HEALTH IN ALL POLICIES:
Case Studies from the Region of the Americas

Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE **Americas**

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Special Program on Sustainable Development and Health Equity (SDE)

Washington, D.C., 2015

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Acronyms

ANEP	National Association of Private Enterprises (for its Spanish acronym)
CISALUD	Intersectoral Health Commission (for its Spanish acronym)
CNCT	National Commission for Tobacco Control
HIA	Health Impact Assessment
HiAP	Health in All Policies
IDB	Inter-American Development Bank
INCA	National Cancer Institute (for its Spanish acronym)
MGES	Municipal Green and Environment Secretariat
PAHO/WHO	Pan American Health Organization/World Health Organization
PNAD	National Survey Household Sample (for its Spanish acronym)
PNBV	National Plan for Good Living (for its Spanish acronym)
SDH	Social determinants of health
UNEP	United Nations Environment Programme
USAID	United States Agency for International Development
WHO	World Health Organization

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Introduction

Nowadays, it is widely acknowledged that multiple factors and the conditions of the environments in which people live, work, and play, also known as the social determinants of health (SDH), can shape population health. It is also widely known that decisions made by sectors other than health can either positively or negatively affect the social determinants of health. This means that complex public health problems can be addressed only through policies that more efficiently coordinate efforts across sectors and the use of public resources and take into consideration the health impact of decisions made by entities outside the health sector. This recognition has given rise in recent years to a new approach to intersectoral collaboration and policy-making known as "Health in All Policies" (HiAP).

"Health in All Policies" has been defined as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity" (Leppo & Ollila, 2013). It aims to ensure that policy decisions across sectors result in neutral or beneficial impacts on the SDH. This is achieved by promoting changes in the systems that determine how policy decisions are made and implemented at the local, state, and national level. In so doing, HiAP reaffirms the essential role of public health in addressing policy and structural factors that affect health, as well as its leadership to engage a broader array of partners (Leppo & Ollila, 2013).

HiAP is an innovative approach to the processes whereby policies are created and implemented. It is grounded in health-related rights and responsibilities and collaboration across sectors to achieve common health goals; it fosters greater accountability on the part of public policymakers for the health impacts of their decisions; highlights the consequences of public policies for health systems, health determinants, and well-being; and contributes to sustainable development.

HiAP builds on the concepts of "healthy public policies" and "intersectoral action for health," which were first introduced by the Alma-Ata Declaration (WHO, 1978) and later consolidated in the Ottawa Charter for Health Promotion, which outlines the key areas for action in health promotion (WHO, 1986). In recent years, the HiAP approach has gained momentum and support from public health practitioners, governments, and organizations worldwide. The 2010 Adelaide Statement on Health in All Policies called for a new alliance among all sectors to advance human development, sustainability, and equity, as well as to improve health outcomes through the adoption of a new approach to policymaking and governance that invests in leadership within governments across all sectors and levels of government.

That same call was later echoed in the 2011 Rio Political Declaration on Social Determinants of Health, the 2011 Political Declaration of the UN High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, and the 2012 Rio+20 outcome document The Future We Want. In June 2013, Finland's Ministry of Social Affairs and WHO hosted the 8th Global Conference on Health Promotion in Helsinki. The conference addressed the challenges facing the implementation of HiAP and the importance of developing effective pathways for intersectoral

collaboration. The Conference's recommendations for action are outlined in the Helsinki Statement on Health in All Policies (WHO, 2013). HiAP principles are also reflected in other WHO frameworks, strategies, and resolutions, and are currently contributing to the formulation of the Post-2015 Development Goals.

In June 2013, WHO published its Health in All Policies Framework for Country Action, which proposes a roadmap for countries to implement the approach at the national level and orient national and local decision-making processes. The framework highlights six key features of HiAP for successful implementation at the national level: (1) establish the need and priorities for HiAP; (2) frame planned action; (3) identify supportive structures and processes; (4) facilitate assessment and engagement; (5) ensure monitoring, evaluation, and reporting; and (6) build capacity (WHO, 2013).

While still marked by stark inequalities and challenges related to economic growth and sustainable development, the Region of the Americas has witnessed a rise in well-being in recent years as a result of country investments in social policies (ECLAC, 2013). This highlights the key role that HiAP can play in guiding the structural and policy changes that the Region requires to continue meeting better health, social, and equity goals.

"Health in All Policies" must remain a key consideration in the drafting of national policies and plans, as well as the Post-2015 Development Agenda. The current platform for the discussion of the Post-2015 Development Agenda constitutes a real-life experiment in the HiAP's potential to bring different sectors together around common health and societal goals while maintaining each sector's leadership in its respective sphere of action. It also offers a remarkable opportunity to fully implement the recommendations that emerged from the Helsinki Conference to advance the HiAP approach and ultimately improve health and health equity worldwide.

This report presents five case studies that highlight some of the best country experiences with the application of the HiAP approach in the Region of the Americas. These case studies were selected from a collection of 26 cases put together by countries in preparation for the 8th Global Conference on Health Promotion, held in June 2013. The case studies were prepared using a common framework developed for this purpose. The studies represent some of the Region's best practical experiences in developing HiAP and highlight the key principles and factors that made HiAP possible, as well as some of the challenges faced. The case studies can serve to orient future regional initiatives and policy processes and improve North-South and South-South cooperation.

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Background

In February 2013, a regional meeting was held in Brasilia, Brazil, in preparation for the 8th Global Conference on Health Promotion planned for June 2013 in Helsinki, Finland. It brought together representatives from 30 Member States from the Pan American Health Organization/World Health Organization (PAHO/WHO). The goal of this meeting was to introduce the HiAP Conceptual Framework to key stakeholders from the Americas and reach consensus on a regional position on the topic of HiAP (Pan American Health Organization/World Health Organization, 2013), which was later incorporated into the WHO HiAP Framework for Country Action (World Health Organization, 2013).

During the regional meeting, a series of case studies from the Region were presented that focused on some of the core principles and mechanisms of HiAP and the latest research on the topic. The case studies were prepared using a template developed by PAHO/WHO in collaboration with ministries of health, offering guidance to the countries on how to collect and analyze data on their HiAP initiatives. A total of 26 case studies from 15 countries were completed in the Region of the Americas.

The case studies focused on describing how the HiAP initiatives addressed the following key domains: political support; intersectoral structures; budget allocation; commitment from other sectors; commitment to reduce inequity; use of scientific evidence; participation and participatory mechanisms; empowerment; ownership; and sustainability.

From the 26 cases studies documented, five were selected and are described in this report. They represent some of the best examples of intersectoral collaboration and cross-sector work focused on common health goals. They also demonstrate the importance of working toward a synergy of policies and actions and of strengthening participatory mechanisms. The case studies highlight practices that could guide other countries as they venture toward adopting a new approach to policy and decision-making and further strengthen technical cooperation and South-South collaboration efforts.

Finally, these five case studies will serve to inform the development of the PAHO Plan of Action on HiAP, as called for in the WHO HiAP Framework for Country Action. The Plan of Action was presented during the PAHO Directing Council in September 2014 and offered important insights on how to move the HiAP agenda forward in the Region.

Case Studies

The selected case studies represent national experiences from Brazil (two cases), Ecuador, El Salvador, and Mexico. They showcase different approaches to HiAP that revolve around the common goals of incorporating health concerns into policy-making processes and decisions, as well as to improve population well-being through partnerships and intersectoral collaboration. These case studies demonstrate that it is feasible to achieve health and societal goals through public policies and intersectoral action, maximizing resources while addressing the persistent health inequalities that still plague the Region.

Case Study 1

Building Integrated Public Policies in São Paulo, Brazil: the Case of the Green and Healthy Environments Program (PAVS)

Background

The Green and Healthy Environments Program (PAVS, for its Portuguese acronym) was launched by the municipal government of the city of São Paulo, Brazil, in order to address environmental issues within the context of health promotion activities.

The PAVS proposal was originally drafted by the Municipal Green and Environment Secretariat (MGES) of the State of São Paulo between 2005 and 2006; the program was later placed under the Municipal Health Secretariat and institutionalized through ordinance 1573/11, published on August 3, 2011. PAVS is currently managed and funded by the São Paulo City Council. The Municipal Parliament also supports the initiative and evaluated it through the Municipality of São Paulo's Environmental Commission in 2011.

Through a series of environmental projects, the PAVS program aims to:

- Strengthen health promotion activities;
- Challenge, contextualize and reflect upon the reality experienced by the population;
- Promote a culture of peace and non-violence;
- Systematically disseminate and build knowledge;
- Strengthen intersectoral and interdisciplinary action;
- Build an integrated health and environment agenda;
- Promote empowerment and effective community participation; and
- Promote stakeholder participation in the management of environmental projects for the sustainability of interventions within a given territory.

In the city of São Paulo, the Family Health Strategy currently deploys 1,269 teams to areas of high social vulnerability with significant environmental problems. Each family health team consists of one doctor, one nurse, two nursing assistants, and six community health workers, all of whom reside in the area in which they operate. This local set-up provides a far-reaching network for strengthening health promotion activities.

At the program's inception, environmental challenges and priorities were identified in the local areas covered by the community health agents and the community as a whole. Special emphasis was

placed on learning the communities' perceptions and understanding of health and the environment. The results of this assessment became the operational basis for an intersectoral intervention. The local discussion addressed the causes of the problems identified and spurred social mobilization to seek institutional partnerships that could intervene in the issues and challenges identified by the community.

Environmental projects based on the needs identified by the community within a specific territory were then developed in conjunction with staff from the Family Health Team, focusing on the following themes:

1. Biodiversity and afforestation;

2. Water, air, and soil;

3. Solid waste management;

4. Environmental agenda in public administration;

5. Healthy eating and agriculture;

6. Revitalization of public spaces;

7. Culture and communication.

Between 2007 and 2008, the MGES trained 5,000 community health agents from the Municipal Health Secretariat and 101 Social Protection Agents from the Municipal Social Assistance and Development Secretariat.

Both PAVS and the Family Health Program incorporate health promotion and human rights approaches. For example, they prioritize action targeting low-income families living in the areas of greatest vulnerability. The application of these approaches has enabled the two programs to better adapt the interventions to the municipality's health promotion strategy and to include activities aimed at heightening environmental awareness and educating communities for a healthier quality of life. These activities, in turn, have helped increase the population's access to safe housing, healthy environments, and clean water, safeguarding some of their basic human rights.

Although applied at the local level, PAVS could potentially be replicated at the national level through the Family Health Strategy.

Intersectoral action

PAVS has operated in an intersectoral manner throughout the initiative, from planning and design to implementation and evaluation. Although the health sector spearheads and manages PAVS, several other sectors have also been actively involved, including partner organizations from the Municipal Health Secretariat and the Family Health Strategy, as well as a number of other institutions. Each partner actively contributes in its own area of expertise and experience. Table 1 describes the roles of each participating institution.

Table 1. Intersectoral action in PAVS	
Stakeholder	**Role in PAVS**
MGES	Technical support for specific environmental issues
Infrastructure Secretariat	Support for infrastructure and sanitation improvements in the city
Municipal Urban Sanitation Agency (AMLURB)	Collaboration on solid waste issues
Municipal and State Education Secretariats	Strengthening of environmental education and social mobilization
Municipal Assistance and Social Development Secretariat (through the Management Board of the Basic Health Unit)	Support to draft local intervention projects and implement and evaluate the project

An intersectoral Board of Directors was created during the PAVS design phase to coordinate program activities. This Board draws representatives from an ample spectrum of sectors and institutions, including the:

- Brazilian Cooperation Agency (ABC);
- Latin American Faculty of Social Sciences (FLACSO);
- Oswaldo Cruz Foundation (FIOCRUZ);
- Ministry of Health (MS/SVS);
- Pan American Health Organization (PAHO);
- United Nations Environment Programme (UNEP);
- Municipal Health Secretariat/São Paulo;
- Municipal Social Welfare and Development Secretariat/São Paulo;
- University of Brasilia (UNB); and
- University of São Paulo (USP).

During the program implementation phase, local committees were set up to help incorporate and monitor environmental projects in the Basic Health Units. Each committee was comprised of community representatives, the Council Manager, workers and local employees, and representatives from other sectors and institutions such as the Municipal Urban Sanitation Secretariat, Education Secretariat, Municipal Social Welfare and Development Secretariat, and the Green and Environment Secretariat.

Community and nongovernmental organizations have played a central role in the program. These include neighborhood associations, trade and business associations, and nongovernmental organizations working on environmental issues. They support the program mainly by contributing to the identification, monitoring, implementation, and evaluation of the action taken.

The School of Public Health's Center for Studies, Research, and Documentation on Healthy Cities (CEPEDOC/FSP/USP) conducted research focusing on the sustainability of the program through a survey in southern São Paulo that addressed six key issues: (1) characteristics and interests of the actors involved; (2) work processes and organization; (3) intersectorialism; (4) partnerships and social networks; (5) production of subjectivities; and (6) ability to influence the future.

Participation and participatory mechanisms

Community participation was strengthened through the action of community health workers and community leaders working to identify local needs. These needs were closely related to issues such as infrastructure, housing in risky areas, contamination, the presence of garbage and rats, lack of open public spaces for recreation, a sedentary lifestyle, and poor diet and eating habits.

The use of participatory methodologies for local assessments, prioritization, and planning supported the design of the socioenvironmental projects. Inputs were provided by several sectors. Within the health sector, the program was supported by the CAPS (Psychosocial Care Centers) and the Traditional Medicine, Homeopathy, and Integral Health Practices (MTHPIS, for its Portuguese acronym), which furnishes guidance on medicinal plants and orchard development and encourages physical activity, healthy eating, and other practices. Other municipal sectors that provided support included urban infrastructure, street cleaning services, waste management, public spaces development in at-risk areas, housing, and environment.

The media actively participated in the program. Social media tools in particular were used to bolster civic engagement. The Healthy São Paulo TV show was instrumental in disseminating information to health professionals from the municipal network. A series of informational bulletins, books on specific topics, and newspaper articles were also published to promote this initiative (see list of publications).

PAVS also sought to empower and build capacity among participating communities. This led some families to embrace new environmental health practices, such as planting orchards and gardens, separating trash, and adopting healthier eating habits, making them part of their daily lives.

Sustainability

Securing financing remains critical to the sustainability of any program. While PAVS has its own budget, the design phase was funded by the United Nations Environment Programme (UNEP), the Inter-American Development Bank (IDB), MGES, and the Municipality of São Paulo Health Secretariat. PAVS is currently funded through the municipal budget. Since 2011, it has also received funding from the Family Health Strategy budget, which allows for the delivery of effective government interventions, economies of scale, and the alignment of local governance with regional and national mandates.

Capacity building, another key component of sustainability, was emphasized by PAVS through various platforms such as training activities and public awareness campaigns targeting community health and environmental promotion agents and the community as a whole.

PAVS also sought to strengthen community networks and empower the family health teams. This helped increase the number of primary care units interested in undertaking environmental projects, as well as the number of employees involved in such projects.

Finally, institutionalization of the program greatly increased its sustainability. This was achieved with two key strategies, namely (1) the incorporation of cross-cutting issues into the project so it would be adopted and supplemented by other municipal programs; and (2) formal approval of the program through ordinance 1573/11, published on August 3, 2011.

What have we learned from PAVS?

Integrated local action geared to the most vulnerable populations, such as the activities promoted by PAVS, can foster significant social change. One example is that of the PAVS activities to plant school orchards. By getting students and the school community involved and educating them about matters such as cultivation, soil care, organic farming, pesticide alternatives, and healthy eating, the program encouraged the schools to adapt their educational programs to support healthier lifestyles. In addition, PAVS' environmental projects with the homeless and senior population promoted the recovery of citizenship, self esteem, self-care, and independence.

The intersectoral and participatory approaches adopted by PAVS also helped address health inequalities among the participating communities. This was achieved by:

- targeting specific health conditions present in the population and improving access to health services;
- improving access to knowledge about the causes of the environmental problems in their territories through the application of the principles of critical social pedagogy;
- empowering community health agents, community members, and community leaders to search for collaborative solutions to their problems; and
- improving intersectoral linkages and partenerships.

Facilitating factors and challenges to implementing PAVS

Factors that facilitated the implementation of PAVS included:

- the existence of municipal managers with a sound integrated vision for the program, including the willingness to work in an intersectoral manner;

- provision of adequate technical/political support during the design and implementation phase; and

- adoption of an integrated approach to the implementation phase that included effective municipal management, training of community workers, hiring of managers, and linkages with local and regional actors to promote and support the efforts of partners working on environmental issues.

Challenges identified

- Fragmented organizational culture among the different sectors involved in this initiative, which created difficulties integrating issues related to health and the environment into the work plan and plans of actions of certain institutions;

- Predominant government-assistance mentality to health care, which hampered the adoption of health-promoting approaches;

- A qualitative evaluation conducted in 2011 identified some of the main difficulties faced by PAVS. These included low levels of technical knowledge about issues related to the environment (32.6% of survey participants), little support from partner institutions (2.0%), and lack of financial resources (84.3%).

Evaluation and dissemination of results

PAVS conducted a qualitative evaluation that included a systematic annual review of PAVS processes in each participating basic health unit. This effort involved the people working in the units (physicians, nurses, nursing assistants, community health agents, environmental promotion agents), as well as regional and local managers, coordinators, health supervisors, and partner institutions. The evaluation methods included meetings, roundtable discussions, and questionnaires.

A summary of the latest evaluation in 2011, which included 1,224 participants, shows that:

- 92% of basic health units managed environmental projects as part of their portfolio;

- community participation was considered satisfactory by 69% of participants and unsatisfactory by 28%, with 3% undecided;

- the project's visibility within the community was considered high by 68% of respondents, good by 9%, and low by 21%. Two percent did not think the program had any visibility;

- 95% of participants reported positive changes in the routines and processes of the basic health units or in the communities as a result of the program's implementation.

PAVS also publishes quarterly reports that track the number of environmental projects by theme. Results from the 2011 evaluation initiative are shown in Table 2.

Table 2. PAVS environmental projects by theme						
Main topics	Number of Projects - Health Coordination Regions					2011
	Center-West	East	North	Southeast	South	Total Projects
Afforestation	0	24	2	4	7	37
Gardens/Healthy Foods	8	51	35	42	25	161
Educational Workshops/ Culture of Peace	16	52	91	76	86	321
Waste Management	25	90	107	119	146	487
Environmental Agenda in Public Administration	3	87	8	20	74	192
Construction of Living Spaces	0	9	0	3	5	17
Infrastructure/Revitalization of Public Spaces	5	14	17	17	6	59
Income Generation	0	29	0	1	4	34
Educational Communication	4	2	33	12	35	86
Watershed Area	0	1	1	1	7	10
Healthy Living with Animals and Zoonosis Prevention	5	21	9	8	7	50
Total projects	66	380	303	303	402	1,454

The initiative successfully motivated and mobilized community health workers. Over 1,400 environmental initiatives and projects were developed as a result of the training sessions. In addition, the Municipal Health Secretariat incorporated PAVS into the Family Health Strategy, resulting in the creation of a team of environmental managers.

Achievements

- Construction of an agenda addressing environmental health and health promotion in an integrated manner. The number of projects is steadily growing, increasing from around 400 projects identified between September 2008 and January 2009 to 705 in December 2009, 968 in December 2010, and 1,454 in December 2011;

- Improved intersectoral action: all projects were designed and are currently being implemented in an intersectoral manner;

- Greater participation: growing number of participants, both individuals as well as partner institutions;

- Greater empowerment: some environmental projects were replicated in the community;

- Greater autonomy: projects involving homeless people and garbage pickers have documented greater autonomy and self-care behaviors among these populations;

- Improved sustainability: the Municipal Health Secretariat issued a decree formalizing the program (number 1.573/2011-SMS-G) and hired new professionals to work on it (environmental promotion agents and environmental managers from diverse backgrounds, among them ecologists, geographers, historians, and publicists).

Conclusions of case study 1

PAVS offers an innovative model that makes it possible to tackle environmental issues of community concern, translating them into local health promotion activities. This model fosters community creativity in the mobilization and use of resources, increases environmental awareness and knowledge, and supports collaborative action among the various actors.

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Case Study 2

The National Policy for Tobacco Control in Brazil

Introduction

Despite extensive evidence demonstrating the relationship between smoking and health, the number of smokers worldwide has increased from 1.1 billion in the 1990s to 1.3 billion in the 2000s. According to the World Health Organization and the World Bank, if this consumption trend continues, the number of tobacco-related deaths will increase to 8 million annually by 2030, and about 80% of these deaths will occur in developing countries, where 80% of the world's smokers live.

In the case of Brazil, the prevalence of smoking decreased from 32% in 1989 to 17% in 2009 among the population over 15. However, the number of smokers is disproportionally higher among the population with lower income and education levels. Although some positive effects of reduced smoking in Brazil, such as lower mortality from cardiovascular disease, chronic respiratory diseases, and lung cancer among men, have already been seen, each year approximately 137,000 deaths from tobacco-related illnesses, equivalent to 11% of the total deaths in the country, occur among Brazilians.

A recent study that employed Health Impact Assessment (HIA) revealed that in 2011, the Brazilian health system (public and private services) spent approximately US$21 billion to treat just 15 of the 50 different types of tobacco-related illnesses. This represents nearly 30% of the total funds allocated to the Unified Health System.

In 1999, the 52nd World Health Assembly spearheaded ratification of an international treaty that included a set of intersectoral national and international cooperation measures to halt the spread of smoking. This has since been known as the WHO Framework Convention on Tobacco Control (FCTC), which was ratified in 2005 by the Brazilian Congress and later promulgated by the Executive branch through Decree No. 5658/2006. These initiatives demonstrate the highest level of commitment by the government to address the issue of tobacco control. Implementation of these mandates was entrusted to the Ministry of Health and the National Cancer Institute.

Brazil played a prominent role in negotiating the FCTC due to its position as chair of the WHO Intergovernmental Negotiating Body between 2000 and 2003. Even though it is a developing country and major tobacco producer, Brazil has succeeded in taking significant, comprehensive action with real results in terms of reducing the prevalence of smoking. One example is the federal government's program to support crop diversification in areas devoted to tobacco-growing, launched in 2005.

Public policies and intersectoral action for tobacco control

Brazilian tobacco control policies are the product of strong political will and well-coordinated intersectoral action. This stems from an acknowledgement that the issues addressed by the FCTC, such as price, tax, and advertising regulations and encouraging alternative crop production, cannot be tackled exclusively by the health sector.

The FCTC negotiations led the Brazilian government to create the National Commission for Tobacco Control (CNCT) on August 13, 1999 through National Decree No. 3136. The CNCT supported the Government of Brazil in its decisions and positions during the FCTC negotiations between 1999 and 2003. The CNCT was composed of representatives from the Ministries of Health; Foreign Affairs; Agriculture, Livestock, and Food Supply; Finance; Justice; Labor and Employment; Education; Development, Industry, and Foreign Trade; and Agrarian Development. The Ministry of Health co-chaired this Commission with the National Cancer Institute and acted as its Executive Secretariat.

Brazil was the second country to sign the FCTC, doing so on June 16, 2003. Soon after, the National Commission for Implementation of the Framework Convention on Tobacco Control and its Protocols (CONICQ) was created by Presidential Decree. This new Commission replaced the CNCT and represented a new impetus for tobacco control in Brazil, moving beyond the advisory nature of the previous body.

CONICQ is an interministerial commission with representatives from 18 government sectors including: the Ministry of Health; Ministry of Foreign Affairs; Ministry of Finance; Ministry of Planning, Budget and Management; Civil House of the Presidency; Ministry of Agriculture, Livestock and Food Supply; Ministry of Justice; Ministry of Education; Ministry of Labor and Employment; Ministry of Development, Industry and Foreign Trade; Ministry of Agrarian Development; Ministry of Communications; Ministry of Environment; Ministry of Science, Technology, and Innovation; Secretariat of Policies for Women of the Presidency; the National Drug Policy of the Ministry of Justice; Attorney General's Office; and the National Health Surveillance Agency.

CONICQ's responsibilities include assisting the government in advancing the FCTC; articulating intersectoral agendas for its implementation; promoting the development, implementation, and evaluation of strategies, plans, and programs, as well as policies, legislation, and other measures to fulfill obligations under the FCTC; identifying, promoting, and facilitating the mobilization of financial resources; promoting studies and research on topics related to issues of interest to the FCTC; establishing dialogue with institutions and national and international organizations whose goals and activities can make a significant contribution to the issues under its purview; requiring, as appropriate, cooperation with other national and international entities; considering, as appropriate, other action necessary to reach the goal of the FCTC.

Since April 2012, CONICQ has also implemented ethical guidelines applicable to all its members to prevent interference by the tobacco industry in public policies for tobacco control. The guidelines call for CONICQ members not to accept sponsorship or gifts from the tobacco industry or conduct research funded it.

The actors involved in CONICQ exercise a variety of roles in their areas of expertise and experience. Examples include:

- The Ministry of Finance, which sets tobacco prices, levies taxes, and works to combat the illicit market for tobacco products to reduce smoking among youth and the low income population. Raising taxes on cigarettes has proven an effective mechanism for improving the quality of life for Brazilians, as higher taxes can reduce cigarette smoking and its impact on health;

- The Ministry of Justice's National Secretariat for Drug Policy, which helps produce informational materials about licit and illicit drugs, including tobacco, and supports research on the subject;

- The Ministry of Agrarian Development, which is responsible for national diversification in tobacco-growing areas, aimed at offering cost-effective alternatives for small tobacco growers;

- The National Health Surveillance Agency, which regulates tobacco products and their content and emissions. It also coordinates a national health surveillance network to monitor compliance with the national law on smoking in enclosed spaces, as well as bans on advertising and promotional activities for tobacco products;

- The National Cancer Institute, in addition to its coordinating role, provides treatment to support smoking cessation, in partnership with the state and municipal departments of health;

- The Commission also has Senate and House Representatives that are committed to addressing the issue of tobacco control; and

- The Ministry of Health and the National Cancer Institute together serve as the Executive Secretary of CONICQ. Additionally, the Minister of Health chairs the Commission.

Of particular importance in this initiative is the role of the National Cancer Institute (INCA), a Ministry of Health agency that has coordinated tobacco control activities for over 20 years at the national level and in partnership with other governments through international organizations. INCA manages implementation of the FCTC in Brazil, mobilizes resources, and directs actions to implement CONICQ activities. It also manages a mailing group to keep government officials informed about CONICQ activities (http://www2.inca.gov.br); this is an important mechanism for facilitating intersectoral action.

As stated in the 2003 Presidential Decree, INCA is responsible for:

- Assisting the Brazilian government in the FCTC ratification process and effective fulfillment of the ensuing obligations;

- Assisting the Brazilian government in the negotiation and adoption of additional protocols, annexes, and amendments to the Framework Convention;

- Coordinating the organization and implementation of an intersectoral government agenda for the fulfillment of obligations under the Framework Convention;

- Promoting the development, implementation and evaluation of strategies, plans and programs as well as policies, legislation, and other measures to fulfill its obligations under the Framework Convention;

- Identifying, promoting, and facilitating the mobilization of financial resources to guarantee its operations and support the fulfillment of obligations under the Framework Convention;

- Promoting studies and research in areas related to issues of interest to the Framework Convention;

- Establishing dialogue with relevant institutions and national and international organizations;

- Requiring, as appropriate, cooperation and information from government agencies and other organizations or nongovernmental bodies, national or international, as well as experts in matters related to its areas of interest;

- Considering, as appropriate, other action necessary to reach the goal of the Framework Convention, and

- Performing other duties, as appropriate, for compliance with the Decree.

CONICQ's financing mechanism also employs an intersectoral strategy. While CONICQ has its own budget, the participating ministries allocate funding from their budgets to cover action pertaining to their particular responsibilities. For example, between 2006 and 2012, the Ministry of Agrarian Development allocated US$25 million to the Crop Diversification Program for tobacco-growing areas.

Public participation

Scientific and medical associations, together with the Alliance for Tobacco Control and other nongovernmental organizations, have been instrumental in mobilizing public opinion against tobacco industry interference in tobacco control policies. They are staunch collaborators not only in supporting the National Policy for Tobacco Control but protecting it from interference by the tobacco industry and preventing backsliding on measures already adopted. The Pan American Health Organization (PAHO) Office in Brazil has also played a key role in developing the National Policy for Tobacco Control. The media has supported the initiative in the regulation of advertising for tobacco products.

INCA is at the forefront of a series of initiatives promoting civil society participation and capacity building. For example, it manages the Observatory for National Tobacco Control and various networks of social stakeholders. In coordination with other partners, INCA and CONICQ also unflaggingly promote training courses for health professionals, seminars open to civil society on the main themes of the FCTC, and awareness campaigns for public administrators.

Generating social change through public policies

Brazil is the second largest producer and exporter of tobacco, which proved to be a real challenge to ratification of the FCTC. One example of this was the intense movement and campaign spearheaded by major transnational tobacco industries in Brazil alleging that Brazil's ratification of the treaty would negatively impact the livelihoods of 200,000 small tobacco growers. However, the CNCT has been vital in protecting the tobacco control policy from undue interference by the tobacco industry.

The initial resistance and opposition to the treaty among growers, legislators, and politicians were overcome through an informational campaign to raise awareness carried out in 2004 and 2005. Through public hearings held in tobacco-growing regions, most of the tobacco industry's arguments were refuted and demystified.

This change of position among growers was further supported by provisions in the FCTC offering technical and financial assistance to facilitate the economic transition of growers and workers affected by the tobacco control programs.

However, since 85% of national tobacco production is exported, any future economic impact on tobacco production will depend on changes in the global trade environment and ratification of the FCTC by other governments.

The National Policy for Tobacco Control has produced a major shift in the social acceptance of smoking through the recent laws banning smoking in public places, as well as the action taken to ban the advertising of tobacco products. Several studies show significant popular support for these measures.

Finally, the National Policy for Tobacco Control addresses the issues of health inequities and human rights through action targeting women; adolescents; and low-income, low-education, and rural communities. Another important goal that it addresses is eliminating child labor in tobacco-related activities.

Barriers and factors facilitating the initiative

Some of the factors identified as facilitators of the successful implementation of this initiative include: the intersectoral nature of the governance model for the National Policy for Tobacco Control and the social networks and alliances that support the policy.

However, interference by the tobacco industry to halt or prevent the adoption of tobacco control policies is considered a serious challenge. The industry operates through lobbying strategies targeting elected authorities and public administrators, using front groups to defend the interests of the tobacco industry, and by championing socially responsible activities to convey a positive image as a contributor to society. In addition, the considerable weight of tobacco production in the economy of certain regions of Brazil remains an issue that must be addressed by tobacco control policies and strategies.

Evaluation and dissemination of results

The initiative has successfully met many of its objectives, especially those related to intersectoral action. Some examples include:

- Reduction in smoking prevalence in Brazil: in 1989, the National Health and Nutrition Survey conducted by IBGE showed a smoking prevalence of 32% among the population over 15 years of age. According to the Special Survey on Tobacco Usage, in 2009 the prevalence of smoking among the over-15 population had dropped to 17.2%;

- Reduction in mortality from cardiovascular disease, chronic respiratory diseases, and lung cancer;

- Restriction of the use of additives in tobacco products;

- Smoking ban in public places: Law 12.546/2011 forbade the use of tobacco products in public and enclosed spaces throughout Brazil;

- Ban on advertising at points of sale: enacted through Law 12.546/11, whose regulations are still pending;

- Price and taxes increase: Law 12.546/11 instituted the policy of minimum prices for cigarettes;

- Inclusion of health warnings: as of 2016, an additional health warning must cover 30% of the lower front of cigarette packages;

- Crop diversification in tobacco-growing areas: this took place through a pilot project in some municipalities in the state of Rio Grande do Sul that provided aid to tobacco growers for the production of other crops and health services for the population.

A series of evaluations was conducted throughout the different phases of this initiative. One example is the epidemiological surveillance evaluations, which were conducted by VIGITEL, a program to monitor the frequency and distribution of risk and protective factors for NCDs in all 26 of Brazil's state capitals and the Federal District. The evaluation was conducted through telephone interviews with random samples of adults living in households with at least one landline in each city.

Another evaluation effort is the Special Smoking Survey (PETab, for its Portuguese acronym) which provided an overview and detailed description of tobacco use among people aged 15 or older in Brazil, with information for the country, the major regions, and units of the federation. The PETab was conducted by the Brazilian Institute of Geography and Statistics (IBGE, for its Portuguese acronym), in partnership with the Ministry of Health and INCA. It was administered to a subsample (about 51,000 households) of the National Household Survey Sample (PNAD) of 2008. The research followed the GATS model (Global Adult Tobacco Survey).

Finally, this initiative was part of the International Project for the Evaluation of Policies on Tobacco Control (ITC). This first international cohort study on tobacco use assesses the impact of policies implemented in CONICQ. One round of evaluations was conducted and another is in the planning stage. This research project is being conducted in Brazil through a partnership among INCA, the National Secretariat for Policies on Drugs (SENAD), and the Alliance for Tobacco Control, with the support of the University of Waterloo in Canada.

Conclusions of case study 2

Brazil is the first country to have a government commission to coordinate intersectoral implementation of the FCTC. The sustainability of the initiative is ensured by sustained funding, as well as changes in behaviors and habits that tend to reduce the use of tobacco products over time.

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Case Study 3

Integrated Policies and Social Action for Sustainable Development in Ecuador: the Case of the National Plan for Good Living

Introduction

The Ecuadorian National Plan for Good Living[1] (Plan Nacional del Buen Vivir, or PNBV, for its Spanish acronym) grew out of an effort to coordinate various sectoral agendas and devise policies, strategies, programs, and projects to be executed by the coordinating ministries and sectoral cabinets of the Ecuadorian executive body. The Plan was developed and initially implemented in 2009, with the first cycle scheduled to end in 2013.

The PNVB proposes an integrated view of social policy from a rights-based and social justice perspective. It aims to:

- promote equality, cohesion and social and territorial integration within a framework of diversity;

- improve citizen capacities, potential, and quality of life;

- guarantee rights with respect to nature to promote a healthy and sustainable environment;

- ensure peace and sovereignty and promote Ecuador's strategic insertion in the world, as well as Latin American integration;

- generate stable, fair, and decent employment;

- build and strengthen intercultural public spaces;

- affirm and strengthen national identity, as well as diverse identities (plurinationalism, and interculturalism);

- guarantee rights and justice;

- increase access to public and political participation;

- establish a social, solidary and sustainable economic system; and

- build a democratic State for "Good Living."

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[1] The concept of "Good Living" comes from the Quechua worldview of *sumak kawsay*, the notion of finding a balance with nature to meet people's needs, instead of focusing solely on economic growth. In contemporary political philosophy, the concept of ¨good living¨ refers to a lifestyle that promotes economic, social, and cultural rights, as well as a more sustainable relationship with nature.

This initiative grew out of the new institutional structure of the State resulting from the Constitutional reform. The new Constitution called for democratization of the right to water, land, credit, technologies, knowledge and information, and diversity in the forms of production and ownership. It also included the right to nature and a sustainable development strategy.

The development of coordinated sector agendas likewise grew out of the new institutional structure of the State resulting from the Constitutional reform. This new vision is based on the territorialization of policies and responds to five main challenges:

1. Territorialization/contextualization of policy to reduce the inequality gap and meet the basic needs of the territories and their population;

2. Territorial planning and organization of policies;

3. Acknowledgement of regional dynamics that contribute to a new accumulative and redistributive model in the framework of PNBV;

4. Acknowledgement and recognition of the plurinational and intercultural nature of the State;

5. The design of a new administrative structure that links public interventions at all levels of government and reaffirms the redistributive role of the State.

This initiative has the highest political commitment from the executive and legislative branches. It not only guides the government's action plan but enjoys strong presidential support. The budget for the PNBV is secured within the general budget of the State. International cooperation funds supplement it but are not essential for meeting the goals of the Plan. The central government guarantees continued funding for the strategy.

A new model for intersectoral action

The new vision of the State is enshrined in the new Constitution and its institutional arrangements, which created coordinating ministries that initially brought different sectors together and highlighted the need to promote intersectoral action in all areas relevant to the notion of "Good Living." Based on this innovative framework, the Ministry of Development Coordination called on the ministries of health, education, labor, and welfare, and all other pertinent institutions work in concert to build a coordinated strategy.

The challenges involved in that effort demanded the design and implementation of mechanisms for coordination between the central government and decentralized autonomous governments and their sectoral agencies to guarantee a consensus on the action to be taken. This methodology employed the framework of the National Decentralized System for Participatory Planning, which sets strategic policies and objectives in public investment and democracy building.

The National Planning Council spearheaded the design of the PNBV strategy. This intersectoral team coordinated by the National Secretary for Planning and Development (SENPLADES), served as the PNVB's technical secretariat, integrating the different levels of government in the implementation phase of the PNVB. Development Coordination, which supervises the ministries of health, labor, education, social inclusion, migration, and housing.

The National Planning Council is responsible for approving the National Development Plan, which guided implementation of PNBV. The National Planning Council also establishes short- and long-term guidelines and policies; sets qualitative, quantitative, and effectiveness standards for national public policies on territorial and development issues; annually validates goals and results achieved through the National Development Plan; evaluates the results and determines the necessary corrections to the plans, when pertinent; ensures the best results in responding to national objectives; and approves the long-term National Development Strategy.

Through the Planning Council, all relevant sectors were mobilized and participated in the dialogue to reach a consensus on National Development Plan guidelines, resulting in a significant and relevant interagency effort.

Public participation and participatory mechanisms

PNBV provides a framework of respect for all cultures, lifestyles, and knowledge and acknowledges the diverse natural environment of Ecuador. This helped to ensure that communities were included and actively involved in the design of the initiative and benefited from its results.

All phases of the National Development Program—planning, design, implementation, and evaluation—involve active social participation. The national and local processes have mechanisms for accountability to the public such as focus groups, consultations, and consensus-building activities.

The design of local development plans is also based on inputs from the community through formal and informal representatives. However, while there is significant participation by governmental agencies and grassroots organizations, it is not clear what, if any, other actors are involved in the various processes and phases.

The National Decentralized System for Participatory Planning spearheaded the development of the strategy and the design of the policies to be implemented at the national and local level. This allowed for the inclusion of participatory methodologies throughout the life of the program. This participatory approach to local processes has led to community empowerment and greater capacity to implement the policies and development plans created.

In addition, the National Development Plan focuses on reducing inequality gaps by promoting redistribution of the benefits of development and acknowledging the country's multicultural nature, which has led to regional development plans tailored to local realities.

Changing sectoral policies through intersectoral action

The National Development Plan devised by the National Planning Council became the roadmap for the development and implementation of social policies. Based on this Plan, regional and local governments develop their own implementation plans, taking local priorities and needs into account in an ongoing dialogue with civil society.

The National Development Plan is also used to guide the preparation of sector-specific work plans, with health being one of them. The goals of each sector must be consistent with the national

strategy, whose guiding principles are the social determinants of health approach and the broad integral definition of health as understood in the concept of "good living."

Evaluation and dissemination

Between 2006 and 2011 (when the National Development Program was implemented), income inequality, as measured by the Gini coefficient, fell by 12% At the same time, public investment and credits for agriculture doubled, while social investment increased 2.5 times; the proportion of urban households with toilets and sewerage systems increased from 71% to 78%; rural households with access to waste collection increased from 22% to 37%; investments in justice increased 15 times; and medical consultations in the public health services increased to 2.6 per 100 inhabitants.

Conclusions of case study 3

PNBV gives life to a new vision of government's role in social policy and public administration. It calls for inclusive, multicultural, and sustainable development, offering a new understanding of growth, participation, and distribution of the benefits of growth. Development is broadly defined, moving beyond the quantitative margins of the economic lens toward an inclusive, sustainable, and democratic economic strategy.

By coordinating action among different sectors and levels of government, the PNBV creates economies of scale and supports efficient resource allocation and intense intersectoral efforts. It also innovates through the participatory design of development plans at the national and local level. Sustainability is improved by ongoing civil society participation in all phases and by the budget provided by the central government.

PNBV provides an innovative model for public development and administration. It is further strengthened by constitutional reform and a new institutional State structure, where the focus is on redistribution of the benefits of development and its outcomes, an inclusive policy in a plurinational State, and more equitable distribution of services.

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Additional resources

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Case Study 4

Addressing the Social Determinants of Health through Intersectoral Action: the Case of the Intersectoral Health Commission (CISALUD) of El Salvador

Introduction

Like many other countries, El Salvador is plagued by the unequal distribution of health, lack of access to public services, the high impact of private health expenditure on family finances, and existing health inequities—issues that require coordinated efforts beyond the scope of the health sector.

Acknowledging this reality, in 2009 the Government of El Salvador launched a profound structural reform of the national health system to incorporate the principles of equity, social participation, and intersectoral action, as proposed in the Alma-Ata Declaration. In addition, the government established the national health policy, which it called "Building Hope" (2009-2014).

Within this framework, the Intersectoral Health Commission (CISALUD, for its Spanish acronym) was established in 2009 by Executive Presidential Decree and placed under the Ministry of Health's Vice Ministry of Health Policies and coordinated by the Vice Minister. Its purpose was to promote intersectoral action to address the social determinants of health and health inequalities. CISALUD grew out of the previous experience with CONAPREVIAR, a commission created in 2006 in response to the WHO recommendations for managing the avian flu crisis.

Intersectoral action for health

Under the leadership of the health sector, other areas of government and civil society, including the private sector, were mobilized to tackle priority health issues as members of CISALUD. The agencies called upon were those whose actions could have an impact on health, among them the institutions charged with managing natural disaster response, mining activities, epidemics, industrial pollution, waste management, etc. Participating members agreed to work on the following priority areas:

a) Water

b) Food security

c) Illicit drugs

d) Environment

e) Working conditions

f) Children and adolescents

g) Lifestyles

h) Chronic diseases

i) Communicable diseases

j) Disasters

k) Intersectorialism

More than 50 agencies are currently part of CISALUD. Government agencies include ministries (Education, Defense, Interior, Public Safety, Finance, Labor Agriculture, Public Works, Environment, Transportation, and Tourism); FOSALUD, ISRI, COSAM, PNC, COMURES, COAMSS, ISSS, ISBM, DGCP, and IML. The Legislative Assembly also participates, along with CEPA, CEL, ANDA, OIRSA, Consumer Protection, Civil Protection, and CENSALUD.

Participating international and nongovernmental organizations include PAHO/WHO, the Red Cross, USAID, World Vision, Salvadorian Commandos, U.S. Centers for Disease Control and Prevention (CDC), the National Association of Private Enterprises (ANEP), the National Health Forum, the Medical School of El Salvador, Citizen Alliance against the Privatization of Health, CARE, International Plan, and the Infectology Society of El Salvador.

As part of the process, all sectors are requested to issue recommendations for the agencies to implement these priorities within the scope of their mission. CISALUD, in turn, identifies specific challenges to be addressed (such as avian flu, cholera, etc.) and the root causes and factors associated with them. Actions are then determined and included into intersectoral plans developed by the participating agencies. This strategy has led to policy changes in the pertinent sectors that more appropriately take into account the health impact of their actions. CISALUD has also developed guidelines for policies and standards, in addition to other technical and legal instruments to improve health promotion initiatives.

CISALUD adopted a horizontal structure, creating an important mechanism for intersectoral action, as all members can propose items for the Commission's agenda. In order to facilitate the work, it holds regular workshops to foster discussions and agreements on priority issues.

In addition, two intersectoral commissions were created to support the work of CISALUD:

1) Political Commission: the heads of the participating agencies meet monthly to decide on various issues. It is chaired by the Minister of Health; and

2) Technical Commission: focal points from participating agencies meet regularly to issue recommendations to their leaders and implement the recommendations. It is chaired by the Vice Minister of Health Policies.

CISALUD has also fostered public-private collaboration. ANEP works with CISALUD's Technical and Political Commissions. For each specific health challenge addressed, the private sector may be asked to contribute and propose solutions. For example, when tackling health challenges affecting mine workers, the private sector is called upon to participate in the discussion and the development of proposals to improve working conditions.

CISALUD does not have its own funding. The action taken depends on the budgets of each participating institution. Hence, each agency contributes to the decisions made as finances permit. However, despite the lack of its own funding, CISALUD has managed to sustain its activities over time.

Public participation and participatory mechanisms

Organized civil society is active through its representatives in CISALUD's Political and Technical Commissions. With the support of the Foro Nacional de Salud and the University of El Salvador, CISALUD has also enlisted citizen participation to provide inputs on the issues addressed by the Commission. Community participation generally increases in the implementation phase of specific initiatives due to the use of strategies to raise awareness, change behaviors, and carry out activities targeting families and households. The CISALUD also contributes to capacity building through training activities and workshops for specific professionals and/or target populations.

In particular, CISALUD seeks to reduce health inequities. It prioritizes municipalities with higher levels of poverty and exclusion from health services and focuses on empowering the most vulnerable populations. Emphasis is always placed on health issues that predominantly affect women, children, gay and lesbian communities, indigenous communities, and rural populations. Although no specific agency focuses on how to approach the issue of ethnic diversity, this factor is always considered when making recommendations for action.

The media are also involved with this initiative. Television shows have presented progress reports and promoted campaigns to support humanitarian assistance for people affected by natural disasters.

Lessons learned

The previous experience with CONAPREVIAR greatly facilitated the development and operations of CISALUD. This experience also provided an important platform for its members to understand and better adapt to the government's new approach to health as a human right.

The current sustainability of CISALUD, even without its own funding, demonstrates its success and great potential for tackling specific health issues through intersectoral and joint action. By taking on cases such as the avian flu and cholera through intersectoral action, CISALUD ensured active and collaborative participation, developed guidelines and documentation for the process, and helped reduce the incidence of these epidemics..

Evaluation and dissemination of results

Internal and external evaluations of the action taken through CISALUD are conducted and their results submitted to the Accountability Agency of the Presidency and Congress, as well as the Foro Nacional de Salud. The CISALUD model has also been replicated in departmental and municipal cabinets and local committees to address specific local health issues.

Conclusions of case study 4

Intersectoral action remains the only effective way to address the social determinants of health. Although its scope to act on the broader factors that affect health is limited, the health sector can lead the way by mobilizing sectors and guiding multisectoral action. The CISALUD experience demonstrates the potential for such strategies to sustainably address health challenges.

CISALUD offers a unique forum for intersectoral dialogue, consensus, and joint action to tackle health issues. It promotes interagency alliances, government leadership, and the commitment of participating institutions to policies, plans, and interventions. It also provides better planning mechanisms for the allocation of technical, financial, and international cooperation resources.

An important factor supporting this initiative is the government's explicit commitment to recognizing health as a public good and a fundamental human right. This has provided a platform for the development of joint, democratic. and participatory intersectoral efforts to broadly and comprehensively address the social determinants of health. It has also facilitated the establishment of a health care system based on equity, efficiency, solidarity, and universal access, promoting health policies at the subregional and regional levels.

Additional resources

For more information, visit: http://siis.salud.gob.sv/.

CISALUD publishes a periodic bulletin sponsored by PAHO/WHO that reports on its work and progress.

Case Study 5

The National Agreement for Healthy Food: Strategies to Combat Obesity in Mexico

Introduction

Mexico has one of the highest rates of overweight and obesity in the world. Since 1980, the prevalence of obesity and overweight has tripled in Mexico, especially among the adult population, with 70% having a BMI above the healthy range. Data also show a rapid increase in overweight and obesity among children and youth, especially children aged 5-11. This epidemic translates into high costs for the health system, impacts the sustainability of the social security system, and threatens the economic and social stability of the population.

The cost of dealing with the health challenges stemming from overweight and obesity is high and rapidly rising, posing a serious problem for the delivery and financing of the health system. Medical attention for health problems connected with overweight and obesity rose by 61% between 2000 and 2008. The indirect costs stemming from lost productivity due to premature death had also increased significantly by 2008. The direct and indirect cost of overweight and obesity is projected to quadruple between 2000 and 2017.

Research has shown that multiple factors are responsible for overweight and obesity, among them changes in access to food and food consumption, lifestyle, physical activity levels and eating habits due to economic growth, urbanization, longer life expectancy, women's inclusion in the workforce, mass production of food and lower food and beverages prices, the use of additives to increase shelf life, and easier access to processed food as opposed to fresh food.

Mexico's National Development Plan 2007-2012 (NDP) included a National Health Program that set five overarching goals:

1) Improve the health conditions of the population;

2) Reduce the inequality gap in health through targeted interventions in vulnerable and marginalized communities;

3) Offer safe, quality health services;

4) Prevent the risk of poverty due to health problems;

5) Guarantee that health contributes to the fight against poverty and the country's development.

Within this framework, in 2010, the Mexican government launched the National Agreement for Healthy Food. The Agreement is based on the Global Strategy on Diet, Physical Activity, and Health for the prevention of chronic diseases, adopted by WHO in 2004. The Agreement, headed by the

Secretary of Health, mobilized 15 heads of government agencies and received the support of the President. It incorporated the mandate of the Charter of Ottawa on Health Promotion and the principles of equity, gender, interculturalism, and social inclusion.

The Agreement has three main goals, which are to:

- reverse the growth of overweight and obesity among children aged 2-5 years;
- halt the growth of overweight and obesity among the population aged 5-19 years; and
- slow the growth of overweight and obesity among the adult population.

Intersectoral action to combat the obesity epidemic

As the epidemic of obesity and overweight turned into a national public health priority in Mexico, the National Agreement became a tool to guide the development of multisectoral national plans and mobilize all governmental agencies to work together to achieve the following 10 main objectives:

1) Encourage physical activity in the workplace, schools, and communities, with the collaboration of the public, social, and private sectors;

2) Increase the availability, accessibility, and consumption of clean drinking water;

3) Reduce the consumption of sugar and fats in drinks;

4) Increase the consumption of fruits and vegetables, grains, legumes, and whole grains;

5) Improve decision-making processes in communities through clear and explicit iinformation about processed food;

6) Promote and protect breastfeeding;

7) Reduce the consumption of sugar and caloric sweeteners by increasing the availability of alternatives;

8) Reduce the consumption of saturated and trans fats in processed food;

9) Educate the public about portion control at home and in restaurants;

10) Reduce salt intake.

These 10 objectives are further planned along four cross-cutting lines of action:

1) information, education, and communication;

2) advocacy, co-regulation, and regulation;

3) monitoring and evaluation;

4) research.

Some 103 activities are currently being implemented under the Agreement, and the aim is to meet 245 project goals through the work of the participating agencies. Each agency takes the specific action assigned under the National Agreement. Examples include:

- Health Sector (SS): promote sectoral programs; update standards and regulations on food and advertising; support breastfeeding and nutritional literacy; promote the inclusion of plain drinking water in school breakfasts; train state and local family support agencies (DIF) on healthy school meals; promote physical education; train health professionals on healthy food.

- Secretary of Education (SEP): promote physical education in schools and gender equality in sports; promote the consumption of plain drinking water and nutritional literacy through the curriculum; guarantee public water fountains in schools; facilitate access to water and low-calorie drinks in collaboration with the food industry; develop guidelines to provide school meals with less sugar content; promote the Secretariat's Agreement for the sale of food and beverages in schools with healthier options.

- Secretary of Labor and Social Security (STPS): promote physical education and healthy food in the workplace; ensure implementation of the regulation for free access to drinking water; promote breastfeeding and review legislation to protect it for working mothers.

- Secretary of Social Development (SEDESOL): promote the use of public spaces for physical activity; encourage physical activity among youth within the "Oportunidades" Program; and promote access to and the availability of skim milk.

- Secretary of Economy (SE): create support systems for distribution chains to improve access to fruit, vegetables, legumes, and whole grains; disseminate information about healthy product markets to industry.

- Secretary of Agriculture, Livestock, Rural Development, Fishing, and Diet (SAGARPA): promote alternatives to the use of cane sugar; increase the supply of low-fat products; address structural issues to support agricultural food options; strengthen the Agreement to promote the consumption of fruits and vegetables.

- Secretary of Finance (SHCP): analyze instruments to promote the consumption of healthy food.

- Water Commission (CONAGUA): promote access to drinking water for vulnerable populations.

Other agencies involved include COFEPRIS, SNDIF, IMSS, ISSSTE, PEMEX, SEDENA, and CONADE. The initiative does not have its own budget but is funded through budget allocations among the participating agencies, including the health sector.

Within the framework of this initiative, the National Council for the Prevention and Control of Noncommunicable Chronic Diseases (CONACRO) was established, chaired by the Secretary of Health and vice chaired by the Undersecretary for Disease Prevention and Health Promotion. While the Secretary of Health appoints a coordinator, the main participating institutions nominate their own representatives to the Council.

A variety of mechanisms are used to promote intersectoral action. For example, five joint workshops for the education and health sector have been held since 2010 to decide how to implement the General Guidelines for Delivery and Distribution of Food and Beverages to School.

The Agreement has also resulted in key policy changes in sectors other than health. The Secretariat of Labor and Social Welfare has taken advantage of the Food Assistance Law to promote a healthy diet for workers. The Secretary of Education has developed a Plan of Action in the basic education school system to promote physical activity, food literacy, and a healthy diet; it has also issued General Guidelines for the Delivery and Distribution of Food and Beverages in School Environments. The Secretary of Health has issued guidelines to strengthen public policy on breastfeeding. In addition, several state-level agreements have been reached as consequence of this national initiative.

Public participation and participatory mechanisms

Organized civil society, NGOs, academia, and the food and beverage industry actively participate in both the processes related to the Agreement and the Council.

Public consultations and formal partnerships with NGOs were set up as part of the Agreement's planning phase.

Given the central role of the food and beverage industry in the factors that influence obesity and overweight, the National Agreement particularly emphasized public-private collaboration. Given its key role in food production, advertising, and access, as well as in the promotion of healthier options, the food and beverage sector has committed to making some changes in its processes and products and to collaborating in advocacy efforts and activities to raise awareness. This agreement with the industry includes the development of new products and changes in the composition of old ones; the provision of clear information to consumers; voluntary adoption of marketing that offers children healthier options; and the promotion of physical activity and healthy lifestyles.

The media also play an important role by complying with new regulations on the advertisement of food and nonalcoholic beverages, which are aligned with the Agreement's goals and objectives.

The National Agreement pays particular attention to the aspects of gender and ethnic diversity. It has supported women's health by issuing guidelines to strengthen public policy on breastfeeding—for example, by providing support to working mothers who are nursing. Specific materials have also been developed to help improve the quality of food among indigenous populations.

Lessons learned

Significant progress has been made in reducing salt, fats, trans fat, sugar, and caloric sweeteners in processed foods, and in increasing physical activity in schools and the workplace.

The National Agreement provided a platform for establishing a fruitful relationship with the food and beverage industry, which resulted in the following achievements:

- Gradual reduction of sugar, sodium, and saturated fats in processed food;
- Elimination of trans fats of industrial origins;
- Reduction of portion sizes offered in processed foods and restaurants;
- Underwriting of international commitments to limit advertising that targets children (Code PABI); and
- Joint efforts to provide better information through product labels that enable consumers to make better decisions about their health and food choices.

Development of the National Agreement allowed for the implementation of important mechanisms and tools for intersectoral action, which were key to negotiating important achievements such as the regulation of food and beverages and their distribution, marketing, and advertising. Private sector participation is central because of the need to modify food and beverage products through new regulations and/or voluntary agreements when no new rules are adopted.

This experience has highlighted the importance of partnerships to facilitate changes in sectors other than health. One example is the need for school and work environments to offer healthier alternatives to students and workers. Further research is still needed to identify the key causes and factors, as well as the potential solutions to the problem obesity and overweight.

Data have indicated that populations in vulnerable conditions, who are disproportionally affected by this public health challenge and have limited access to health services, have exhibited the greatest improvements in terms of food availability and access, lifestyles, and income. This suggests that the action taken under this Agreement could reduce their likelihood of developing health problems.

Challenges and facilitating factors

Some of the factors that facilitated the drafting and implementation of this Agreement include the promotion of this policy at the highest political level, the main stakeholders' recognition of the importance and scope of the problem, the existence of an economic impact analysis that more clearly outlined the potential consequences of the problem, and incorporation of the social determinants of health approach in the framework of the Agreement and planning.

Some of the main challenges, on the other hand, include insufficient budget, uncertainty about the continuity of activities in the event of political changes at the federal level, weak legal and regulatory frameworks, difficulties implementing intersectoral educational and public awareness campaigns, lack of mechanisms to increase civil society participation, and lack of an evaluation plan to demonstrate the impact and results of the integrated intersectoral effort of the initiative as a whole.

Evaluation and dissemination of results

Even though no formal evaluation of the initiative has been conducted, some components have been evaluated, and the results show that:

- 80% of companies that advertise their products in the media have joined the Advertising Self-Regulation Code for Food and Non-Alcoholic Beverages (PABI) targeting children. As a result, 41% of the industry's ads currently promote healthy life styles;

- the General Guidelines for Delivery and Distribution of Food and Beverages in Basic Education School Buildings have successfully been issued;

- 98% of primary and secondary schools currently include physical activity in their curriculum;

- 78% of basic education schools have access to drinking water;

- the creation of a website allows the government to publish a list of products that meet the established nutritional criteria; almost 2,000 products are currently registered; and

- educational materials have been developed, including guidelines for physical activity, school lunch manuals for parents (16 million copies), and a manual for hygiene in food preparation at schools (250,000 copies).

Conclusions of case study 5

This is the first time in Mexico that a public health policy has set out to address the challenges of overweight and obesity from a multifactorial perspective and adopted mechanisms and actions that go beyond the scope of the health sector. This experience demonstrates that strong leadership and the adoption of tools and mechanisms for intersectoral action are essential to addressing public health challenges and that, similarly, they can facilitate the mobilization of resources toward a common goal. The sustainability of the initiative has been improved by action not only at the federal level but at the state and local levels as well, and by the issuing of key standards and regulations that apply to a variety of sectors.

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Additional resources

For more information about this initiative published in periodic health reports, reviews of the evidence, web portals, social networks and special campaigns through electronic media, visit: www.promocion.salud.gob.mx/dgps/interior1/programas/acuerdo_nacional.html.

Conclusions

As the international community strives to address growing health and social inequalities and other international development goals, the need for a Post-2015 Development Agenda has become more and more evident. The discussion around the Post-2015 Development Agenda comes at a time when sustainable development is at the political forefront, and health is increasingly recognized as a key element and prerequisite for development.

Framing the Post-2015 Development Agenda requires an examination of the past, a full understanding of the current situation and challenges, and a vision for the future. Nowadays, there is greater recognition of the need to focus on the means, as well as the ends: health as a human right; health equity; equality of opportunity; global agreements; stronger, more resilient health systems; innovation and efficiency as a response to financial constraints; and addressing the social determinants of health.

HiAP offers a comprehensive framework and practical response to these issues through a multisectoral approach with an understanding of the wider policy-making, economic, cultural, and political contexts. It also provides strategies, tools, and mechanisms to support more coordinated action and better relationships among sectors to contribute to the achievement of positive public health and societal outcomes.

Countries worldwide have adopted the HiAP approach to varying degrees and demonstrated its potential to create meaningful changes in policies and structures. The case studies presented here offer examples of best practices in how HiAP can contribute to the achievement of health goals while at the same time contributing to other non-health sector goals and improved governance for health.

How countries design their policies and the quality of the intersectoral action established will be key to determining the future of global and local policies. As we move toward defining the Post-2015 Development Agenda, the HiAP approach is as important as ever.

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