Guard performs the operation and control of transit. The Secretary of State of Social Defense develops educational campaigns on the use of alcohol. The Traffic Department of Minas Gerais has an information Bank of accidents and examines the risk factors. The military police of Minas Gerais is member of the Commission that manages information and executes monitoring actions along with BHTRANS. WHO/PAHO offers advice to the Ministry of health and the local government. International NGOs offer consulting services and financial support. Relevant unions give political support and help articulate the project.

Although it lacks its own funding, it receives support from the municipal health secretariat and BHTRANS. Each institution involved assigns part of their budgets to this initiative.

While it does not directly seek to reduce inequality, the project included the study and identification of groups especially in conditions of vulnerability, such as youth, motorcyclists and pedestrians, and developed specific actions for them.

It is based on inter sectoral work. This project makes more effective the intersectorality, especially in the production of information on traffic accidents and joint planning of actions to reduce mortality.

It develops public policies that impact on health. As example, as consequence of this project, school curriculums gave changed to incorporate training and awareness of public road use, in order to prevent accidents and promote a culture of peace.

It has scientific based evidence of its results. Quarterly monitoring of factors and risk groups is developed, with internal impact assessments and adaptations of actions and programs accordingly. The Federal University of Minas Gerais and John Hopkins University carried out external evaluations too. Additionally, Mortality Information Systems, Hospitalization on the Single Health System are fed by the BHTRANS databank. Some results: reduction of mortality rate from 2.36 in 2009, to 1.52 in 2011 every 10,000 vehicles; and the number of accidents from 3,076 to 2,852.

Social participation. Active through local councils and municipal forums of health within the technical team that formulates and plans local actions.

The Role of Violence Prevention and Health Promotion Nucleus

and its articulation with the Network of Care for People in situations of Violence (NPVA) - Red Illuminar

The initiative seeks to reduce the incidence of violence in the municipality, especially sexual violence. It is a network, based on permanent trainings for health professionals, National Guard, teachers and educational counsellors in the municipal education system. Seminars on prevention of violence and culture of peace are also developed. Intersectoral actions are undertaken, understanding violence as a public health phenomenon of multiple causes and not only just a judicial and criminal issue. It consequently convokes sectors of health, education, public security, social welfare, along with civil society and universities, in order to work together. This is a comprehensive care for victims, and it also includes support to children, as well as teenagers and men. The main goal is to provide care within the 72 hours of an act of violence working in a network format with professionals is also instrumental to help break the cycle of violence, and to make the victim feel protected permanently. The Red Illuminar was created in 2001 and the NPVA in 2007.

It fulfills the requirements to be considered an example of Health in All Policies because:

It has the highest political commitment of the municipality of Campinas and the State of São Paulo.

It has its own structure. An inter-institutional and inter-sectorial Committee operates in the form of a network, and it holds bi-monthly meetings.

Other sectors along with health participate in this initiative. The municipal secretariats of health, assistance and Social integration, education, public safety, transport, women's Affairs participate. They also support (PUCC and UNICAMP) universities, NGOs and advice of rights of women and girls. Social movements and public safety agencies are also involved.

It has its own funding. The Illuminar network receives initial funding for training and equipment purchases. The NPVA network receives support from the Ministry of Health for equipment, training, educational materials and communication (production of videos, brochures, etc.). This endeavor does not require greater resources, since it is an initiative to better articulate the existing services for the implementation of public policy.

It seeks to reduce inequality. Despite attending the entire population, it gives priority to women and girls in situations of vulnerability and subject to potential gender violence and/or sexual, domestic or psychological abuse.

It is based on inter sectoral work. Caring for physical, mental, social and civilian health of women, men and girls victims of violence and their families within the framework of the network requires cross-sectoral policies, and collective work and support from the federal, State and municipal services.

It develops public policies that impact on health. Changes can be perceived in the paradigm of a multidisciplinary care of violence, moving away from the exclusive realm of police action, and addressing it as a public health problem. The program contributed to the production of information and implementation of public policies to address situations of violence. Networking helped incorporate other services of care and protection of the population served.

It has scientific based evidence of its results. The program includes an internal evaluation that assesses and monitors the work of the networks every two months. External evaluations of Red Illuminar include technical visits to health professionals and areas involved The NPVA was evaluated in 2010-2-11 by the Latina American Center of Violence and Health Studies and the Surveillance Secretariat of the Ministry of Health. The state of Minas Gerais also performs its own assessment of the networks. Since 2005, 5,735 victims were cared for and there is a growing number of police reports of violence. Improvements shown in the time elapsed between an act of violence and the care offered to under 72 hours.

Social participation. Two members of the municipal Council of Health participate in the planning of actions and goals of health surveillance.

In the Radio waves: communication on health through the AMORB/FM Community Radio

This initiative seeks to promote education and awareness on priority health issues, such as mental health issues, within the community through programming in a community radio. Training activities are periodically on issues of interest for the community in general and are offered. Partner institutions (UFRGS, GHC) help promote this endeavor, and provide regular training activities for the actors involved and convoked (professionals/workers, students, residents, etc.).

In the Radio waves: communication on health through the AMORB/FM Community Radio

Although it does not meet all the criteria to be considered as an example of health in all policies, it can be noted that:

It does not have the highest political commitment at local level, although the Municipal Secretariat of Health (SMS) of Porto Alegre supports it, along with the Federal University of Rio Grande do Sul (UFRGS).

Is has its own structure, under the UFRGS. Planning and implementation of the programming is done through a Committee, composed of the school of nursing, AMORB (holding the franchising of the community radio station and I charge of coordinating its relationship with the community), GHC (to which service of community health workers are represented), the Sec. of Health of the municipality of Porto Alegre; The Faculty of dentistry and the Institute of Philosophy and Human Sciences (where some of the students involved come from), and the Faculty of education (participation of postdoctoral fellows CAPES / meeting).

Other sectors along with health participate in this initiative. The Ministry of Health (MS) - through workers and residents of the GHC (Community Health and Psychosocial care center); the Ministry of Culture (MINC) (2009-2011) - through the point of culture and health financing; and the Ministry of Education (MEC) - through teachers and learners of the UFRGS.

Although it does not have its own funding, the MEC, MS and SMS provide support through their budgets.

It seeks to reduce inequality. The radio broadcasts to communities under contexts of social vulnerability, with high levels of violence and social exclusion. The radio project prioritizes work to address issues of mental illnesses - traditionally marginalized in health support systems.

It is based on inter sectoral work. All stakeholders participate in a democratic and active manner, both in the planning and implementation of all actions of the project. The Coordinating Committee analyzes and implements policies related to the project, develops radio programs, selects and supervises workers and students involved in the case, and manages the interaction with the community.

It does not appear to develop public policies that impact on health, according to the information provided

It does not provide scientific based evidence of its results. While not offering scientific information, some achievements are highlighted such as: active participation of the community in general and of students in radio programs; integration of the University (UFRGS), workers (SMS/PMPA and GHC) and community (AMORB); participation of the users of mental health services, which means a major extension of its socio-cultural inclusion.

Social participation. The establishment of the community radio and its programming results from the direct interest of the organized community, in collaboration with the previously mentioned institutions. The design of the project was developed in permanent dialogue with the community and geared towards their needs and demands. The citizenry participation is intensified as the community and users become more actively involved in the planning and implementation of the radio shows.

Costa Rica

Executive Decree regulating Sodas in Schools

Two cases from Costa Rica showcase the traditional strong alliance between health and education, with special focus on nutrition of children. While the CEN-CINAI program focuses on early childhood care and by doing so providing support to working mothers, the National Decree Regulating Sodas in Schools targets children at basic and secondary education levels. CEN-CINAI is a clear case of strong and traditional ***intersectoral cooperation*** between education and health, although the prevalent approach is of assistance, rather than active community participation and empowerment. The National Decree, issued recently, is mainly highlighting an ***exchange of information and cooperation levels of intersectoriality,*** while focusing on regulating food sold in schools.

The Presidency of Costa Rica issued a decree which regulates the sale of certain foods in schools, in order to reduce the incidence of overweight and obesity in children and young people. According to January 2012 statistics, overweight and obesity affects 21.4% of children between 5 and 12 years in Costa Rica, and 20.8% of the population between 13 and 19 years old. The Decree establishes that schools can only sell fresh produce and packaged beverages and foods that meet specific nutritional characteristics (low in calories and saturated fat). The goal is to decrease cardiovascular diseases, diabetes, the loss of calcium and tooth decay. Briefings and communications were prepared for students and teachers. Costa Rica's food industry Chamber, CACIA, immediately questioned the constitutionality of the decree, alleging violation of trade regulations and freedom of consumption. The Court rejected the complaint and the Decree entered into force.

Although the decree does not meet all the criteria to be considered as an example of health in all policies, it can be noted that:

It has the highest political commitment, given that the presidential decree was signed jointly and with the commitment of the Ministers of Education and Health.

Although it does not have its own structure, the Executive Decree implies mandatory compliance by all providers of meals in schools. The ministries of Health and Education were assigned to monitor and follow-up its implementation.

Other sectors along with health participate in this initiative. The health sector acted in coordination with the education sector. In addition, the Advisory Board of the Office of the Dean of Medicine of the University of Costa Rica (which brings together the schools of medicine, nutrition, nursing, and public health), will organize research activities with students at schools, to determine the results and impact of the decree. In addition, the Attorney-General's Office, defended the policy against the claim of the private sector.

It does not have its own budget. The initiative does not require it. The products are purchased by the students in the schools. The school lunches for underprivileged children are financed by the Ministry of Health through the program CEN CINAIs (Education and nutrition centers). It is financed by the budget of each Ministry. No Office or Department was created for this purpose.

It does not seek to reduce inequality, given that the decree applies to all public and private schools, and policy affects the entire population.It is a universal measure affecting all boys and girls.

It is based on inter sectoral work, as the health and education sectors must coordinate their actions.

It develops public policies that impact on health. The decree establishes that only fresh foods and processed food that meets specific nutritional requirements established through the decree can be sold in schools.

Scientific based evidence of its results. While no evaluation mechanisms were developed, the national nutrition surveys will be used to evaluate the effectiveness of the Decree. The Ministry of Health and INCIENCIA (National Institute for research in health sciences) will be responsible of conducting periodical surveys. The Ministry of Health develops these surveys every ten years, while INCIENCIA do them annually. The next survey will show the impact of the measure taken.

Social participation While there is no active social participation in the process, information campaigns in different media were developed to raise awareness concerning the content of the decree and to generate social support for the proposal.

National education centers nutrition program and comprehensive care (CEN-CINAI)

National program that seeks improve the nutrition of mothers and children participating in these centers. It also aims at improving potential in children development to overcome conditions of poverty or social vulnerability. It offers nutrition, care and child protection services, and promotes growth and development until 13 years of age - especially helping working mothers.

National education centers nutrition program and comprehensive care (CEN-CINAI)

It fulfills many of the requirements to be considered an example of Health in All Policies because:

Although it may not have the highest political commitment of the executive branch, various laws were adopted since 1970 to strengthen the institution and its financing, creating in 1977 the Children's Centers of Nutrition and Care (CINAI).

It has its own structure Since 2010, with the adoption of the law No. 8809, the execution of the program is conducted by a National Office for Education and Nutrition, which has regional and local offices.

Other sectors along with health participate in this initiative. The Ministry of Education is in charge of developing the comprehensive integral programs at the Centers. Other collaborating agencies include: the Joint Institute for Social Assistance (IMAS), the National Office for Community Development; Specific Associations that support CEN-CINAI and communal well-being; the National Kindergarten Board, municipal governments; the Social Security Department, the National Institute for Women; the Costa Rican Institute of Sport and Recreation; the National Institute of Learning; the National Institute of alcoholism and drug abuse; and national network of domestic violence.

It has its own budget. The program is financed through the national budget, as part of the resources allocated to health. The Fund for Social Development and Assignments (FODESAF) which reports to the Ministry of Labor and Social Security also supports the initiative.

It seeks to reduce inequality. The program serves pregnant and nursing mothers and children at social risk, in order to enable their social integration and foster the possibility that these children will become healthy citizens and contribute to the well-being of the country.

It is based on inter sectoral work. The focus of work in the centers involves both the sectors of education and health, as well as other agencies involved and which provide. On the other hand, within the framework of the same centers' pedagogy, other initiatives are conducted such as the "Bibliobús" and "Grow with music", in addition to campaigns to raise awareness as "educate without hitting" promoted by other national ministries.

It develops public policies that impact on health and the institutional framework of the sector. After being establishing the Department of Nutrition at the Ministry of Health by Decree in 1955, the Legislative Assembly approved two laws inherent in the program: Law No. 5662 of Social development of family allowances (1974) and law No. 8809 (2010) elevating the program to rank of Office, as the Office for Education and Nutrition Children's Centers for Comprehensive Care, giving it functional autonomy.

It has scientific based evidence of its results. The program is evaluated through internal (Health) and external (Ministry of Labor and the General Comptroller of the Republic), as well as routine internal audits of the CEN-CINAI (in terms of fulfillment of planned activities, and impact on coverage expansion and improvement of health and bio-psycho-social development of children). While the results of these audits are being reviewed, it is important to highlight that by the end of 2011, there were 624 centers serving 125,030 beneficiaries.

Social participation. Communal assemblies are held for the establishment of specific development assocaitions for CEN-CINAI centers and for Communal well-being (ADEC) - who are community representatives involved in the implementation at local level. In some communities, networks of governmental institutions have been set up to join efforts in addressing their constituents needs.

Health promotion, a strategy for health programs – Single Health System

The Cuban Single Health System was established in 1960 as an essential component of the transformation process undergone by the revolutionary period - in the context of a rights perspective which is permanently being updated in response to new challenges emerging. Its intended is to increase the efficiency and quality in services, ensure sustainability of the system, and continue studying and working to eliminate persisting small inequalities in health status and use of the services. Its governing principles are: universal, free, accessible, equitable and participatory.

The Cuban example presents the mainstreaming of health promotion since the time of the Revolution, and its adaptation to the social determinants of health perspective throughout time. It is a case of ***intersectoral work that has been institutionalized*** and reflected in the Constitution, where all relevant stakeholders are involved in the design, implementation and assessment of policies and programs, including members representing the communities. It is also interesting to note that the National Assembly has an important role in issuing recommendations, monitoring the implementation and receiving progress reports.

It fulfills the requirements to be considered an example of Health in All Policies because:

It has the highest political commitment, with the national coordination by the Ministry of Public Health and within the framework of the constitutional reform and the revolution produced.

It has its own structure. With the triumph of the insurrection in 1959, political, economic and social transformations were initiated to improve the conditions of life, especially in health and education. The National Assembly of the Popular power (Parliament), through its Health Commission promotes public policies, guidelines and regulations for the fulfillment of its objectives. For its implementation, health councils at national, provincial, municipal and local level were set up with representation from all the agencies of the central administration of the State, non-governmental organizations, religious institutions and others.

Other sectors along with health participate in this initiative. Ministry of Education: teacher training in the field of health to incorporate healthy lifestyles. Cuban Institute of Radio and Television (ICRT): social communication in health issues. Institute of sports, physical and recreation (INDER): physical activity and recreation as a means of protection of the health and quality of life. Ministry of transport and the National Office of Traffic Control: accident prevention. Ministry of agriculture: prioritize food production for a better food culture. Civil Defense: addresses emergency disaster situations.

It has its own budget ensured within the budget allocated for each participating agency. Local actions carried out on a voluntary basis with the active participation of the community.

It seeks to reduce inequality. It is accessible to the entire Cuban population with special emphasis on vulnerable groups and disadvantaged communities.

It is based on inter sectoral work of the agencies mentioned above

It develops public policies that impact on health. Policies periodically reviewed and reaffirmed or modified according to social determinants of health they affect. For example, in internal trade: regulations for the sale of cigarettes and alcohol to minors. Education: Smoking ban to all staff on school premises, establishment of circles of interest (conversations on sexual and reproductive health, first aid and prevention of addictions and violence, hygienic handling of food, etc). Along with trade unions, actions are taken for health protection and hygiene of workers. Agriculture: prioritization of crops. Culture: ban on smoking in rooms of theatre, cinemas, art galleries and other venues.

It has scientific based evidence of its results. Assemblies for accountability before the population were established to evaluate the actions of health. The Ministry of Public Health has established control mechanisms, internal and external audits and mechanisms to address complaints or recommendations of the population. There are also systematic analyses of the health situation and strategies and action plans are established accordingly. Studies on behaviors of the population in response to prevention and control in health are carried out; Analysis of the main indicators of health and mortality and morbidity are taken into account; as well as national surveys of risk factors.

Social participation. Involved through coordination with social groups, such as the Federation of Cuban women (FMC) and the Committee for the Defense of the Revolution (CDR), the National Association of small farmers (ANAP).

**Boca de Mao,
Dominican Republic**

Implementation of the initiative of FVP using SAN strategy within the framework of the concept of human security: sustainable human development of Boca de Mao

The Dominican experience in Boca de Mao is a local example that shows how a Health in All Policies approach can be present at a smaller scale. Like many of this local experiences, the intersectoral work can reach a ***coordination level***, and enhance the participatory component of the HiAP framework. This experience, which faces the challenge of achieving sustainability and commitment at higher levels of governments, can nonetheless be very effective in changing people´s behavior and empowering communities to become active agents in improving their health.

Boca de Mao region participated in the Inter-American Faces, Voices and Places (FVP) initiative promoted by the Pan-American Health Organization. This initiative supports average-income countries to close the inequality gaps in their poorer localities. It also seeks to strengthen the construction of citizenship with a rights based and shared responsibilities approach. It promotes inter-sectoral and interagency action, contributing to fulfill the MDGs. Along with the implementation of community activities; it also develops a training plan on health, environment, food security, and health and nutrition surveillance. This initiative was developed based on the needs expressed by the community, in terms of sanitation, hygiene and living conditions and food production mainly.

It fulfills many of the requirements to be considered an example of Health in All Policies because:

Although it does not have the highest political commitment at local level, the community was strongly involved and there was a very active participation and coordination of the program by the Local Council for Sustainable Human Development (LCSHD).

Even though it doesn't have its own structure, the process is driven by the LCSHD. The Ministry of Health has set up a Community Health Committee, which - through its members – participates in the LCSHD and carries out health promotion and disease prevention actions.

Other sectors along with health participate in this initiative. In addition to the health sector, the Council has members of the community, municipal authorities, and representatives of PAHO, the Institute of nutrition of Central America and Panama, and neighborhood representatives. The sectors of agriculture and education also participate in this initiative.

It has its own budget. The interventions are financed by the institutions participating in the Local Council. Funds from the City Council are also allocated in this initiative. The Local Council also raises its own resources.

It seeks to reduce inequality. The program serves a rural population of agricultural workers, with high population of Haitian immigrants. The region is considered as an endemic area of dengue and malaria. The gradient in health was addressed by offering free medicine, setting up community laboratories for water testing, delivery of home-made filters for water, nutritional monitoring, following up people with HIV, providing equipment for chlorine production, and executing the program of zero garbage, among other things.

It is based on inter sectoral work. Three ministries (agriculture, health and education) join forces in a comprehensive response to the needs of this populating living in the border area. Specific needs were requested grassroots organizations that represent them, which strengthen the local work. The intersectorality occurs through the participation of the Council in all social and political spaces in the Valverde province, taking advantage of the opportunity to express the needs of the population and the convergence of the State and non-governmental institutions in addressing those needs.

It develops public policies that impact on health. The celebration of the Well-Being Week promoted by the Council, as part of this initiative, is now part of the annual budget of the City. A day is dedicated to cleaning the area in order to sensitize the population on the importance of environmental hygiene. The municipality placed collectors plastic cans of garbage in every area of the district.

It has scientific based evidence of its results. The evaluation process is scheduled for 2013. However, immediate results show that cholera has been contained, maternal death has been eliminated deaths from dengue have been reduced. Improvement was seen in the quality of life for people living with HIV. The community garden was planned, organized and implemented in partnership with the Ministry of Agriculture, the Local Council and PAHO. INCAP has contributed to the confidence and credibility of the community that teamwork can protect them against any adversity, in case of potential hunger threats due to increased food prices.

Social participation. The LCSHD has members from local and grassroots organizations, such as the neighborhood Council. Public participation is exercise through open Council meetings, advocacy, health fairs, the Well-being Week, the food fairs. Two information systems are being developed for water quality monitoring and surveillance of nutritional trends in vulnerable groups.

Nation Plan for Good Living (NPGL)

Plan Nacional para el Buen Vivir

The NPGL is a program that develops public policies that impact health and other social issues as an example of HiAP in a constitutional level with a commitment at the presidential level. The National Development Plan of 2007-2010 for Ecuador aims to reduce inequality gaps and address basic needs of people. It uses a rights based, social justice and equity lens to promote equality, cohesion and social and territorial integration, improve citizenry capacities and potential and build a democratic state for good living. It works at the central, regional and local level. Other sectors, including health, participate in the initiative through the development-coordinating ministry, which supervises several other ministries. Monitoring and evaluation results show that between 2006 and 2011 (when the National Development Program was implemented, upon which this Good Living Plan was implemented), the relationship between urban rich and poor populations fell 10 points. At the same time, public investment was doubled, social investment grew 2.5 times; credits for agricultures was doubled; the proportion of urban homes with w/c and sewage systems grew from 71% to 78%; rural homes with access to collection of waste increased from 22% to 37%; investment in justice grew fifteen times; and health appointments in the public service area increased to 2.6 per 100 inhabitants.

The National Plan for Good Living of Ecuador is an excellent example of ***intersectoriality at the integration level*** and responds to all Health in All Policies criteria. It is a case of the whole-of-government approach, where health is one of many areas tackled by the policy. Public institutions are re-designed to reflect this vision, where, for example, coordinating ministries are created. This plan redefines the role of the state in social policy as a whole, and establishes equity and re-distribution goals from a rights-based perspective. In this case, not only the highest political will of the executive power is evident, but also the commitment from the legislative branch, which among other things, worked towards the adoption of a new Constitution for the country that set the grounds for this Plan. Active civil society is promoted at all levels, and the Plan provides spaces for dialogue that ensures adaptation to local needs and enables ownership from their stakeholders.

Nation Plan for Good Living (NPGL)
Plan Nacional para el Buen Vivir

NPGL fulfills the requirements to be considered an example of Health in All Policies, because:

It has the highest political commitment a presidential level. It results from a constitutional reform that designs governmental action in an integral and comprehensive manner. It is coordinated by the National Secretariat for Planning and Development (SNPD).

It has its own structure. The National Planning Council (collegial and intersectoral body) functions as technical secretariat. The NPGL is present in all the central, regional and local State Structure.

Other sectors along with health participate in the initiative. All sectors and levels of governments are part of it. Health goals are realized through the Development Coordinating Ministry, which supervises the ministries of health, labor, education, inclusion, migration and housing.

It has its own Budget. National budget allocated to each institution involved, as the Program is a strategic vision for implementing al public policy and it guides all governmental action.

It seeks to reduce inequality. The Program focuses on reducing inequality gaps through promoting redistribution of benefits of development, and acknowledging the multicultural composition of the country –manifested in the regional development plans which are adapted to local realities.

It is based on inter-sectoral work. Lead by the SNPD, in collaboration with the other coordinating ministries, the Program supervises work plans from sectoral ministries under their responsibility. Additionally, regional authorities develop their provincial development plans. The inter-sectoral work is inherent to all the design and implementation processes, at all governmental levels.

It develops public policies that impact on health. The approach of the Program is translated into sectoral specific work plans, health being one of them. The goals in this sector have to be consistent with the national strategy – which has as guiding principal the social determinants of health approach, where the concept of Good Living has a broad definition of health, and which has to be addressed from different sectors.

It has scientific based evidence of its results. Even though no formal evaluation documents are presented, and given its recent implementation, the Program developed a baseline for monitoring. Additionally, between 2006 and 2011 (when the National Development Program was implemented, upon which this Good Living Plan was implemented), the relationship between urban rich and poor populations fell 10 points. At the same time, public investment was doubled, social investment grew 2.5 times; credits for agriculture was doubled; the proportion of urban homes with w/c and sewage systems grew from 71% to 78%; rural homes with access to collection of waste increased from 22% to 37%; investment in justice grew fifteen times; and health appointments in the public service area increased to 2.6 per 100 inhabitants.

Social participation. All the development, construction, design, implementation and evaluation of the Program includes active social participation. The central and local processes have citizenry accountability processes, including focal groups and consultations and consensus building activities. Local development plans are designed including inputs from the community through formal and informal representatives.

El Salvador

Intersectoral Health Commission (CISALUD)

The Intersectoral Health Commission of El Salvador is another strong example ***of intersectoral work at the coordination level***. The Commission convoked different sectors in order to issue recommendations that are later implemented in each sectoral institution. This is a case were a new structure is clearly developed to address challenges of social determinants of health understanding that the health sector cannot affect them in isolation.

CISALUD was established within the framework of a health reform process, in order to develop an inter-sectoral space that could address social determinants that create inequities in health among specific population groups. These inequities are present due to the inequitable distribution of health problems, the exclusion from access to public services of health, the impact on the family economy of the high private expenditures on health, lack of information of inequities in health among different population groups, lack of identification of health issues that go beyond health services and that may require interventions from other sectors.

Intersectoral Health Commission (CISALUD)

It fulfills the requirements to be considered an example of Health in All Policies because:

It has the highest political commitment from the president. Created by presidential decree, it is coordinated by the Ministry of Health through the Vice-Ministry of health policy.

It has its own structure. CISALUD has a policy Committee and a technical Committee. The first is chaired by the Ministry of Health, and including heads of ministries and other governmental agencies as well as NGOs leaders (more than 35 government agencies and civil society). It meets once a month and make decisions on how to address social determinants and take actions on challenges identified. The Technical Committee is composed of technical representatives of governmental institutions and cooperation agencies. They hold monthly meetings and it is chaired by the Vice-Minister of health policies. Its job is to analyze the problems identified by the political authorities and make recommendations and proposals that policymakers that meet at this Commission can take on.

Other sectors along with health participate in this initiative in the intersectoral dialogue headed by the Commission participate in the diagnoses and actions to be recommended for implementation (education, defense, foreign affairs, public security, finance, work, agriculture, public works, environment, tourism, FOSALUD, ISRI, COSAM, PNC, COMURES, COAMSS, ISSS, transport, DGCP, Institute of legal medicine; Legislative Assembly; ECA; CEL; ANDA; OIRSA; The Consumer Ombudsman; Civil protection, CENSALUD).

Although it does not have its own budget for the Commissions to meet, the actions that are executed as part of the agreements reached at the session are financed with the budgets of each of the institutions that comprise it, in accordance with its financial possibilities.

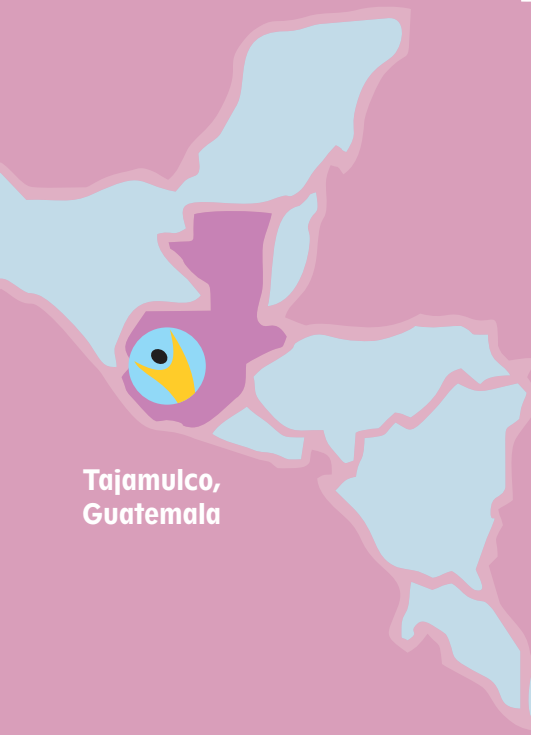
It seeks to reduce inequality. Proposed actions apply for the entire population of the country; but provide greater emphasis on the population in extreme poverty or population groups that have traditionally been excluded from decisions affecting their health: women, teenagers, groups with non-traditional sexual orientation, indigenous peoples, rural communities, etc. and that is why they are in higher level of vulnerability and risk.

It is based on inter sectoral work. At the central level, workshops were held to prioritize problems and define a strategic vision, defining technical and political actions in cross-cutting plans through commissions. The implementation of this plan is then done in a sectoral approach, and according to the possibilities of each agency.

It develops public policies that impact on health. This initiative responds to a more comprehensive understanding of health challenges. For example, the Integral Plan to Fight Dengue developed as result of the work of CISALUD, had 5 strategic lines launched in 2010: implementation of the management system of the municipal, departmental, regional and national plans; social community and institutional communication actions; implementation of environmental control actions; strengthen of the the clinical management of dengue; and strengthening epidemiological surveillance. Additionally, the national health policy "Building hope" contemplates the reorientation of all national health system towards primary health care that is based on an intersectoral work.

Even when there is no evidence of its results, each Member of the Commission is accountable to the institution which it represents and to CISALUD in terms of the activities implemented in response to the results of this inter-institutional body.

Social participation. Public consultations are developed in the framework of this initiative, with the support of the National Forum of Health - consisting of community leaders and non-governmental organizations-; as well as with the public University and other academic centers.



Tajamulco, Guatemala

The zero hunger Pact and its implementation in Tajumulco

- under the framework of the strategy for healthy municipalities

Guatemala´s Hunger Cero Program and its implementation in the municipality of Tajumulco is a good example of how a national policy can be implemented and executed at local level. The case represents another example of ***intersectoral cooperation*** among sectors, that come together to address a specific goal. Guatemala´s initiative is centered in improving food and nutrition for all children, especially focusing on the municipalities with the highest levels of malnutrition and living in vulnerable conditions.

The Zero Hunger Pact is established in 2012 by presidential decree in order to reduce the rate of malnutrition by 10% in four years. Families in poverty and extreme poverty are the focus of this initiative. The program health care and education components, understanding them as assets that can break the circle of poverty and improve opportunities for families served. The municipal government of Tajumulco has formally agreed to join the healthy municipalities' strategy, and established and implemented a local health plan that is based on the development of the determinants of health in the light of the national hunger pact.

The zero hunger Pact and its implementation in Tajumulco

The Pact fulfills the requirements to be considered an example of Health in All Policies because:

It has the highest political commitment from the president, who issued a decree on the matter.

It has its own structure. The national system for food and nutritional security (SINASAN) was established. It is comprised by CONASAN (National Food and Nutritional Security Council, led by the Vice-Presidency which has inter-ministerial representation as well as members of NGOs and private sector), SESÁN (Secretary for Food and Nutrition Security), INCOPAS (spaces for social consultation and participation) and GIA (Group of supporting institutions).

At National level it will also be supervised by the Accompanying Inter-institutional Technical Council, composed by experts from various ministries (environment, health, education, agriculture), cooperating national e International agencies (PAHO/who, GIZ, UNDP, AID) and key associations (National Association of municipalities).

At the local level in Tajumulco, municipal commissions on health, food security and nutrition (COMUSSAN) coordinate the implementation of the initiative. The City Council, represented by the Health Chancellor leads the Commission and provides the legal/official support.

Other sectors along with health participate in this initiative. In addition to other sectors involved in the inter-agency technical Council, the Pact is linked to other programs such as bond insurance, secure bag, window of the thousand days and the triangle of dignity for the delivery of benefits to families.

It has its own budget. Each member institution of the CONASAN has identified budgetary programs which include actions in food safety. By presidential decree, the Ministry of Finance must include in the general budget allocation at least half a percentage point (0.5%) for food security and nutrition programs and projects. The municipality through the municipal Plan of Health has also allocated funds for this matter.

It seeks to reduce inequality. In its initial stage, Zero Hunger prioritizes municipalities most affected by chronic and acute malnutrition. The development of municipal plans contextualizes actions necessary in each region. These municipalities have high indices of extreme poverty and an elevated number of children with chronic malnutrition, a problem that at national level affects 49% of children under five years of age.

It is based on inter sectoral work. The intersectoral action takes place through COMUSSAN at the municipal level. The SESAN provides operating mechanisms of the plan of action at national level, with the participation of different institutions, national and international cooperation agencies, private sector and civil society. The intersectoral plan's aim is to ensure that the population enjoys living conditions necessary to access health, especially with regards to food.

It develops public policies that impact on health. The health sector articulates efforts from the municipality and SESAN to strengthen COMUSSAN and the drafting of a municipal health plan based on the development of the determinants of health. In addition, the COMUSSAN has identified policies and regulations that need to be processed or updated (management of solid waste, trails, regulation of construction) and has included in its plan the preparation of proposals for action to be taken by municipal authorities.

Even though it has not produced scientific based evidence of its results yet, given its short life, the program identified preliminary successes demonstrated through the fast municipal institutionalization within the framework of healthy municipalities to implement Zero Hunger. The capacities of the actors and sectors represented in the Commission have been strengthened by implementing activities to improve the determinants of health of the municipality. At the central level, the 2012-2015 planning includes a results-based management plan for evaluation and monitoring of the strategy. Additionally, the National Institute of statistics led a national survey on the impact of the Pact in late 2012 to measure its efficiency and provide a basis for determining coverage in 166 of the 334 municipalities that were consider as priority.

Social participation. Community participation is one of the cross-cutting axis of the strategy at the central level. In the local level, public participation is essential to identify needs and facilitate the implementation of actions in the communities. Health, food and nutrition security plan was performed collaboratively with representatives of communities (private and civil).

Haití

Promotional strategy on health and quality of life in the fight against cholera in the Republic of Haiti

Although the Promotional strategy on health and quality of life in the fight against cholera in the Republic of Haiti was led by the Minister of Health with the support of international organizations, this case was presented by an international non-governmental organization. It is important to highlight how this program is implemented as consequence of the devastation and health challenges that arose after the earthquake that hit the island. This case represents ***information and cooperation*** levels of intersectoral work, with the goal of developing community awareness to control de epidemic through community participation and empowerment. The focus is placed in training and education the population in order to avoid the spread of cholera.

Initiative promoted by UNASUR and in partnership with the NGO Doctors of the World, developed in order to educate the public on the prevention of cholera and respond to situations of emergency generated after the earthquake of 2012. The strategy also included training of 450 people of community networks and rural grassroots organizations through courses for health with a focus on health promotion, social determinants and public surveillance. Workshops were held to train local authorities and local networks, agrarian workers, and women. It sought to raise public awareness through outreach written materials and other media.

It fulfills many of the requirements to be considered an example of Health in All Policies because:

It does not have the highest political commitment. Doctors of the World is the leading agency, with the support of PAHO and Unasur, and in coordination with the Office of the Water and Sanitation Management (DINEPA) of the Ministry of Public Health and Population (MSPP) of Haiti.

It has its own structure. The Local Forum of Collective Health and Quality of Life was established, as a participatory assembly at local level where all actors have institutional representation and decisions are taken by consensus.

Other sectors along with health participate in this initiative. Sectoral authorities, NGOs and community networks, as well as local organizations were convened. Municipal districts also participated, as local promoters together with grassroots organizations in the convening the communal assemblies, drafting preventive and promotional radio messages were developed, and others actions. DINEPA delivered materials and was also present in all the actions of this strategy.

It has its own budget, only in the framework of the international cooperation of Unasur, which provided the resources.

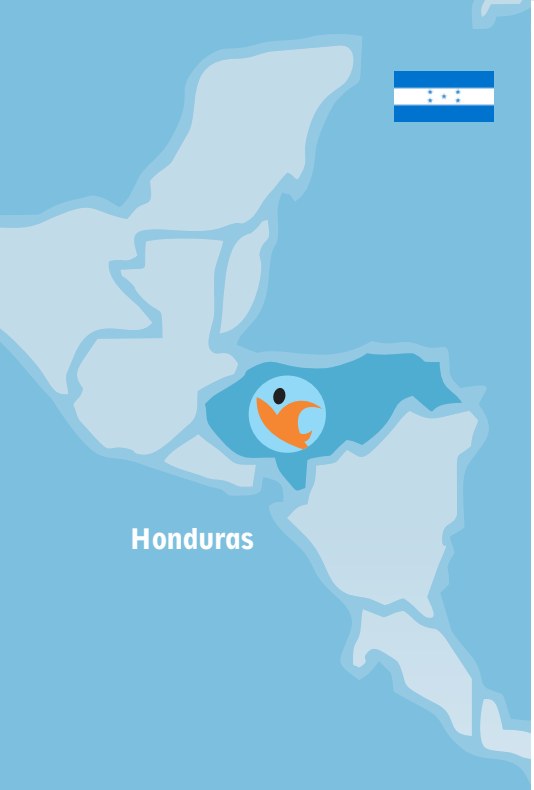
It seeks to reduce inequality. The emergence of cholera has higher prevalence in the areas of informal settlements established with the people displaced after the earthquake of 2012, so the program served populations under conditions of poverty and vulnerability.

It is based on inter sectoral work. Even though it is an intervention in the health sector, the NGO lead cross-sectoral forums of health and quality of life with all the social actors present in the territories (international and grassroots organizations, NGOs, churches, communal State, MSPP).

It develops public policies that impact on health. The NGO developed integrated actions of monitoring of the collective health and sanitation in a house by house visit, with 4 specific moments: 1 - bond with the family and presentation of the experience, 2 - community epidemiological survey and identification of social determinants, 3 - promotion of rights and identifying determinants of cholera and water and sanitation problems, 4 - prevention protection and care with delivery of cholera prevention kits built by the own community networks.

Even when it does not provide scientific based evidence of its results, it has been reported that an evaluation process is present throughout the implementation of the strategy which includes: internal evaluation with direct participation of local stakeholders; a critical analysis matrix of processes monitoring-tracking opportunities, progress, setbacks, threats and problems; and reporting is presented in different instances.

Social participation was crucial to the implementation. Community networks of rural grassroots organizations and peasant women have mobilized and carried out community government assemblies every 50 homes to define the problem through needs assessments processes, as well as prioritize actions to report back to the municipal commune and the MSPP at a central level.



Special Tobacco Control Law

In 2011, the law was adopted in order to regulate the production, distribution, marketing, importation, consumption, advertising, promotion and sponsorship of tobacco products, with the goal of reducing and gradually eradicating tobacco use. A committee was set up to draft the law and work towards its adoption in the political bodies, as well as to socialize it with the citizenry.

Honduras presented as their Health in All Policies example the negotiation process and content of the Special Tobacco Control Law. This law regulates various aspects of tobacco, including its production, distribution, marketing, importation, consumption, and advertising. Although the negotiation process included an inter-institutional structure for the design of the law, and represented a case of ***intersectoral cooperation,*** it will be important to monitor its implementation and how it sustains its intersectoral nature throughout the process. Not less important is the fact that this law, as in many other countries, was propelled by international regulations and norms on the matter, headed by the WHO.

It fulfills the requirements to be considered an example of Health in All Policies because:

It has the highest political commitment from the legislative body, and a strong presidential mandate, where the execution is carried out by the Honduran Institute for the Prevention of Alcoholism, Drug addiction and Drug dependence (IHADFA).

It has its own structure, as an inter-agency committee (CONAPROCTA) was established to draft the law. The Committee was coordinated by IHADFA, and composed of: the Honduran anti-smoking Alliance, the National Alliance against drugs (ANCOD), action for the promotion of environments free of tobacco (APALTA), Centre for Informatics and legislative studies of the national Congress (CIEL/CN), Secretaries of State of: Labor and Social Security (STSS), finance (SEFIN), Industry and trade (SEIC); National Children Boar (PANI), Association of Honduras on the fight Against Cancer, National Commission for the Control of tobacco (CONACTA). They worked on a strategy to achieve the adoption of the law, based on two missions: law and policy, and socialization.

Other sectors along with health participate in this initiative. In addition to the health sector and the National Congress, other areas participated in the implementation: the Secretariat of natural resources and environment (CERNA), Secretary of industry and Commerce (SIC), Ministry of agriculture and livestock (SAC), a Special Prosecutor's Office for the environment, National Institute for women (INAM), national women's Institute, National Institute for Heart and Lung Disease, the Autonomous National University of Honduras, Honduras Medical School, Natural Resources offices.

Although the law does not have its own budget, each agency involved allocates resources for its implementation.

It seeks to reduce inequality. The law aims to reduce the social gradient between all social groups, and impact communities with high levels of tobacco products use.

It is based on inter sectoral work. The law seeks to simultaneously regulate marketing, advertising, traffic possession and use of tobacco. All institutions involved collaborated in the drafting of the law by submitting scientific evidence, engaging in political advocacy, designing and providing follow-up to policies aimed at protecting the environment, and promoting the anti-tobacco law. It Is implemented through a legal mandate, and the development of an inter-agency plan as well as a plan of each institution involved in order to socialize the law.

It develops public policies that impact on health. Actions in all sectors by means of their implementation plans have an impact on the reduction and control of tobacco use and promote a healthier life style.

Collection of scientific evidence of its results is included in the plan. The process of evaluation is currently being designed. Additionally, the IHADFA gather date permanently through focus groups.

Social participation. Even though no information is provided on the role of civil society for the drafting, negotiation and adoption of the law, its role will be crucial for its effective implementation and compliance.

Social violence and crime prevention with citizen participation

The Government of Chihuahua issued the General Law for the Social prevention of violence and crime in the framework of the National System of Public Security. This system seeks to establish the bases for coordination between the federal government, the states, the capital city and municipalities in social prevention of violence and crime. This concept is understood as a set of public policies, programs and actions aimed at reducing risk factors that promote violence and crime, as well as to combat the different causes and factors that generate it. To this end, the government of Chihuahua worked directly with communities and the sectors of education, media, business, the police and civil society organizations through participatory processes for the drafting of its plan of action.

Two cases were presented by Mexico, one of them national and the other sub-national. The first one, the National Agreement for Healthy Food targets the issue of obesity from various sectors, with the goal of regulating food products, changing personal behaviors and promoting healthier lifestyles. This is a case of ***intersectoral cooperation,*** where all sectors have to carry out a specific agenda to address this issue. The Social Violence and Crime Prevention Law issued in the state of Chihuahua is also a case of ***intersectoral cooperation,*** although it is implemented at regional level. The most important aspect of this last case is that the state's General Attorney's Office takes the lead and tackles crime from a public health perspective, moving beyond the exclusively criminal aspect of the issue.

The Law and its action plan fulfill the requirements to be considered an example of Health in All Policies because:

It has the highest political commitment of the State of Chihuahua, through the promotion and design of the initiative by the executive authorities - and with support from national mandate-; and the adoption in 2012 of the law No. 2012.04.18/No. 31.

It has its own structure Operated by the recently created the General State Prosecutor's Office, this initiative is established within State Council of public security, which is comprised by all levels of government, representatives of the legislative branch and sectors of civil society: local universities, parents associations and entrepreneurs.

Other sectors along with health participate in this initiative, such as various municipal and state institutions (regional councils, DIF, addiction Centres, Institute of women, urban development and ecology, Social development, public safety, education and culture, urban services, care citizen); as well as civil associations, neighborhood committees, religious organizations, businessmen and citizens in general.

It has its own budget. The program is financed with federal resources earmarked for security policy, it has its own resources from the state and the municipalities, as well as support of civil society organizations.

It seeks to reduce inequality. It focuses primarily on youth, and also targets elder people and children in urban areas, where increased violence is consequence of social and territorial inequalities arising from process of urbanization, the inadequacy of public policies in the field of social integration, as well as the perception of increasingly organized crime.

It is based on inter sectoral work – The Plan and program of social prevention of violence and crime, to be designed by the State Center for Violence and Crime with citizen participation (in process of creation), will be monitoring and ensuring that transversal actions on citizenry security is present in all programs defined by the 2010-2016 State Plan. This Plan includes sectoral axis that will have to reflect these actions on their annual operating programs and budgets. The establishment of a cross-sectoral body is a pending task, although visits to raise awareness to different State secretariats have already been made (economy, urban development and ecology, Social development, SEDESOL), and municipal (public safety, care citizen). The Council has the attribution of defining strategies for inter-agency collaboration to facilitate cooperation, agreements and exchange of information and experiences; as well as establishing guidelines to collect, analyze, assess and share information.

It develops public policies that impact on health. Although the health sector has been absent in participatory diagnosis stage, there are guidelines focused on reproductive health and women, within the State Development Plan. Additionally, the State Development Plan states conditions for opportunities and strengths of the health sector, and lays down eleven strategic fundamental objectives related health, to be carried out by the Ministry of health.

Given its recent adoption, there is no scientific evidence of its results yet. Social participation. Diagnoses on social and economic context of violence in participating municipalities were carried out in a participatory manner in order to collectively develop municipal plans of prevention and/or intervention. There are also formal spaces for participation (in State Councils, regional councils, committees, organizations of civil society, formation of groups guide in colonies, formation of cross-sectoral tables, etc).; well as Informal one (forums, thematic tables, work with community leaders, direct work with target populations objective).

National Agreement for Healthy Food.

Strategy to combat overweight and obesity

This agreement seeks to address the scourge in obesity through comprehensive and concerted actions, convoking multiple sectors in order to modify family diets, eating habits and physical activity. The plan is to address this problem of public health through actions targeting children, as well as improving supply and access to healthy food and beverages, and promote constant physical activity. The strategy has a comprehensive approach to fight overweight and obesity, issuing actions and regulation on production, marketing, advertising and education for a healthy selection food and lifestyle. It also has strong awareness and training components for teachers, health care providers as well as for community members in general.

National Agreement for Healthy Food. Strategy to combat overweight and obesity

This program fulfills the requirements to be considered an example of Health in All Policies because:

It has the highest political commitment of the federal Government, which appoints the Secretary of Health to implement this initiative.

It has its own structure. A National Council for the prevention and Control of chronic non-communicable diseases (CONACRO) coordinates the government action. It is formed by: a President (Health Secretary), Vice-Chairman (Undersecretary of prevention and health promotion, Sec of Health); a Coordinator (designated by the Sec of Health); and vocals (heads of 15 federal governments agencies).

Other sectors along with health participate in this initiative. Participating agencies: Treasury; Social Development; Economy; Agriculture; Livestock; Rural Development, fishing and food; Education; Labour and Social Welfare; Social Security; Workers Safety and Social Services; Innovation and quality of the Secretary of Health; Administration and Finance of the Secretary of health; Coordinating Commission of national institutes of health and hospitals of the Secretary of health; Federal Commission for protection against health risks; National Commission on Social protection in health, and National Council of health of the Ministry of health).

Although it does not have its own budget, it is supported by the budgets from all agencies involved.

It seeks to reduce inequality. The program predominantly addresses the prevalence of overweight and obesity in children. It also tends to be focused in low-income populations – where the prevalence is higher. Additionally, is also serves groups such as indigenous communities, nursing mothers, etc.

It is based on inter sectoral work. Each of the governmental agencies departments have specific actions within their sphere of responsibilities in the national agreement, in order to address 10 priority 0bjetives: 1. physical activity, 2. drinking clean water, 3. Control in consumption of sugar and fat in beverages, 4. consumption of fruits and vegetables, legumes, whole grains and fiber cereals, 5. useful labelling and nutritional literacy, 6. Breastfeeding, 7. Reduction in use of sugars and sweeteners in foods, 8. Decrease in consumption of saturated fats and trans, 9. Decreasing size of servings, 10.salt control.

It develops public policies that impact on health. The Secretary of Labor has promoted a law to promote healthy food for workers. The Secretary of Education developed an action plan for schools at the national level that promotes physical activity, proper food and nutritional literacy. General guidelines for sale or distribution of food and beverages in schools were issued. The Secretary of Health issued a decree to establish guidelines in order to strengthen public policy in breastfeeding.

It has scientific based evidence of its results. It was noted that 41% of the messages developed by 80% of companies that advertise in the media contribute to the promotion of healthy life styles. General guidelines for the sale or distribution of food and beverages in schools were issued. 98% of schools have regular physical activity in their plans. 78% of basic education schools provide safe drinking water. The website developed to register recommended products due to their nutritional values has more than 2850 products that meet nutritional criteria. Educational support materials were produced and delivered. Committees in schools were set up with active social participation to promote and monitor actions aimed at ensuring availability of healthy food in schools.

Social participation. Public consultations, formal alliances, and workshops were developed. Although social participation is not the main focus of action, there is a strong component of education and awareness.

National Plan for Food and Nutritional Sovereignty and Security (PLANAL)

Paraguay launches in 2007 the PLANAL to respond to the challenges of food insecurity, commitment taken at the World Food Summit of Rome 1996, and reaffirmed the Millennium Declaration, among others. The Plan includes: (1) the development of products and use of markets for environmental services, ecotourism, art and crafts, forestry, organic products, and ethno-Pharmacology; (2) the promotion of chains of production and trade of agro-products, including technology and storage systems; processing, preparation of food; market development, production management and integral trade; (3) productive and commercial partnerships; (4) establishment of a fund for subsidies, applicable to the financing of expenses and investments for the production of food and small industrial infrastructures, as well as for financing and improving access to basic services; (5) promotion of professionalization of labor, integral training of youth and employment promotion, in partnership with the private sector. The General Plan and the intervention programs of PLANAL were implemented with a systemic, comprehensive, territorial, participatory and intercultural strategy; actively convoking local, departmental and national levels of government.

Paraguay presented a case of ***intersectoral coordination,*** and an example of all of government action - that responds to specific needs of the population in conditions of extreme poverty. It promotes and develops policy and actions in an integrated approach to respond in a holistic way to the causes of food insecurity (beyond the traditional perspective of increasing agricultural production) It is based in a global governance strategy to improve the efficiency of state action, as a vision to overcoming the existing fragmented efforts that exist on the matter. It finally also seeks to provide actions to revert the unequal distribution of resources that are part of the cause of this challenge.

PLANAL fulfills many of the criteria to be considered a case of Health in All Policies, as:

It has the highest political commitment at the national level. The Presidency of the Republic through his Social Cabinet, supports and oversees this initiative. The departmental governments and locals authorities also actively participated in the process.

While if does not have its own structure, the Social Cabinet (members of the national Parliament, ministries, Secretaries of State and Academy) was strengthened, with the appointment of a Executive Secretary (SE) and a highly trained technical Office, to oversee the initiative at central level. Additionally two instances of participation and consultation were established, inside the Cabinet: the Interinstitutional Committee (IC) and the public hearing office (AP).

It involves other sectors along with health. This Plan includes a vision that demands the participation of all the Government, at the central, departmental and local level. The Plan includes the active participation of more than 30 Agencies of Government, non-governmental and international institutions, including: the Technical Planning Secretariat, the Ministries of Agriculture and Gain, Justice and Labour, Public Health and Social Welfare, Education and Culture, Finance; Secretary of Social Action, the General direction of statistics, surveys and censuses; PAHO; UNICEF; UNDP, AECID; etc. Additionally, it includes spaces to receive inputs from representatives of cooperatives, guilds and enterprises; of indigenous and agrarian people's organizations, NGOs; and others, through social participation channels.

While it doesn´t have its own budget, it receives the supports of funds from the ministries involved. PLANAL managed to rationalize the use of those resources, organizing and coordinating various projects and programs that are being carried out by different sectors, so that they impact on families effectively.

It seeks to reduce inequity, as the incidence of this challenge is greater in homes in conditions of poverty and vulnerability. The Plan identifies indigenous peoples and rural and urban vulnerable populations as priority groups.

Is based on inter-sectoral work. To meet their stated goals, it requires coordination among various sectors of Government, as well as with the private sector and other actors of civil society. The coordinated effort enabled the elimination of dispersion of institutional efforts for the promotion of development and the establishment of the basis for a State policy to be developed. They rationalized public expenditure through budgets approved for programs on a results based approach. Public-private articulation was also improved.

It develops public policy that impact on health. There have been adjustments in the regulations of the institutions involved and new programs were created to respond to the needs of the PLANAL. The effectiveness and efficiency of social and nutrition programs was also improved.

There is scientific evidence of their results, since the Plan has an Information and Observatory System to increase the efficiency in its management by facilitating access to information that can be used to improve the control of management processes, as well as the evaluation and decision-making in the field of food and nutrition policies. In addition, the technical planning secretariat has a platform to develop and consolidate a national system of monitoring and evaluation of territorial interventions articulated in the framework of the PLANAL. Regarding the accomplishments, some highlights are: increased comprehensive health coverage, increased demand for financing for community social investment, especially geared at improving the sovereignty and food security and nutrition of population groups in extreme poverty in 66 of the poorest districts of the country; increased supply to indigenous communities of basic foods, drinking water and training in issues of health; improved family diet, diversification of garden products, better eating habits, inclusion of knowledge and concepts on food and nutrition in everyday life.

Social participation. The main instrument to achieve the integration of PLANAL programs is the territorial management, where each municipal government installed on its territory a debate mechanisms with the citizenry, which leads to the construction of a strategic land use Plans. Active citizenship participates through their designated representatives. This participatory planning method allowed the development of personal and community capacities that facilitated the follow-up of the plans implemented at the local level, building capacity that ensures sustainability.

Andalucía, Spain

Pilot project for the development of a Local Network Strategy for Action in Health

(project RELAS)

The development of a Local Network Strategy for Action in Health (RELAS) is an example of the importance of developing local networks to support and address issues of health from different perspective. The case focuses in ***intersectoriality at a coordination leve***l and even at the integration level at the municipality where the Mayer with the support of the Junta de Andalucía collectively address issues of education, health, labor, environment and inequity. It convokes governmental and non-governmental institutions.

Andalucía promoted the development of a Local Network Strategy for Action in Health, in order to strengthen the role of city authorities as key agents of public health at the local level. Professional health teams of the provincial and city governments worked jointly and in an intersectoral manner to address challenges for the protection and promotion of health and prevention of diseases by integrating all sectors in a local Pact for health. These challenges were identified in participatory preliminary diagnoses of local health, from which a later exercise to prioritize interventions would be developed - within the framework of local health plans. Demographic, socio-economic and environmental data were considered for these diagnostics, as well as health status; and local health resources. The pilot was developed in 9 municipalities that represent different local governments realities, in terms of size; type of population, geographical location and specific characteristics.

It fulfills the requirements to be considered an example of Health in All Policies because:

It has the highest political commitment, as it is framed in the III Health Plan of Andalucia, which calls for a strategy to promote local authorities' participation in developing their specific health plans – strategy endorsed by the Ministry of health and Social Welfare of Andalucía.

It has its own structure. The creation of the Local Network gives structure to this initiative, with the supervision and technical support of the Government of Andalusia. City mayors are responsible for leading and coordinating the network, involving all relevant sectors.

Other sectors along with health participate in this initiative. In addition to health, different sectors at local level were convoked, especially those relevant to health (education, environment, housing, urban development, employment, equality), to be part of the local network.

It has its own funding. Resources were provide by different sectors. The central Government of Andalusia financed a line of grants to municipalities to head-start the project. It also provided support for funding tecncial personnel that provided advice at provincial level (technicians for local action in health - TALS).

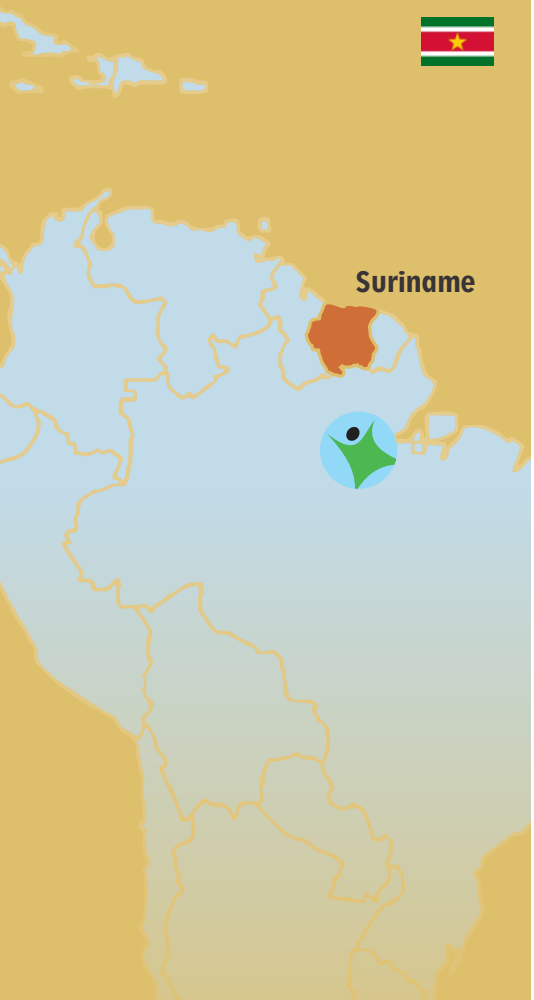
It seeks to reduce inequality. Inequalities are addressed through the social determinants of health approach upon which the network is developed; considering the health challenges. In some local governments, inequality has been the focus to prioritized specific health actions, to respond – among others – to needs of immigrants, areas for prostitution, people with disability and dependency.

It is based on inter sectoral work. At local level, all intervention is based on an inter sectoral action (education, environment, housing, urban development, employment, equality), especially in the preparation of diagnostics on health.

It develops public policies that impact on health. The Pilot Project (2008-2010) RELAS continues to exist today as a consolidated strategy for development of local action in health for Andalusia. Regulations to support for its implementation in all Andalucía cities are contemplated in the text of its provincial Public Health Law.

It has scientific based evidence of its results. Qualitative studies show a move towards a comprehensive approach to health actions in some municipalities. There has been an increased the number of activities that have as objective the promotion of habits of healthy lifestyle and the involvement and participation of citizens. Additionally, 70% of the municipalities in the pilot are continuing the project - where more stable structures have been created.

Social participation. Participation is the basis of the Network. Citizens participate in needs assessments and prioritization of public health problems and risk situations in their territory, through consensus techniques. In a second phase, citizens participate in the design of concrete actions to be included in the local health plans- providing inputs through working groups within the local network in health.



A Rising Tide lifts all Boats: Forging Public-Private Partnerships to Create Momentum in the Successful Passage, Implementation and

Enforcement of Smoke-free Legislation in Suriname

Suriname developed a collaborative effort between branches of powers and all relevant stakeholders, to adopt legislation aligned with the Framework Convention on Tobacco Control (FCTC), ratified by Suriname in 2008 – following successful experiences in countries such as Brazil and Uruguay. The health sector spearheaded the planning and coordination of this initiative, understanding also that it couldn't act alone and that it was important to have the weight of other sectors behind it. The comprehensive smoke-free legislation was passed unanimously by the National Assembly and signed into law by President Bouterse on March 6, 2013. Advocacy for this initiative involved all layers of society and all districts of the country. Reporting avenues, harsh penalties, and intersectoral collaboration on enforcement were all written into the legislation. In addition, the Ministry of Health has made every effort to integrate legislative oversight into all layers of society by educating the public on the expected changes and their rights as an individual.

The adoption of the Smoke free legislation in Suriname is another national example of ***intersectoral cooperation.*** Like other cases reviewed on tobacco legislation, this experience focuses on the negotiation process undergone to adopt the law, which convokes all relevant sectors to provide inputs and by-in so they can move forward with the norms established. The challenge ahead is to ensure that this intersectoral dialogue is present during the implementation phase.

The initiative fulfills the requirements to be considered an example of Health in All Policies because:

It has the highest political commitment. The political will of key decision makers was apparent throughout the policy process. President Desi Bouterse, a known smoker, publicly stated his support for comprehensive smoke-free legislation with adequate enforcement mechanisms. Members of the National Assembly also consistently demonstrated support for this initiative.

It has its own structure. The Ministry of Health and the Pan American Health Organization were both responsible for initiating and leading the policy initiative. Additionally, the Intersectoral Tobacco Commission was formed and approved by the National Assembly shortly thereafter, comprised of representatives from the public and private sector. The Tobacco Board, the first intersectoral committee created in Suriname, and the National Assembly were the two primary formal structures used to coordinate collaboration.

Other sectors along with health participate in this initiative. The effort involved participation of: PAHO; the Ministries of Health, Trade and Industry, Justice, Labor, and Environment; The National Assembly; Anton de Kom University (Law Department for legislation consultation); Sports Groups; Youth organizations; District Commissioners and District Councils; Transportation Organizations (bus and taxi drivers); Chamber of Commerce.

No information is provided with regards to the Law's funding, although implementation will only start after June 2013.

It seeks to reduce inequality. The goal of this law was to protect vulnerable populations from the detrimental effects of secondhand smoke and preserve the health of children, employees, and residents of the interior with limited information and access to services.

It is based on inter sectoral work. The success of the passing of the law depended on intersectoral action from all stakeholders. Intersectoral leaders will also assist in its successful promotion, implementation, and enforcement.

It develops public policies that impact on health, resulting in the adoption of this new lay with strong support from all relevant sectors.

There is no scientific based evidence of its results yet. Involved leaders will be monitoring and evaluating implementation and adherence to the law once it becomes enforceable. The mechanisms established by the law to regulate tobacco have not yet been evaluated, as the legislation will take effect on June 7, 2013.

Social participation. Multiple sectors of society were contacted regarding this initiative including private, government, non-government, civilian, and media. Partners were motivated to participate by the ever-growing momentum towards the goal of tobacco-free legislation in Suriname. In June 2012 the Ministry of Health organized a massive Anti-Smoking Walk with nearly 5000 participants. This walk was a big moment in creating press coverage and awareness for the upcoming tobacco law, and overcoming resistance from some areas of the public sector and hospitality industry.

Campaign against dengue: "Make it be thirsty" (Mátelo de Sed)

The experience presented by Uruguay describes the actions taken to control and decrease the prevalence of dengue in the country. This is a case of ***intersectoral information exchange,*** and while it does not meet many of the criteria established to be considered a Health in All Policies approach, it is an example of a successful partnership with non-governmental institution to address a specific public health issue.

The Ministry of Public Health and the municipal government of the city of Montevideo launched an educational campaign to prevent dengue after identification of high population of mosquitoes in vulnerable socio-economic regions. Print media was used for this purpose, including 75 ads placed on public spaces and public transportation vehicles. The slogan placed was "Kill the dengue mosquito by making it thirsty ". Community workers were trained Brochures were prepared and mass media outlets (television, radio, written press) were used to raise awareness in the community as a whole.

While the program does not meet all the criteria to be considered as an example of health in all policies, it can be noted that:

It does not have the highest political commitment at national level, although the Ministry of Public Health, in collaboration with the National Emergency, the City Council of Montevideo and the departmental governments supported the initiative.

It does not have its own structure, but it relies governmental structure for its implementation.

Although it does not involve other sectors along with health, there is a joint effort from various levels of government. Departmental level of government provided support to kill larvae and mosquitoes, and accompanying brigades using the technology available to kill them. Additionally, the National Movement of Public and Private Health Users (NMPPHU) offered telephone assistance to the population.

It lacks its own budget. Funding was provided by the different departments/levels of Government.

It seeks to reduce inequality. The program served areas with high level of socio-economic vulnerability, where the prevalence of dengue is higher. It tried to reduce the social gradient among all social groups.

It is not clear that it was based on inter sectoral work. However, there are partnerships between health, departmental governments and the NGO NMPPHU. They coordinated actions with regards to disseminating information for the prevention of dengue.

It is not clear that it develop public policies that impacted on health.

Scientific based evidence of its results was not provided. An indicators methodology (LIRAs) was established in 2011 to evaluate its impact.

Social participation. Citizen participation was active through the establishment of networks, formal alliances forums and House-to-House brigades to support the effort.

The 8th Global Conference on Health Promotion 2013, Helsinki, Finland, 10 to 14 of June

SUMMARY
of the Experiences of the Americas

Dr. Clarissa Etienne
Director
Pan American Health Organization

Dr Jose R. Teruel
Assistant Director a.i.
Pan American Health Organization

Dr Luiz Augusto Galvão
Manager
Sustainable Development and Environmental Health (SDE)
Pan American Health Organization/ World Health Organization

Dr Sofíaleticia Morales Garza
Health Promotion and Social Determinants Coordinator
Pan American Health Organization / World Health Organization

Rosana Martinelli
Consultant
Pan American Health Organization

Pan American Health Organization
Rockefeller Foundation
Innovation for the Next 100 Years
8th Global Conference on Health Promotion HELSINKI 2013
aecid

http://www.paho.org/hiap/