

# Summary of Experiences from the Americas

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



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











## INTRODUCTION

There is broad consensus that no sector of government can successfully reach its goals without the participation of other sectors. The Health in All Policies (HiAP) initiative is based on a whole-of-government approach. Working together and across sectors is not only more effective, but also a prerequisite to further improve the health and well-being of our communities at the national, regional and global levels.

Acting alone, the health sector cannot achieve universal health coverage and secure the well-being of communities. These goals require coordinated action by and between governments, health professionals and other social and economic sectors and groups, voluntary organizations, local authorities, industry, the media, and society as a whole. Intersectoral action is needed to reduce health inequities. The High Level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases (2011) endorsed multisectoral approaches, leading many countries to pursue strategies with a Health in All Policies focus.

Intersectoral action is not a new concept in the health sector. In 1978, the Alma Ata Declaration is clear that a multisectoral approach is essential to achieving Health for All. Similarly, the 1986 Ottawa Charter defined health promotion as “the process of enabling people to increase control over, and to improve, their health.” According to the Charter, health promotion—which focuses on achieving equity in health—is “not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being.”

Renewed advocacy is required to solidify a paradigm shift towards more inclusive governance. The health sector will require



retooling and leadership reform to build capacity for meaningful interactions with other sectors. Health in all Policies will continue to be a priority on the Post 2015 development agenda. Our challenge is to frame global problems by stressing not only the importance of health as a driver of change across all social and economic circumstances, but also the consequences of social and economic development for health. If we frame the challenges for sustainable development by involving all sectors of society working together in an aligned, 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 health inequities and ensure the well-being of all members of society, within a construct that places people at the center of sustainable development.

The Pan American Health Organization/World Health Organization (PAHO/WHO) recently created the Special Program on Sustainable Development and Health Equity (SDE) at the level of the Assistant Director (AD). By grouping issues such as social determinants of health, health promotion, the unfinished agenda of the Millennium Development Goals, and the Post 2015 agenda, the program will help Member States develop the capacity to successfully implement whole-of-government approaches.

Let us continue our efforts to secure societies free of inequality, where people have access to healthy social determinants and environments that allow them to live long, dignified, healthy, and productive lives.



## Summary of experiences from the Americas

This report presents 25 case studies from 15 countries of the Americas—and one from the government of Andalucía, Spain—that were selected and prepared by the ministries of health of the Region. While they reflect varying degrees of adherence to the criteria established for Health in All Policies, each case study raises key issues that should be taken into account in the Framework for Country Action. The case studies are presented in alphabetical order by country.

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# Health in All Policies

## A summary of experiences from the Americas

The Pan American Health Organization/World Health Organization—in conjunction with its national offices and the Ministries of the Region—designed an instrument to gather and systematize experiences with intersectoral action at the national, state or departmental, and local levels. A template was designed to identify initiatives that incorporate aspects of the Health in All Policies approach based on the following criteria:

1. Political commitment. The initiative has clear political support at the highest level (it was launched by the president or subnational equivalent).
2. Separate structure. The initiative has a formal, intersectoral operational structure.
3. Separate budget. The initiative has its own operating budget.
4. Participation of other sectors. Other sectors besides health are explicitly committed to participating in the initiative.
5. There is an explicit commitment to reduce inequity in health.
6. Evidence of results. There is scientific evidence of the initiative's impact.
7. Social participation. The initiative includes mechanisms for social and community participation.



Based on these criteria, and the work from the ministries of health, SDE with a PAHO/WHO consultant, assembled a team of reviewers to identify and systematically evaluate 25 cases from 15 countries.<sup>1</sup> The review included a program presented by the government of Andalucía, Spain that, while not from the Region of the Americas, offered valuable input on the topic. While several of the cases presented in this report do not meet all of the criteria for Health in All Policies outlined above, they are relevant examples of intersectoral collaboration to address health challenges outside the traditional scope of the health sector. Most of the case studies describe programs and initiatives at the national or state/departmental levels, although several present interesting local and municipal experiences. In addition to a political commitment at the highest level of government, the latter underscore the importance of municipal and local engagement, since it is at this level that policy integration and synergies between social stakeholders contribute to effective intersectoral collaboration.

Health in All Policies (HiAP) is premised on intersectoral collaboration to address issues that impact health but fall outside the purview of the traditional health sector. The Region's wealth of experience in implementing primary care strategies has shown just how crucial this collaboration is for 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."<sup>1</sup> Accordingly, 52% of the experiences presented in this report include primary health care in their design and implementation.

The selected case studies were evaluated based on the four levels of intersectoral collaboration described in *Moving Forward to Equity in Health* (2009),<sup>2</sup> an adaptation of Evert Meijers work on policy integration.<sup>3</sup>

(1) **Information exchange.** Each sector shares available information about a specific problem or a potential initiative in order to develop a common language for joint efforts. Several of the case studies reflect this level of intersectoral action, one example being Bolivia's Puntos Vida ("Life Points") program.

(2) **Cooperation.** After sharing information, the relevant sectors develop a strategy for cooperation on a particular issue or initiative requiring joint action. This type of cooperation usually occurs in the implementation phase and the programs do not have a shared budget. Most of the cases presented in this report reflect this level of intersectoral action. For example, the Office of the Attorney General of Chihuahua, Mexico, promoted intersectoral collaboration on violence prevention. Similarly, El Salvador presented its experience with the Intersectoral Health Commission (CISALUD) as an example of cooperation and coordination. Created in 2009, CISALUD's structure includes a Policy Committee and a Technical Committee. The Policy Committee is chaired by the Minister of Health and has representatives from over 35 government agencies and civil society organizations, while the Technical Committee brings together technical professionals from public, private, and international cooperation agencies.



1. Epidemiology and Community Health. 2009. Primary health care and the social determinants of health: essential and complementary approaches for reducing Inequities in health. Rasanathan K.1, Villar Montesinos E, Matheson D, Etienne C, Evans T. Journal of Epidemiology and Community Health 2010. Doi:10.1136/jech.2009.093914.

2. Moving Forward to Equity in Health What kind of intersectoral action is needed? An approach to an intersectoral typology. Partnership and Intersectoral Action. Solar, O, Valentine N, Rice M, Albrecht D. Conference Working Document. Seventh Global Conference on Health Promotion, "Promoting Health and Development: Closing the Implementation Gap," Nairobi, Kenya, 26-30 October 2009.

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

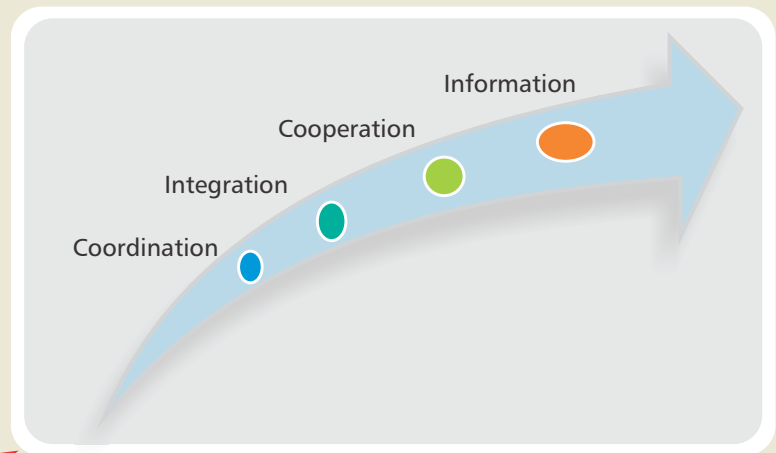


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(3) **Coordination.** In addition to sharing information, relevant stakeholders from each sector work together to develop strategies and mechanisms for inter-institutional coordination to address a particular issue. In contrast to the cooperation level, these initiatives usually have a shared budget and are designed and/or implemented jointly. Many of the cases presented in this report reflect this level of intersectoral action. In particular, the Bolsa Familia (Family Grants) and Brasil sem Miséria (Brazil without Misery) programs reflect a high level of coordination, as do local experiences such as the Healthy Municipalities Network of Pernambuco, also from Brazil.

(4) **Integration.** At this level, new policies mandate an intersectoral approach, including an integrated budget. Although few of the cases presented in this report fall into this category, one example is Ecuador's National Plan for Good Living. The plan coordinates public policy on management and expenditure at the national and subnational levels, with the goals of achieving equality and social justice; recognizing and valuing the knowledge and lifestyles of different peoples and cultures; reducing inequity; and satisfying people's basic needs.





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With support from the Rockefeller Foundation, PAHO/WHO is systematically analyzing intersectoral approaches in the Region through the lens of “health in all policies,” a concept that was originally developed in Europe under Finland's leadership. The Alma Ata Declaration (1978) and the Ottawa Charter (1986) express a solid commitment to intersectoral action. Despite this, the impact of specific intersectoral experiences has yet to be documented systematically. The Region of the Americas lacks a theoretical framework for examining the efficacy of intersectoral action at the program level or for determining what type of intersectoral actions have been undertaken in the prevention and mitigation of communicable and noncommunicable diseases. Similarly, little or no research has been done on the type and level of intersectoral collaboration required to address social determinants of health and make progress in reducing health inequities.

The Region therefore saw the need to develop a framework for evaluating experiences of intersectoral collaboration in health and tailoring Health in All Policies to the regional context. PAHO/WHO assembled a team to conduct a literature review of regional initiatives. The review included scientific journals with unrestricted access, taking into account all articles published in English, Spanish and Portuguese since the Ottawa Charter (1986). The team also reviewed grey literature such as more recent articles that, while not yet published, discussed initiatives and experiences that contributed to understanding the nature of intersectoral approaches specifically in the Americas.

The literature was divided into two categories:

- (1) Articles that contributed to understanding the concept of “Health in All Policies” as it applies to the Region, and
- (2) Articles describing experiences with intersectoral collaboration.

In conjunction with the team of reviewers, PAHO/WHO developed three working hypotheses for its study of intersectoral efforts in the Region:

- (1) There is a correlation between the purpose of a particular program or public policy and the intensity of intersectoral collaboration. For example, a country might adopt an intersectoral approach to a particular disease—e.g. dengue or cholera—in order to share information and coordinate activities to reduce incidence in a specific at-risk population.
- (2) Factors such as an initiative's organizational structure, management, evaluation, and financing influence the nature and outcomes of intersectoral actions. For example, one of the criteria for identifying initiatives that incorporate aspects of Health in All Policies is clear political will at the highest level that reflects a shared commitment among all sectors (integrated management). In this way, the planning and implementation of the initiative—including administration, operations, and financing—is integrated from the outset with a view to reducing inequities in health.
- (3) There is a connection between the type of intersectoral work and the work seen at the country level with that particular country's focus on the health sector associated with the public health approach, both within the health sector, as well as with 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 the objective is to reduce 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.



Representatives from the areas of health promotion and social determinants from 30 Member States participated in the Regional Planning Meeting for the 8th Global Conference on Health Promotion held on 25-27 February, 2013, in Brasilia, under the auspices of Brazil's Ministry of Health. After examining the Framework of National Action of Health in All Policies proposed by WHO, an operational definition of Health in All Policies for the region was drafted:

Health in All Policies is a government strategy that requires a shift in public policy to ensure coherent and coordinated planning and implementation among different government sectors and levels of decision-making. The strategy is premised on achieving equity and guaranteeing the right to health. HiAP generates synergies to advance the well-being of the population in a sustained and sustainable manner.

The Region of the Americas specifically stressed that:

- HiAP is not merely a set of multisectoral or intersectoral actions, but rather a conscious decision to systematically evaluate the impact of integrated policies and actions on people's health and well-being. HiAP is not just a technical matter; instead, and more importantly, it requires political commitment at the highest level.
- HiAP does not impose a health agenda on other sectors. Rather, it is a means of striking a balance in order to avoid a duplication of efforts and strengthen actions in each sector.
- Civil society must be involved in decision-making and resource allocation in order to ensure buy-in and enhance the credibility of HiAP. For that reason, the government must promote the participation of all individuals and make a special effort to include traditionally marginalized and disadvantaged groups.

The case studies presented in this report showcase several experiences related to the Health in All Policies approach that demonstrate how intersectoral collaboration can have a positive impact on people's health and well-being. They are promising examples of how governments can partner with the relevant stakeholders to develop public policies that ensure efficient service delivery and the effective use of resources to address persistent inequalities in health.



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## HEALTH IN ALL POLICIES IN THE AMERICAS

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**Pan American  
Health  
Organization**



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



Cuarirenda community  
in Charagua  
municipality,  
Santa Cruz,  
**Bolivia**

Bolivia presented two case studies. The first, Faces, Voices, and Places, is a local development and health initiative that was implemented in three countries of the Guaraní region of the Great South American Chaco. It is presented from the Bolivian perspective. With its focus on living conditions in communities as a social determinant of health, this initiative highlights the importance of community buy-in. While it enjoyed political backing at the national, subnational, and community levels, this commitment was confined to the health sector. The initiative is an example of intersectoral action at the cooperation level.

The second case study describes a health information and communications effort. Puntos Vida (Life Points) raises awareness about the potential for reducing the risk of noncommunicable diseases. Local residents are involved as co-participants who take responsibility for their own health. It does not, however, reflect the same degree of co-responsibility observed in some of the other case studies. At best, this is a case of intersectoral action at the information level.



## Technical Cooperation among Countries (TCC): Faces, Voices, and Places Initiative in the Bolivian Chaco

The Faces, Voices, and Places (FVP) Initiative was carried out in the Bolivian Chaco region from 2009 to 2011. Promoted by the Pan American Health Organization, this regional initiative helps middle-income countries reduce inequality in their poorest areas and strengthens citizenship through shared responsibilities and a rights-based approach. It also promotes intersectoral and interagency action with a view to reaching the Millennium Development Goals (MDGs). Besides implementing activities at the community level, FVP has developed a training plan on health, the environment, food security, and health and nutrition surveillance. Based on a study conducted in the border region of Argentina, Brazil, and Paraguay, the initiative stressed the need to strengthen local coordination around joint health strategies to ensure that public health measures reach the entire population. National and local agencies collaborated on an intersectoral plan that stressed active local participation. PAHO/WHO provided technical cooperation for programs in maternal and child health, malnutrition, and neglected infectious diseases (e.g. prevention of Chagas disease, control of soil-transmitted helminths, and rabies prevention in dogs), as well as for initiatives to improve water quality and strengthen food security by establishing cooperatives and planting orchards.





While Faces, Voices, and Places does not meet all of the established criteria, it has certain characteristics that are relevant for Health in All Policies, such as:

**Political commitment.** Although FVP might not have enjoyed political commitment at the highest levels, it had national support from the Ministry of Health and Sports as well as local authorities.

**Separate structure.** The initiative did not have a separate operational structure. However, an intersectoral mechanism was established to implement a national policy, with significant support from international cooperation agencies.

**Separate budget.** While the initiative did not have a separate budget allocation, it was financed by PAHO/WHO and national counterparts provided human resources.

**Participation of other sectors.** In addition to the national Ministry of Health and Sports, the local health services and other sectors supported the FVP initiative. For example, the departmental Health Services Office (SEDES) in Santa Cruz carried out education, prevention, and assessment activities through its programs on maternal and child health, malnutrition and Chagas disease, among others. Gabriel René Moreno University (UAGRM) conducted school-based de-worming under the auspices of the autonomous government of Santa Cruz. Other institutions provided technical support for the establishment of family orchards and for poultry production. Charagua municipality monitored water quality with technical assistance from PAHO/WHO.

**Focus on reducing inequity.** The Faces, Voices, and Places initiative's goal of reducing inequity was reflected in its selection of target communities and its focus on addressing the needs of indigenous populations.

**Commitment from other sectors.** FVP entailed interactions between the local health, food safety, and animal health authorities, coordination with departmental authorities, and national supervision. The initiative contributed to the development of public policies that impact health by improving coordination and collaboration with local communities on health care and promotion. As a result, SEDES technical teams have considered spearheading departmental and national actions to improve inter- and intra-institutional coordination for efficient health services delivery.

**Evidence of results.** There is scientific evidence of the results of the FVP initiative. SEDES reported positive outcomes. FVP brought the target communities to the attention of local and departmental health authorities, highlighting their needs for basic health and sanitation to reduce morbidity and mortality. It raised awareness among local residents about the importance of active community participation. FVP empowered women in particular by establishing a poultry cooperative and increasing the number of families involved in poultry production. Finally, the FVP initiative included a program to treat school-age children for parasites.

**Social participation.** The FVP initiative conducted surveys to identify needs for food, health, and sanitation. Its activities reflected close coordination with community leaders and respect for their traditions and cultures.



Bolivia



## Puntos Vida Life Points

Puntos Vida is a community information service designed to raise awareness about risk factors such as smoking, alcohol abuse, poor diet, overweight, and a sedentary lifestyle. It set up mobile information tents in public gathering places such as bus terminals. Visitors to the tents were offered free screening for blood pressure, weight, body mass index and given information on noncommunicable diseases. Launched in La Paz, to date Puntos Vida has installed over 60 tents throughout the country, including in rural areas.



While Puntos Vida does not meet all of the established criteria, it has certain characteristics that are relevant for Health in All Policies, such as:

- Political commitment.** Although it lacks high level political commitment outside of the health sector, the Ministry of Health and Departmental Health Services Office (SEDES) has supported the Puntos Vida program, which is coordinated by the Lions Club.
- Separate structure.** Puntos Vida does not have a separate structure. The Lions Club introduced the program to SEDES in La Paz. SEDES, in turn, integrated the program into its work plan, scaling it up to nine departments throughout the country.
- Separate budget.** Puntos Vida has its own funding. International cooperation agencies, including PAHO/WHO, provided resources for logistical support. The Lions Club and several universities made staff available to provide services in the tents and assisted with printed materials. SEDES and the Ministry of Health committed financial resources and assisted with the procurement of tents and other logistical aspects.
- Participation of other sectors.** There is no evidence that entities outside the health sector are participating in this program. However, various stakeholders within the health sector are involved and others—such as the Bolivian police department—are brought in to assist as necessary. The Lions Club originally steered the program and was later joined by universities, SEDES, the Ministry of Health, scientific societies, and other social organizations.

## Puntos Vida (Life points)

- Focus on reducing inequity.** Puntos Vida seeks to reduce inequities by targeting populations in urban and certain rural areas that generally do not have access to health related information. It erected mobile tents in public spaces near underserved areas.
- Intersectoral action.** While the program is not designed as an intersectoral effort, some departments—including Cochabamba and Santa Cruz—created inter-agency committees for its implementation. In other departments, Puntos Vida relies exclusively on the SEDES or Bolivian police department.
- Public policy.** The program is not involved in policy-making on health. While no changes in policy were observed, many SEDES have incorporated the program into their work plans.
- Evidence of results.** While monitoring was conducted, the case study offers no scientific evidence of the program's results. Preliminary results relate to the demand for the program on the part of institutions and communities. Wherever the tents are set up, there are long lines of people waiting to receive information and primary care services. Additional resources are required to undertake a thorough evaluation at the national level.
- Social participation.** Local engagement is limited to local residents lining up to receive information and primary care services.





Brazil

Brazil presented eight case studies. One of them, Programa Bolsa Familia (PBF, for its Portuguese acronym), meets all the criteria established for Health in All Policies. This program is an example of intersectoral action at the coordination level. The National Tobacco Control program is an experience in building consensus among sectors around a national policy initiative. Four programs illustrate the importance of creating networks at the sub-national level: the Health in Schools Program in Florianopolis; the Pernambuco Healthy Municipalities Network; the Life in Transit program in five cities; and the Illuminar Network. All of these programs are examples of intersectoral action at the coordination level for implementation of Health in All Policies. Another program, In the Radio Waves, empowers communities to take care of their health by broadcasting discussions on specific topics. In this case, intersectoral action occurs at the level of information sharing. A solid program that enjoys high level municipal support and reflects intersectoral action at the coordination level is the Programa Ambientes Verdes e Saudáveis – PAVS (Green and Healthy Environments Program).



## Programa Bolsa Familia – PBF Family Grants Program

Programa Bolsa Familia aims to reduce poverty through direct cash transfers to families in order to fight hunger and promote food security. It attaches specific conditionality to family grants in order to reduce the intergenerational aspects of poverty. It also helps promote and increase families' access to health, social welfare, education, and social assistance networks.





### Programa Bolsa Familia meets the criteria for a Health in All Policies initiative.

**Political commitment.** The PBF enjoys political commitment at the highest levels of the executive and legislative branches. Established by law in 2004, the Ministry of Social Development and Fight Against Hunger (MDS) is responsible for implementing the program at all levels of government (national, federal, and municipal), in coordination with the relevant national ministries.

**Separate structure.** PBF has its own structure. A management council (CGPBF by its Spanish acronym), which operates under the MDS, is responsible for policy-making; establishes guidelines, standards, and procedures; and acts as the conduit for the institutional integration of policies that strengthen beneficiary families. The CGPBF is comprised of the heads of social development, education, health, and planning, and the chief of the Civil House, among others. It also includes representatives of federal, state and municipal administrations, along with the private sector and NGOs. In 2009, an intergovernmental, intersectoral forum for the management of conditionalities was established, comprised of representatives from SENARC, MDS, and the social assistance, continuing education, literacy, diversity, and health care areas.

**Separate budget.** PBF has its own budget. Under Article 195 of the Constitution, policies to support social security are financed with resources from the three levels of Government. In addition, Decree No. 1605/95 stipulates resource allocations for social assistance programs, in addition to contributions from the private sector and nongovernmental organizations (NGOs).

**Participation of other sectors.** Other relevant sectors besides health are involved in this initiative. Different sectors supervise compliance with specific

### Bolsa Familia Program (BFP)

conditionalities under their purview, working through national ministries and state and municipal agencies (social assistance, education, and health). The private sector and NGOs also assist the program with specific activities.

**Focus on reducing inequity.** PBF seeks to reduce inequities in health. The program serves families living in extreme poverty. Through cash transfers, BFP boosts the human capital of families and offers them greater opportunity for development. It increases human and social capital by establishing conditionality related to education and health and the dissemination of information on access to public services.

**Intersectoral action.** The CGPBF meets on a regular basis and has created working groups to address specific issues, conditionalities, and/or indicators.

**Public policy.** PBF contributes to public policy-making for health. After six years of implementation, the program identified the need to strengthen the comprehensive family health component by including men's and aging adult health, neither of which was in the original plan. The program also prompted changes in the Ministry of Health (principles, programs, policies, projects, strategies, instruments, and actions) intended to shift the focus to reducing health inequities.

**Evidence of results.** There is scientific evidence of the PBF's results. Studies and process and impact evaluations (both internal and external) have been conducted, leading to the adaptation and adjustment of the program. PBF has had a tangible impact on reducing poverty and inequity, and has contributed to the fulfillment of some of the Millennium Development Goals. The PBF's most significant results include: (1) an increase in the number of clinical visits by pregnant women; (2) a 14.1% increase in full term births; (3) improved child nutrition; (4) a 47.6% decline in infant mortality over the past ten years; (5) declining fertility rates (from 2.38 to 1.90); (6) reduction in low height-for-age, from 13.5% to 6.8%; (7) increases in maternal schooling, purchasing power, basic health care, and access to vaccinations. Each of the 13.4 million families served in 2012 received an average of BRL 120.66 (for a total of BRL 1,624,325,445 or 0.46% of the GDP).

**Social participation.** While participation in policy-making and implementation is limited, public oversight of the program ensures accountability, since the public sector and civil society representatives are involved in the evaluation process. Beneficiary families are also required to participate through shared responsibilities, as part of compliance with the conditionalities.



## Pernambuco Healthy Municipalities Network

The Pernambuco Healthy Municipalities Network follows the model of PAHO's Healthy Municipalities Initiative. Each municipality pledges to adopt a "healthy action" or a "healthy municipality plan" and to create a cadre of university-trained health promoters. The government is responsible for distributing the network across 23 municipalities. It also offers technical courses on demand, organizes activities, and drafts health plans in a participatory process. The University of Pernambuco offers courses designed specifically for municipal health promoters. Also referred to as local "intersectoral agents," these promoters help to ensure that interventions are sustainable. The purpose of the network is to reduce inequalities in health—by fostering equity, social justice, cooperation and a sense of well-being—and to disseminate and promote intersectoral health activities in the participating municipalities.





### This program meets the criteria for Health in All Policies.

✦ **Political commitment.** There is political commitment at the highest level of the Pernambuco state government.

✦ **Separate structure.** The network's General Management Committee is comprised of the University of Pernambuco, the State Ministry of Planning and Management (SEPLAG), and municipal representatives (two local managers and civil society representatives). SEPLAG coordinates an intersectoral commission made up of all of the state secretariats.

✦ **Separate budget.** The network has its own budget. The state's multi-year budget plan includes allocations for the annual meetings of municipal directors and for regular visits and technical monitoring of local activities. The university has also allocated resources for systematic monitoring and the municipalities make additional contributions as needed.

✦ **Participation of other sectors.** Other sectors besides health participate in the network. It brings together local communities, municipal managers, and municipal health promoters (volunteers with cross-sector training). The network also includes the University of Pernambuco, SEPLAG, and the Intersectoral Commission, along with government social action programs, Health in Schools, other health agencies, arts programs, and planning sectors.

## ✦ Pernambuco Healthy Municipalities Network

✦ **Focus on reducing inequity.** The network has a strong gender component. It promotes women's empowerment through domestic violence prevention, training in handicrafts production, the establishment of cooperatives, etc.

✦ **Intersectoral action.** The network's management structure includes representatives from different sectors with the aim of promoting effective public health policy. Regular meetings are held to enhance the network's visibility and provide a forum for intersectoral interaction. The Network's General Management Committee is currently being reactivated with municipal representatives. It operates with a holistic approach at the state and municipal levels.

✦ **Public policy.** The network develops public policies that impact health. There is a focal point for each sector in every municipality. Intersectoral dialogue among institutions such as the University of Pernambuco and SEPLAG facilitates this process. For example, the network develops and implements General Participatory Health Plans at the municipal level that include an intersectoral approach to health promotion.

✦ **Evidence of results.** There is scientific evidence of the results. The network conducts qualitative assessments on quality of life and social capital. An evaluation of the work of municipal health promoters (2008) characterized this initiative as innovative and intersectoral, with documented activities and demonstrated competencies. Other assessments are currently underway with a view to the institutional integration of the strategy.

✦ **Social participation.** The network is premised on active social participation. Following an assessment of social capital, a municipal health promoters program was designed including university certification and support.





## 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.







### The National Tobacco Control Policy meets the criteria for Health in All Policies.

**Political commitment.** There is political commitment to this policy at the highest levels. The Ministry of Health and the National Cancer Institute are responsible for implementing the policy pursuant to a presidential pledge to tackle this challenge.

**Separate structure.** A structure has been established for implementation of the National Tobacco Control Policy. The National Cancer Institute serves as Executive Secretariat of the National Commission for Implementation of the Framework Convention on Tobacco Control (CONICQ), chaired by the Minister of Health. CONICQ is comprised of high level representatives from 18 government sectors (Ministries of Health, Foreign Affairs, Finance, Planning, Agriculture, Justice, Education, Labor and Employment, Development, Industry and Trade, Agrarian Development, Communications, the Environment, and Science and Technology; the Civil House; and the Secretariats for Women's Affairs, Drug Policy, Human Rights, and the Health Surveillance Secretariat).

**Separate budget.** A budget has been allocated for implementing the policy. It is funded through the national budget for implementation of the Framework. All members of CONICQ also contribute financial resources.

**Participation of other sectors.** Other sectors besides health are involved in this initiative, including the ministries and agencies represented on CONICQ. The Ministry of Finance develops and spearheads efforts to combat the illegal tobacco market. The Ministry of Justice focuses on illicit drugs. The Ministry of Agrarian Development designs national crop diversification programs. The National Health Surveillance Secretariat regulates the contents of

tobacco products. The National Cancer Institute works with state and municipal health secretariats on implementation of smoking cessation treatment programs as well as educational and awareness raising activities.

**Focus on reducing inequity.** The policy seeks to reduce inequity. While it serves the entire population, both smokers and non-smokers, it includes activities targeted specifically to women, children and adolescents.

**Intersectoral action.** CONICQ advises the Brazilian Government on policy-making to ensure compliance with the Framework Convention and regulate tobacco sales. A coordinated intersectoral agenda is required to meet the criteria set out in the Convention.

**Public policy.** This initiative helps develop public policy that impacts health. The government ratified the Framework Convention on Tobacco Control in 2005 and, in 2006, issued a decree regulating its application. Specific actions included raising the cigarette tax to reduce tobacco use among young people.

**Evidence of results.** There is scientific evidence of the results of this policy. Surveillance includes the following: VIGITEL monitors the prevalence and distribution of risk and protective factors for noncommunicable diseases (NCD) in the capitals of Brazil's 26 states and in the Federal District through telephone interviews with the adult population; special smoking surveys (PETab) have been developed to assess the use of tobacco products among children under age 15; the International Tobacco Control Policy Evaluation Project (ICT Project)—the first international study on tobacco use—was carried out in the second half of 2012 to evaluate tobacco policy and its impact. Ministry of Health publications report outcomes on a regular basis.

**Social participation.** Mechanisms for citizen participation are included in policy design, implementation, and evaluation. The participating agencies promote continuing education for health professionals, carry out awareness-raising activities for government managers, and offer public seminars on the main topics covered under the Convention.





## Programa Ambientes Verdes e Saudáveis – PAVS Green and Healthy Environments Program Integrating public policies in the city of São Paulo

PAVS' holistic approach integrates environmental issues in health promotion and activities to improve quality of life under the Programa Saúde da Família – PSF (Family Health Program) in São Paulo municipality. PAVS strengthens intersectoral policy management at the local level by providing training and skills-building opportunities to some 7,000 community health and social protection agents. It promotes community projects based on local strengths and needs.





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



PAVS meets many of the criteria under Health in All Policies.

**Political commitment.** Although it does not reflect a political commitment at the highest levels of government PAVS enjoys the strong support and leadership of the Municipal Health Secretariat of São Paulo.

**Separate structure.** The Municipal Secretariat of Green Spaces and the Environment (SVMA) launched this initiative. Several national and international entities are involved in its implementation: Ministry of Health of Brazil, PAHO/WHO, UNEP, University of São Paulo, FLACSO, FIOCRUZ, the Municipal Secretariats of Environment, Health, Social Assistance, and Development, and twelve partners from the Municipal Health Secretariat that participated in the National Family Health Program (PSF). PAVS' Board of Directors was established in the first phase of the program and includes representatives from several of these entities. The original project has now been converted into a program under the Municipal Health Secretariat.

**Separate budget.** PAVS has its own budget. SVMA, the Ministry of Health/Municipal Health Secretariat, and UNEP provided funding for the planning and training phase. PAVS is currently funded through the municipality under the PSF umbrella.

**Participation of other sectors.** Other sectors besides health are involved in this program. The municipal Secretariats of Health, Environment, Education, and Social Assistance all collaborate under the umbrella of the Family Health Program (PSF). The Secretary of Urban Infrastructure and Services (waste management and other utilities) as well as the subprefectures also provide support for the program.

**Focus on reducing inequity.** São Paulo faces enormous challenges in tackling the effects of social exclusion and inequality on urban and human development. As part of PSF, PAVS operates in high-risk, vulnerable areas.

**Intersectoral action.** PAVS was created to address the lack of coordination among different policies and to develop an environmental management strategy with community participation. It has strengthened an intersectoral approach within the PSF program by stressing health promotion and raising public awareness about environmental issues that can contribute to better health.

**Public policy.** Although PAVS is not involved in the design of public policies that impact health, it raises public awareness about environmental issues that can contribute to better health.

**Evidence of results.** There is scientific evidence of the program's results. PAVS developed its own set of outcome indicators. Families have changed their behaviors and incorporated new environmental practices into their daily lives, including growing their own fruits and vegetables and improving their dietary habits. More than 1,400 projects have been carried out based on this environmental health approach. Some of these have been completed, while others are still in progress.

**Social participation.** Neighborhood, merchant and entrepreneurs associations participate in the program, along with environmental NGOs. They play an important role in supporting and implementing program evaluations. PAVS socio-environmental projects are designed and implemented based on surveys conducted by health agents with community participation.



## Health in School Program

The Health in Schools Program acts on the social determinants of health by incorporating topics such as hygiene, alcoholism and sexual education into school curricula. The program offers skills-building and training activities (workshops, seminars, discussion forums) to educators, teenagers, and parents, encouraging them to become health promoters and create a multiplier effect in their communities.





The Health in Schools program meets many of the criteria for Health in All Policies.

📌 **Political commitment.** Political commitment is limited to the municipal health and education secretariats in Florianopolis, which coordinate the program.

📌 **Separate structure.** An inter-institutional working group includes the state and municipal education and health secretariats. In its initial phase, the program placed an outreach coordinator in each school and in the health center.

📌 **Separate budget.** The Health in Schools Program has its own budget, which is funded by the federal government.

📌 **Participation of other sectors.** The program is a joint effort of the health and education sectors.

📌 **Focus on reducing inequity.** The Health in Schools Program aims to reduce inequity by promoting free and universal access to health services for vulnerable groups and by serving 100% of children enrolled in basic education.

📌 **Intersectoral action.** The Health in Schools program is carried out pursuant to an intersectoral policy. The Social Welfare Secretariat handles cases of students

who experience learning difficulties due to domestic violence or neglect. The program delivers workshops to the school community in order to design a joint health agenda for health care and promotion and lifelong learning that will be followed throughout the school year.

📌 **Public policy.** The program contributes to public policy-making for health. As a result of the program, the Health Secretariat included vision screening in its school health care policy. The Education Secretariat improved the school meals program by prohibiting the sale of unhealthy lunches in schools.

📌 **Evidence of results.** Although scientific evidence is not available, the program developed an indicator to monitor progress in compliance with the school-based health agenda including the number of students who access primary health care services in schools.

📌 **Social participation.** The program sponsors two forums annually to foster youth participation and activism. It also holds workshops and meetings in schools to promote local community involvement (parents' associations, unions, local health boards of health, and so forth).





## Vida no Trânsito Life in Transit

### Intersectoral action as a strategy for reducing road traffic injuries

In 2010 the Ministry of Health, with support from PAHO/WHO, launched the Life in Transit initiative in five Brazilian cities. This national initiative promotes health and a culture of peace on public roadways through training and awareness seminars and specific activities to prevent road traffic injuries and deaths. It created opportunities for intersectoral collaboration and coordination. In Belo Horizonte, the program delivered three workshops with relevant stakeholders to review the data and develop, adopt and implement an Action Plan. Life in Transit involved federal, state and municipal governments, coordinated joint actions, and prioritized collaborative efforts to identify risk factors for road traffic injuries. Based on the findings, the initiative created working groups for specific population sectors like young drivers, passengers, and pedestrians, and to study factors such as alcohol and driving, and speed.





Life in Transit meets many of the criteria established under Health in All Policies.

**Political commitment.** Life in Transit enjoys political commitment at the highest levels. The Ministry of Health supports the initiative at the national and local levels, as does the Belo Horizonte, Minas Gerais Transit Company (BHTRANS).

**Separate structure.** A National Committee on Mobilization for Health, Safety and Peace on Public Roadways coordinates the Life in Transit strategy. Comprised of the Ministries of Health, Cities (Urban development), Justice, Transportation, and Education, the National Committee is responsible for conducting assessments that promote joint, cross-sector road safety strategies. A local inter-institutional commission includes representatives from the Health and Education Secretariats, BHTRANS, DETRAN, the Municipal Guard, and the Municipal Council on health, among others. As a complement to the work of the National Committee, the Intersectoral Commission for Control and Prevention of Traffic Accidents was created in 2004 with representatives of the executive branch, universities, and civil society, among others.

**Separate budget.** Although it lacks its own funding, Life in Transit receives financial support from the municipal health secretariat and BHTRANS. All of the participating institutions allocate a portion of their budget to this initiative.

**Participation of other sectors.** Other sectors along with health participate in Life in Transit. At the

## The intersectorality as a strategy for reducing morbidity from traffic accidents

municipal level, the initiative offers learning activities in public schools and includes driver education in school curricula. The Municipal Guard is responsible for traffic operations and control. The state Social Defense Secretariat designs public education campaigns on alcohol consumption. The Transit Department of Minas Gerais maintains a database on road traffic collisions and examines risk factors. The military police of Minas Gerais is a member of the local inter-institutional commission and, with BHTRANS, conducts data management and monitoring. PAHO/WHO provides advisory services to the Ministry of Health and the local government, while international NGOs offer consulting services and financial support. Some of the main unions offer political backing and are involved in coordinating the initiative.

**Focus on reducing inequity.** While it does not directly address inequity, Life in Transit included a study on particularly vulnerable groups such as youth, motorcyclists, and pedestrians, and developed specific activities for them.

**Intersectoral action.** The initiative reflects effective intersectoral action, particularly in generating data on road traffic collisions and in joint planning of activities to reduce road traffic mortality.

**Public policy.** Life in Transit contributes to public policies that impact health. For example, as a result of this initiative, school curriculums have been adapted to include training and awareness activities on the use of public roadways in order to prevent road traffic collisions and promote a culture of peace.

**Evidence of results.** There is scientific evidence of the results of Life in Transit. The initiative monitors risk factors and at-risk groups on a quarterly basis and its internal evaluations are used as the basis for adapting activities and programs. The Federal University of Minas Gerais and Johns Hopkins University have performed external evaluations. The BHTRANS database feeds the Mortality Information System and hospitalization registries in the Single Health System. These data show that the mortality declined from 2.36 to 1.52 per 10,000 vehicles between 2009 and 2011, while the number of road traffic collisions dropped from 3,076 to 2,852 in that same period.

**Social participation.** This is ensured through the local councils and municipal health forums and is reflected in local action plans.



Municipality of  
Campinas,  
State of São Paulo,  
Brazil



## Red Illuminar Illuminar Network






Created in 2001, Red Illuminar aims to reduce levels of violence, especially sexual violence, in the municipality. It delivers training to health professionals, the National Guard, and teachers in the municipal school system, and holds seminars on violence prevention and a culture of peace. Its intersectoral approach is based on an understanding of violence as a public health issue with multiple causes rather than just a legal or criminal matter. The network fosters collaboration among the health, education, public security, and social welfare sectors, along with civil society and universities. It offers comprehensive care for victims—with the goal of delivering care within 72 hours of an act of violence—and provides support services for children, teenagers and men. It works through teams of professionals to help break the cycle of violence and create a safe environment for victims.











### Red Illuminar meets the criteria established under Health in All Policies.

-  **Political commitment.** It enjoys a political commitment at the highest levels of Campinas municipality and the state of São Paulo.
-  **Separate structure.** Red Illuminar is an inter-institutional and intersectoral committee that operates as a network and meets on a bimonthly basis.
-  **Separate budget.** Red Illuminar has its own funding. The network received start-up funding for training and procurement of equipment. The Ministry of Health allocates funding to the network for equipment, training, educational materials, and communications (videos, brochures, etc.). The network does not require additional resources, since its goal is to implement public policy by improving coordination among existing services.
-  **Participation of other sectors.** Other sectors besides health are involved in this initiative, including the municipal secretariats for health, social assistance, education, public safety, transportation, and women's affairs. Universities such as PUC and UNICAMP are part of the network, along with NGOs, advocates of girls and women's rights, social movements and public safety agencies.
-  **Focus on reducing inequity.** While the initiative serves the population as a whole, its priority is women

and girls in situations of vulnerability with regard to gender-related violence and/or sexual, domestic, or emotional abuse.

-  **Intersectoral action.** Intersectoral policies and actions, as well as the support of federal, state and municipal services, are critical to the network's ability to provide physical and mental health care and social services to women and girls as well as to male victims of violence.
-  **Public policy.** Red Illuminar contributes to the design of public policies for health. There has been a tangible paradigm shift towards addressing violence from the standpoint of public health rather than as a matter exclusively under the purview of the police and legal system. The network has contributed to the production of information and the implementation of public policies to address situations of violence. A network based approach facilitated the integration of additional care and protective services for the population served.
-  **Evidence of results.** Red Illuminar has an internal evaluation process in place that includes bi-monthly monitoring. External evaluations include technical visits to the network's health professionals and target areas.
-  **Social participation.** Two members of the municipal health council are involved in planning activities and designing health surveillance objectives.



## On the Radio Waves: health communication on AMORB/FM Community Radio

On the Radio Waves develops community radio programming to promote public education and awareness on priority health issues, including mental health. It partners with other organizations such as the Federal University of Rio Grande do Sul (UFRGS) and the Conceição Hospital Group (GHC) to offer regular training programs to a wide range of stakeholders including practitioners, students, and other community members.





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



While this program does not meet all of the established criteria, it has certain characteristics that are relevant for Health in All Policies, such as:

**Political commitment.** Although the program cannot be said to have political commitment at the highest level of local government, it has the support of the Municipal Health Secretariat of Porto Alegre and the Federal University of Rio Grande do Sul (UFRGS).

**Separate structure.** The UFRGS sponsors the program. The coordinating committee responsible for planning and programming includes the following institutions: the Schools of Nursing, Dentistry, and Education, the Institute of Philosophy and Human Sciences; Radio AMORB (which holds the community radio franchise and coordinates community outreach), the Hospital Group - GHC (representing community health worker services), and the Health Secretariat of Porto Alegre municipality.

**Separate budget.** Although it does not have a separate budget, the Ministries of Education and Health and the Municipal Health Secretariat include allocations for this program in their budgets.

**Participation of other sectors.** The On the Radio Waves program brings together several different sectors including the Ministries of Health, Culture, and Education.

**Focus on reducing inequity.** Programming reaches vulnerable communities afflicted with high levels of violence and social exclusion. It addresses topics related to mental illness, which are frequently overlooked in the health care system.

**Intersectoral action.** All of the sectors involved collaborate democratically and proactively in planning and implementing project activities. The intersectoral coordinating committee studies and implements program policies, develops radio programming, selects and supervises staff and students, and oversees community outreach.

**Public policy.** According to the information provided, the program does not appear to contribute to public policy-making in health.

**Evidence of results.** While the program did not provide scientific evidence of its results, it reported the following achievements: active community and student participation in the radio programs; integrated action involving the UFRGS, health practitioners and the community (AMORB); and a focus on mental health services users as a reflection of broader socio-cultural inclusion.

**Social participation.** The community radio program was created as a direct result of the interest expressed by organized community sectors, in collaboration with the institutions described earlier. Ongoing dialogue with the community ensured that its design would be responsive to local needs. Public participation has grown as community members have become more actively involved in planning and airing radio shows.





Costa Rica

Costa Rica presented two case studies on childhood nutrition that showcase the traditionally strong alliance between the health and education sectors. The first case study describes the recently issued Executive Order 36910 regulating the sale of sodas and packaged foods in schools in order to improve the diets of elementary and secondary school students. The Executive Order reflects intersectoral information sharing and cooperation around the regulation of food sold in schools. For its part, the Education and Nutrition Center – Integrated Center for Child Health program (CEN-CINAI) focuses on early childhood nutrition and development in low-income communities in part by assisting working mothers. While this program is primarily assistential in nature—as opposed to community participation and empowerment—CEN-CINAI clearly reflects close intersectoral cooperation between the education and health sectors.



## Executive Order 36910 regulating the sale of sodas and packaged foods in schools

In 2012, Costa Rica issued Executive Order 36910 regulating the sale of sodas in schools, in order to reduce the incidence of overweight and obesity in children and young people. Statistics (January 2012) showed that 21.4% of children ages 5 to 12 years and 20.8% of adolescents ages 13 to 19 years were overweight or obese in Costa Rica. Under Executive Order 36910, schools may only sell fresh produce and packaged foods and beverages that meet specific nutritional criteria, such as products that are low in calories and saturated fat. The goal is to reduce cardiovascular disease, diabetes, calcium deficiencies, and tooth decay. The Ministries of Health and Education prepared briefings and other communications materials for students and teachers. The Costa Rican Chamber of the Food Industry (CACIA) challenged the constitutionality of the Executive Order, claiming it interfered with freedom of commerce, among other rights. The Constitutional Court rejected the challenge, allowing Executive Order 36910 to enter into force.



While Executive Order 36910 does not meet all of the established criteria, it has certain characteristics that are relevant for Health in All Policies, such as:

- Political commitment.** Signed by both the Ministers of Education and Health, Executive Order 36910 enjoys political commitment at the highest levels.
- Separate structure.** The Executive Order does not create a separate structure. The Ministries of Health and Education are responsible for monitoring implementation and compliance is mandatory for all companies that provide school meals.
- Separate budget.** The Executive Order does not require a separate budget. Regulated products are available for sale to schoolchildren. The Ministry of Health funds school lunches for underprivileged children through its Education and Nutrition Centers (CEN-CINAI). The Executive Order does not require the creation of a separate office or department.
- Participation of other sectors.** The health and education sectors coordinate implementation of the Executive Order. An Advisory Board created by Office of the Dean of Medicine of the University of Costa Rica—which includes the Schools of Medicine, Nutrition, Nursing, and Public Health—will design research projects to study the results and impact of the Executive Order. The Office of the Attorney General defended the Executive Order against an unconstitutionality suit brought by the private sector.
- Focus on reducing inequity.** The Executive Order does not directly seek to reduce inequities insofar as it applies equally to the student population in all public and private schools.
- Intersectoral action.** Implementation of the Executive Order requires the coordinated efforts of the health and education sectors.
- Public policy.** The decree stipulates that only fresh foods and processed foods that meets specific nutritional requirements can be sold in schools.
- Evidence of results.** While no specific evaluation mechanisms were developed under the Executive Order, national nutrition surveys will be used to evaluate its impact. The Ministry of Health and the National Institute for Health Sciences Research (INCIENCIA) conduct periodic surveys, the Ministry of Health conducts surveys every ten years, and INCIENCIA conducts annual surveys. The next round of surveys should reflect the impact of the Executive Order.
- Social participation.** While the Executive Order entails no active social participation, the Ministries of Health and Education launched joint media campaigns to raise public awareness and encourage public support for the Executive Order.



Costa Rica



## Dirección Nacional de Centros de Educación y Nutrición y de Centros Infantiles de Atención Integral – CEN-CINAI Education and Nutrition Centers – Integrated Center for Child Health Program

This national program aims to improve the nutrition of participating mothers and children and enhance children's potential for development as a means of lifting them out of poverty and vulnerability. The program offers assistance in the areas of nutrition, child care, and child protection services, and promotes the growth and development of children up to age 13. Its activities are designed to support working mothers.



### CEN-CINAI meets many of criteria of Health in All Policies, such as:

- Political commitment.** Since 1970, the government of Costa Rica has enacted several laws to strengthen the program's operations and financing.
- Separate structure.** Under Law No. 8809 (2010), the National Office for Education and Nutrition, which has regional and local offices, is responsible for implementing this program.
- Separate budget.** Law No. 8809 (2010) converted the program into an office under the Ministry of Health and granted it operational autonomy. The program is financed through national budget allocations in the health category. The Fund for Social Development and Assignments (FODESAF), which reports to the Ministry of Labor and Social Security, also supports the initiative.
- Participation of other sectors.** Other sectors in addition to health are involved in this program. The Ministry of Education is responsible for designing the centers' integrated programs. CEN-CINAI collaborating agencies include: the Joint Institute for Social Assistance (IMAS); the National Office for Community Development; Community Development and Welfare Association the National Kindergarten Board; municipal governments; the Social Security Department, the National Institute for Women; the Costa Rican Institute of Sports and Recreation; the National Learning Institute; the National Institute on Alcoholism and Drug Abuse; and the National Network on Domestic Violence.

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

**Focus on reducing inequity.** The program serves pregnant and nursing mothers and at-risk children to foster social assimilation and set them on a path towards becoming healthy, contributing citizens.

**Intersectoral action.** The health and education sectors are actively involved in the centers, along with other relevant agencies and service-providers. The centers' curriculum is enriched by activities sponsored by other ministries, including the "Bibliobús" and "Grow with music" programs and awareness-raising campaigns like "Teaching without hitting."

**Public policy.** The CEN-CINAI program contributes to public policies that impact health. A 1955 Executive Order created a Nutrition Department under the Ministry of Health. Since then, the Legislative Assembly has enacted two laws relevant to the program: Law No. 5662 – Social Fund for Development and Family Allowances (1974) and Law No. 8809 (2010), which converted the program into an office under the Ministry of Health and granted it operational autonomy.

**Evidence of results.** There is scientific evidence of the program's results. The Ministry of Health conducts internal evaluations, and the Ministry of Labor and Comptroller General of the Republic conduct external evaluations and audits of CEN-CINAI. The audits look at completion of planned activities, impact on coverage levels, and improvements in child health and bio-psycho-social development). While the results of these audits are currently being reviewed, by the end of 2011, the program was operating 624 centers serving 125,030 beneficiaries.

**Social participation.** Communities hold assemblies to form local Community Development and Welfare Associations (ADEC) to support CEN-CINAI's centers. These community representatives are involved in local program implementation. In some communities, networks of government institutions have been set up to coordinate efforts to meet local needs.



## Health promotion as a strategy of health programs – Single Health System

The Cuban case study describes the mainstreaming of health promotion following the 1959 Revolution and the country's gradual shift to a social determinants of health approach. Intersectoral action is constitutionally mandated and institutionalized. All of the relevant stakeholders, including community representatives, are involved in the design, implementation, and evaluation of policies and programs. In addition, the National Assembly plays an important role in issuing recommendations, monitoring implementation, and receiving progress reports.

Established in 1960 as an integral part of post revolution reforms, Cuba's Single Health System is rights-based and continuously adapted in response to emerging challenges. The system aims to increase the efficiency and quality of services, ensure sustainability, and generate research that can inform efforts to eliminate any remaining inequities in health status and access to services. It is governed by the principles of universal, free, accessible, equitable, and participatory health services.







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



### Health promotion as a strategy of health programs – Single Health System meets the criteria of Health in All Policies.

**Political commitment.** Cuba's health promotion-centered Single Health System enjoys political commitment at the highest levels. It is constitutionally mandated and coordinated by the Ministry of Public Health.

**Separate structure.** With the triumph of the revolution in 1959, the country instituted political, economic and social reforms—particularly in the health and education sectors—to improve people's living conditions. The Health Commission of the National Assembly of the Popular Power (Parliament) promotes public policies, guidelines, and regulations to achieve health objectives. Health councils were established at the national, provincial, municipal, and local levels to implement policies and actions. The councils include representatives from all central government agencies, non-governmental organizations, religious institutions, and others.

**Separate budget.** The health system has its own budget, which includes allocations from each participating agency. Communities participate actively in local volunteer activities.

**Participation of other sectors.** Sectors other than health participate in the Single Health System. The Ministry of Education trains teachers in health topics to encourage healthy lifestyles. The Cuban Institute of Radio and Television (ICRT) collaborates in the area of

health communication. The Institute of Sports, Physical Education and Recreation (INDER) promotes physical activity and recreation as a means of protecting health and quality of life. The Ministry of Transportation and the National Traffic Control Office work on accident prevention. The Ministry of Agriculture prioritizes food production to improve diets. Finally, Civil Defense is responsible for emergency and disaster response.

**Focus on reducing inequity.** The system is accessible to the entire Cuban population, with special emphasis on vulnerable groups and disadvantaged communities.

**Intersectoral action.** It is premised on intersectoral action involving all of the agencies mentioned above.

**Public policy.** The system develops public policies that impact health. Policies are reviewed periodically and modified as needed, based on the social determinants of health they are intended to address. For example, in the area of internal trade, there are regulations governing the sale of tobacco and alcohol to minors. The education sector prohibits smoking on school grounds; conducts circles of interest (dialogues on topics such as sexual and reproductive health, first aid, addiction and violence prevention, safe food handling, etc.). Trade unions are involved in activities to protect worker health and safety. The agriculture sector sets priorities for crop production. And the Ministry of Culture bans smoking in theaters, cinemas, art galleries, and other public cultural venues.

**Evidence of results.** Programs are held accountable through community assemblies to evaluate health activities. The Ministry of Public Health has established internal control mechanisms, internal and external audits, and procedures to address public grievances and recommendations. The government conducts systematic research on the health situation and designs strategies and action plans based on the findings. Scientific evidence is obtained through studies of behavioral changes as a result of prevention and control activities, evaluations of the main indicators for health, mortality and morbidity, and national surveys on risk factors.

**Social participation.** The health system coordinates with social organizations like the Federation of Cuban women (FMC), the Committee for the Defense of the Revolution (CDR), and the National Association of Small Farmers (ANAP).



**Boca de Mao,  
Dominican Republic**



## Faces, Voices and Places Initiative based on the Food Security and Nutrition (FSN) concept: sustainable human development in Boca de Mao

The case study from Boca de Mao is an example of how the Health in All Policies approach can be implemented on a smaller, local scale. As this and other experiences have shown, local intersectoral action can occur at the coordination level and contributes to the participatory aspect of the HiAP framework. This experience faces the challenge of ensuring sustainability and commitment at higher levels of government. Nonetheless, it has proven effective in modifying behaviors and empowering communities to become active agents in improving their own health.

The Pan American Health Organization's Faces, Voices and Places (FVP) initiative was carried out in the Boca de Mao region of the Dominican Republic. This regional initiative helps middle-income countries reduce inequality in their poorest areas and strengthens citizenship through shared responsibilities and a rights-based approach. It also promotes intersectoral and interagency action with a view to reaching the Millennium Development Goals (MDGs). Besides implementing activities at the community level, FVP has developed a training plan on health, the environment, food security, and health and nutrition surveillance. This initiative was developed based on the needs identified by the community, primarily in the areas of sanitation, hygiene, living conditions, and food production.



This program meets many of the criteria of Health in All Policies, such as:

- Political commitment.** While it may not enjoy political commitment at the highest levels of the local government, the Local Council for Sustainable Human Development (LCSHD) coordinates the program and the community is actively involved.
- Separate structure.** The program does not have a separate structure. The LCSHD coordinates the program. The Ministry of Health has set up a Community Health Committee to implement health promotion and disease prevention activities. Committee members are part of the LCSHD.
- Separate budget.** The program has its own budget, which is funded by the institutions belonging to the LCSHD and by allocations from the City Council. The Local Council also raises its own resources.
- Participation of other sectors.** In addition to the health sector, the LCSHD includes representatives from the community and neighborhood associations, the municipal authorities, the agricultural and education sectors, PAHO/WHO, and the Institute of Nutrition of Central America and Panama (INCAP).
- Focus on reducing inequity.** The program serves rural agricultural workers, including a large population of Haitian immigrants. The region is considered dengue- and malaria-endemic. Among other activities, the program acts on the social gradient in health by: (1) distributing free medicine; (2) setting up community
  - laboratories for water testing; (3) distributing homemade water filters; (4) conducting nutritional monitoring; (5) monitoring HIV-positive individuals; (6) providing chlorine production equipment; and (7) implementing the zero garbage program.
- Intersectoral action.** The Ministries of Agriculture, Health and Education work together to mount an integrated response to the needs of this border population. Intersectoral action occurs at the level of the LCSHD, which operates across social and political sectors in Valverde province, channels the needs expressed by the population, and brings together governmental and nongovernmental agencies to address those needs.
- Public policy.** The Council sponsors Well-Being Week, which is now included in the annual municipal budget. This event includes a local clean-up day to raise awareness on the importance of environmental hygiene. The municipality also distributed plastic throughout the district.
- Evidence of results.** There is scientific evidence of the program's results and an evaluation has been scheduled for 2013. Preliminary data show that cholera has been contained, maternal deaths have been eliminated, dengue-related deaths have been reduced, and the quality of life of people living with HIV has improved. The LCSHD, partnering with Ministry of Agriculture and PAHO/WHO, planned and implemented a local community garden program. INCAP's efforts have enhanced its credibility and boosted the community's confidence in its ability to take joint action against potential threats to food security caused by rising food prices.
- Social participation.** The LCSHD includes representatives from local and grassroots organizations including the neighborhood association. The public participates in open council meetings, advocacy efforts, health fairs, Well-being Week, and food fairs. The program is developing two information systems for water quality monitoring and nutritional surveillance in vulnerable groups.



Ecuador

Ecuador's National Plan for Good Living (2009-2013) is a solid example of intersectoral action at the integration level and meets all the criteria for Health in All Policies. The national plan takes a whole-of-government approach that includes health. The government has restructured public institutions and created coordinating ministries. NPGL redefines the government's role in social policy and establishes targets for equity and redistribution from a rights-based perspective. The policy enjoys the highest level of political commitment from the Executive Branch and the legislature adopted a new national constitution that creates a framework for the national plan. NPGL promotes active civil society engagement at all levels. It provides opportunities for dialogue to make sure that activities are tailored to local needs and to encourage buy-in on the part of different stakeholders.



## Plan Nacional para el Buen Vivir National Plan for Good Living – NPGL

Ecuador's "National Plan of Good Living 2007-2010" (NPGL) sets out public policies that impact health. It is an example of HiAP that enjoys constitutional and presidential backing. The NPGL aims to reduce inequality gaps and address people's basic needs based on a new vision of the role of government in social policy and management. It calls for inclusive, multicultural and sustainable development, promoting a new way of understanding growth, participation, and the distribution of benefits. Development is defined broadly—beyond the quantitative margins of an economic lens—as an inclusive, sustainable and democratic economic strategy. By coordinating action among different sectors and levels of government, NPGL creates economies of scale and supports efficient resource allocation and intersectoral work. It also strengthens the participatory design of development plans at the national and local level. Civil society involvement throughout the process (planning, design, implementation and evaluation) and a budget allocation from the central government contribute to its sustainability. From 2006 to 2011, when the Program was implemented, public investment in agriculture doubled and social investments increased 2.5 times; the proportion of urban homes with toilets and sewage systems increased from 71% to 78%; rural homes with access to waste collection services increased from 22% to 37%; and health appointments in the public service sector increased by 2.6 per 100 inhabitants. NPGL has become the road map for social policy-making and implementation in Ecuador. Based on the National Plan, regional and local governments develop their own plans tailored to local priorities and needs. The NPGL also guides the design of sector-specific work plans, including health. The goals of each sector must be aligned with the plan, which is premised on a social determinants of health approach and the comprehensive definition of health suggested by the concept of "good living."



### NPGL meets the criteria for Health in All Policies.

**Political commitment.** NPGL has the highest level of political commitment, beginning with the president. Created through a constitutional reform that mandates a comprehensive approach to governance, the plan is coordinated by the National Secretariat for Planning and Development (SENPLADES).

**Separate structure.** The National Planning Council (an intersectoral, professional body) serves as the technical secretariat. The NPGL operates at the central, regional, provincial, and local levels.

**Separate budget.** The NPGL has its own budget, with national government allocations to all of the institutions involved. The plan provides the strategic vision for all public policies and governmental actions.

**Participation of other sectors.** The NPGL involves every sector and level of government. The Coordinating Ministry of Social Development, which supervises the Ministries of Health, Labor, Education, Economic and Social Inclusion, Migration, and Housing, is responsible for meeting health targets.

**Focus on reducing inequity.** The NPGL focuses on reducing inequality. It promotes the redistribution of the benefits of development and takes into account the country's multicultural composition by tailoring regional development plans to local conditions.

**Intersectoral action.** Under the leadership of SENPLADES, and in conjunction with the other coordinating ministries, the NPGL supervises the work plans of the relevant ministries. Regional authorities develop provincial development plans. Intersectoral action is built into the design and implementation of programs and activities at all levels of government.

**Public policy.** Under the NPGL, sector-specific work plans, including health, must set goals aligned with the national strategy's social determinants of health approach. The concept of "good living" includes a broad definition of health that requires the involvement of different sectors.

**Evidence of results.** There is scientific evidence of the impact of the NPGL. Since this is a recent program, no formal evaluations were submitted. However, the NPGL established a baseline for monitoring. From 2006 to 2011—the period of the National Development Program, which was the platform for the NPGL—the gap between the urban rich and poor dropped by 10 percentage points. At the same time, public investment doubled, social investment increased 2.5 times; agricultural credits was doubled; the percentage of urban homes with toilets and sewage systems rose from 71% to 78%; the percentage of rural homes with access to garbage collection services rose from 22% to 37%; investment in justice grew fifteen times; and health visits to public service providers increased to 2.6 per 100 inhabitants.

**Social participation.** Opportunities for public participation are incorporated into the planning, design, implementation, and evaluation of all activities under the NPLG. Public oversight mechanisms are in place at the central and local levels and include focus groups and opportunities for consultation and consensus-building. Community representatives participate in the design of local development plans.





El Salvador

The Intersectoral Health Commission (CISALUD, for its Spanish acronym) of El Salvador offers another important example of intersectoral action at the coordination level. The Commission brings together the relevant sectors to decide on recommendations that are later implemented by the agencies in each sector. In this case study, a new structure was created to act on social determinants of health, in the conviction that the health sector cannot accomplish this on its own.



## Comisión Intersectorial de Salud – CISALUD Intersectoral Health Commission

Created in the context of El Salvador's 2009 health reform, CISALUD is an intersectoral forum that has adopted a social determinants approach to inequities in health among population groups caused by: inequitable distribution of health problems; lack of access to public health services; impact of elevated health costs on the family economy; lack of information on health inequities among different population groups; and the failure to identify health issues that may require interventions from other sectors besides health.





## CISALUD meets the criteria for Health in All Policies.

**Political commitment.** CISALUD enjoys political commitment from the highest levels. Created by presidential decree, it is coordinated by the Ministry of Health through its Vice- Ministry of Health Policy.

**Separate structure.** CISALUD has a Policy Committee and a Technical Committee. The Ministry of Health chairs the Policy Committee, which is comprised of the heads of over 35 government ministries and agencies and nongovernmental and civil society organizations. The committee meets monthly to make decisions concerning social determinants and activities to address the challenges identified. The Technical Committee includes technical professionals from government institutions and cooperation agencies. Chaired by the Vice-Minister of Health Policies, it meets on a monthly basis to formulate recommendations for actions by the Commission.

**Separate budget.** CISALUD does not have its own budget for committee meetings. Each institution involved is responsible for financing, according to its means, the activities to be implemented pursuant to the Commission's decisions.

**Participation of other sectors.** CISALUD is a forum for intersectoral dialogue. It involves a range of sectors and stakeholders in conducting assessments and developing recommendations for action, including: education, defense, foreign affairs, public security, finance, work, agriculture, public works, environment, tourism, FOSALUD, ISRI, COSAM, National Civilian Police (PNC), COMURES, COAMSS, ISSS, transportation, DGCP, Institute of Forensic Medicine; Legislative Assembly; ECA; CEL; ANDA;

OIRSA; the Consumer Ombudsman; Civil Protection, (CENSALUD).

**Focus on reducing inequity.** While CISALUD's recommendations apply to the population as a whole, they particularly target groups living in extreme poverty or traditionally excluded from decision-making that affects their health, which increases their vulnerability and risk: women, teenagers, groups with different sexual orientations, indigenous peoples, rural communities, etc.

**Intersectoral action.** Every sector is asked to make recommendations for implementing the priority actions under its purview. CISALUD, in turn, identifies specific challenges to be addressed—such as avian flu, cholera, etc.—, their causes, and other associated factors. Actions are identified and included in the intersectoral plans developed by the participating agencies. This strategy has prompted the relevant sectors to implement policy changes that better reflect the health impact of their actions. CISALUD has also developed guidelines for policies and norms, as well as for other technical and legal instruments that strengthen health promotion initiatives.

**Public policy.** CISALUD contributes to policies that impact health based on a holistic vision of health challenges. For example, CISALUD designed the Integrated Plan to Fight Dengue which was launched in 2010. Its five strategic lines include: (1) implement a management system for municipal, departmental, regional and national plans; (2) develop social, community and institutional communications systems; (3) implement environmental controls; (4) strengthen clinical management of dengue; and (5) strengthen epidemiological surveillance. El Salvador's national health policy, "Construyendo la Esperanza" (Building hope), includes reorganizing the national health system around an intersectoral approach to primary health care.

**Evidence of results.** No scientific evidence was presented of CISALUD's results. However, its members are accountable to their respective institutions and to CISALUD for all activities carried out pursuant to the Commission's decisions.

**Social participation.** CISALUD sponsors public consultations with the support of the National Health Forum, which is made up of community leaders, nongovernmental organizations, the national university and other academic institutions.



Tajumulco,  
Guatemala

Guatemala's Pacto Hambre Cero (Zero Hunger Pact) in Tajumulco municipality is a good example of how a national policy can be successfully implemented at the local level. The case study describes intersectoral cooperation to address a specific goal. The program aims to improve the availability and accessibility of nutritious foods for all children, but with a focus on the most vulnerable municipalities with the highest malnutrition rates.



## Pacto Hambre Cero Zero Hunger Pact Healthy Municipalities Strategy




Created in 2012 by presidential decree, the Zero Hunger Pact aims to reduce malnutrition rates in the country by 10% in four years. The program's health care and education components are designed to break the cycle of poverty and create better opportunities for families, with a focus on groups living in poverty and extreme poverty. The municipal government of Tajumulco formally adopted the healthy municipalities strategy and designed and implemented a local health plan to address social determinants of health in alignment with the Zero Hunger Pact.











### The Zero Hunger Pact meets the criteria for Health in All Policies.


-  **Political commitment.** Created by a presidential decree, the Pact enjoys political commitment at the highest levels of government.
-  **Separate structure.** The National System for Food and Nutritional Security (SINASAN) was established under the Office of the Vice President of the Republic. It is comprised of the National Council for Food Security and Nutrition (CONASAN)—an inter-ministerial body that includes nongovernmental and private sector entities—, the Secretariat for Food and Nutritional Security (SESAN), the Social Consultation and Participation Forum (INCOPAS), and the Group of Supporting Institutions (GIA). An Inter-agency Technical Committee was established as a national supervisory body with experts from the Ministries of Environment, Health, Education, and Agriculture, international cooperation agencies (PAHO/WHO, GIZ, UNDP, USAID), and key associations (National Association of Municipalities). At the local level, Tajumulco has set up a Municipal Commission on Health, Food Security and Nutrition (COMUSSAN) to coordinate implementation of the Zero Hunger Pact. The City Council, represented by the councilmember for health, chairs the Commission and provides legal backing for its activities.
-  **Separate budget.** CONASAN member institutions include food security activities in their budgets. By presidential decree, the Ministry of Finance's general budget must include an allocation of at least 0.5% for food security and nutrition programs. The Municipal Health Plan also includes budget allocations for these activities.


-  **Participation of other sectors.** In addition to the sectors represented on the Inter-agency Technical Committee, the Zero Hunger Pact is linked to family benefits programs such as Ventana de los Mil Días, and Triangulo de la Dignidad.

-  **Focus on reducing inequity.** In its initial stage, the Zero Hunger Pact targets municipalities most affected by chronic and acute malnutrition. Municipal plans tailor activities to the needs in each region. The target municipalities present high rates of extreme poverty and children with chronic malnutrition, a problem that affects 49% of children under age five nationally.

-  **Intersectoral action.** COMUSSAN serves as the vehicle for intersectoral action at the municipal level. The Secretariat for Food and Nutritional Security (SESAN) establishes operational mechanisms for implementation of the national action plan with the participation of the relevant government agencies, national and international cooperation agencies, the private sector, and civil society. The overarching objective of the intersectoral plan is to ensure healthy living conditions for people, especially in relation to access to food.

-  **Public policy.** The Zero Hunger Pact contributes to public policies that impact health. The health sector coordinates the efforts of SESAN and the municipality to strengthen COMUSSAN and to design a municipal health plan based on social determinants of health. COMUSSAN, in turn, has identified policies and regulations that need to be updated (solid waste management, trails, construction) and its plan includes proposals for actions by municipal authorities.

-  **Evidence of results.** The Zero Hunger Pact is a relatively new program that has yet to generate scientific evidence of its results. It has identified preliminary successes including the speed at which municipalities formally integrated the program into the Healthy Municipalities Strategy for implementation.

-  **Social participation.** Community participation is a cross-cutting aspect of the national strategy. At the local level, it plays a key role in identifying needs and facilitating community-based activities. Community representatives were actively involved in implementing the plan for health, food security and nutrition.



Haiti



The Haitian Ministry of Health spearheaded the Strategy to Promote Health and Quality of Life in the Fight against Cholera in Haiti with support from the international community. This program grew out of the destruction and health challenges caused by the 2010 earthquake that devastated the island. An example of intersectoral action at the information sharing and cooperation levels, this strategy provides education and training to promote public awareness and community participation and empowerment to control the epidemic.

## Strategy to promote health and quality of life in the fight against cholera in Haiti

With support from UNASUR, the Haitian Ministry of Health partnered with Doctors of the World, an international nongovernmental organization, to educate the public on cholera prevention and emergency response in the wake of the 2010 earthquake. The program delivered training to 450 people in community networks and rural grassroots organizations on health promotion, social determinants of health, and public surveillance. It held workshops for local authorities and networks, agrarian workers, and women and developed materials for community outreach and for the media.



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



### The Strategy meets many of the criteria of Health in All Policies, such as:

**Political commitment.** The strategy does not enjoy political commitment at the highest levels. Doctors of the World is the lead agency and the strategy is implemented with support from PAHO/WHO and UNASUR and in coordination with the Bureau of Water and Sanitation Management (DINEPA) of the Ministry of Public Health and Population (MSPP).

**Separate structure.** The strategy created a Local Forum on Collective Health and Quality of Life as a participatory, multi-stakeholder assembly that makes decisions by consensus.

**Separate budget.** The strategy is implemented with resources from UNASUR.

**Participation of other sectors.** The strategy involves authorities from different sectors, NGOs, and community networks and local organizations. Municipal districts, local promoters and grassroots organizations helped set up the community forums and develop preventive and promotional radio messages, among other activities. DINEPA provided materials and participated in all of the activities carried out under the strategy.

**Focus on reducing inequity.** The cholera epidemic is strongest in and around the informal settlements of people who were displaced by the 2010 earthquake and therefore the program targets the most impoverished and vulnerable groups.

**Intersectoral action.** While the intervention is implemented through the health sector, Doctors without Borders sponsors intersectoral forums on health and quality of life for a range of stakeholders (international and grassroots organizations, NGOs, churches, local governments, and the MSPP).

**Public policy.** Doctors without Borders carried out integrated monitoring of health and sanitation through house-to-house visits in four stages: (1) establish a relationship with the family and describe the situation; (2) conduct the community epidemiological survey and identify social determinants; (3) focus on rights promotion and identifying determinants of cholera and water and sanitation problems; and (4) foster prevention, protection, and care through distribution of cholera prevention kits put together by the communities themselves.

**Evidence of results.** While no scientific evidence was provided, monitoring and evaluation has been ongoing throughout the implementation process. An internal evaluation process involves direct participation from local stakeholders and a critical analysis matrix is used to track opportunities, progress, setbacks, threats and problems. Reports are submitted to various entities.

**Social participation.** Rural community networks of grassroots and women's organizations have mobilized. They have held community-government assemblies for every 50 households to carry out needs assessments and identify priorities for action. The results are reported back to the municipality and the national MSPP.





## Honduras

The Honduran case study described the negotiation process and content of the Special Tobacco Control Law regulating tobacco production, distribution, marketing, imports, consumption, and advertising. An inter-institutional structure was created to negotiate and draft the language of the law. While this process was an example of intersectoral cooperation, it will be important to monitor the law's implementation to determine whether this intersectoral approach can be sustained. As is the case in many countries, the law was prompted by international regulations and standards spearheaded by WHO.



## Special Tobacco Control Law

In 2011, Honduras enacted the Special Tobacco Control Law regulating tobacco production, distribution, marketing, imports, consumption, advertising and promotion, and sponsorship, with the goal of reducing and gradually eradicating tobacco use. An inter-agency committee was formed to draft the law and guide it through the enactment process, and educate the public about its provisions.





### The Special Tobacco Control Law meets the criteria for Health in All Policies.

- Political commitment.** The legislature enacted the law, which is supported by a strong presidential mandate. The Honduran Institute for the Prevention of Alcoholism, Drug Addiction and Drug Dependence (IHADFA) is responsible for implementing the law.
- Separate structure.** An inter-agency committee (CONAPROCTA) was formed to draft the law. Coordinated by IHADFA, the committee is comprised of the following institutions: the Honduran Anti-smoking Alliance; National Alliance against Drugs (ANCOD); Action for Tobacco Free Environments (APALTA); Computer Science and Legislative Studies Center of the National Congress (CIEL/CN); the Secretariats of Labor and Social Security (STSS), Finance (SEFIN), and Industry and Trade (SEIC); the National Children's Board (PANI); Honduran Cancer Association; and the National Commission for the Control of Tobacco (CONACTA). The committee designed a two-pronged strategy for enactment: (1) law and policy and (2) dissemination.
- Separate budget.** While no separate budget was allocated for the law itself, each one of the relevant agencies allocates resources for its implementation.
- Participation of other sectors.** In addition to the health sector and the National Congress, other sectors were involved in the law's implementation: Secretariat of Natural Resources and Environment (CERNA); Secretary of industry and Commerce (SIC); Ministry of

Agriculture and Livestock (SAC); Office of the Special Prosecutor for the Environment; National Institute for Women (INAM), National Institute for Heart and Lung Disease, the Autonomous National University of Honduras, Honduras Medical School, and the Natural Resources Office.

- Focus on reducing inequity.** The law is intended to reduce the health gradient between groups and impact communities with high levels of tobacco use.
- Intersectoral action.** The law regulates tobacco marketing, advertising, sales, possession, and use. All of the relevant institutions were involved in drafting the law, whether by providing scientific evidence, engaging in political advocacy, designing and following up on environmental protection policies, or promoting the anti-tobacco law. An inter-agency plan as well as sector- or agency-specific plans were drafted to publicize the law.
- Public policy.** Through their implementation plans, every sector will have an impact on reducing tobacco use, control of tobacco products, and promoting a healthier lifestyle.
- Evidence of results.** The plan includes compiling scientific evidence of the results. An evaluation is currently being designed and IHADFA gathers data on a regular basis through focus groups.
- Social participation.** While no information was provided on civil society's role in the drafting, negotiation and enactment of the law, public participation will play a key role in implementation and compliance.





Chihuahua,  
Mexico



Mexico presented two case studies, one at the subnational and the other at the national level. The Social Violence and Crime Prevention Law enacted in the state of Chihuahua, and its plan of action, is an example of intersectoral cooperation at the regional level. The State Attorney General's Office plays a leading role in tackling crime from a public health perspective, rather than as a purely criminal or legal matter. The National Agreement for Healthy Food—a multi-sector initiative to fight obesity—aims to regulate food products, modify individual behaviors, and promote healthier lifestyles. This is also an example of intersectoral cooperation in which each sector creates its own agenda to address the issue.



## Social violence and crime prevention with citizen participation

The Government of Chihuahua enacted the Social Violence and Crime Prevention Law. The law operates in the context of the National Public Security System, which establishes mechanisms for coordination between the federal government, states, Mexico City, and municipalities for the prevention of social violence and crime. In this approach, a series of public policies, programs and actions are designed to reduce risk factors that promote violence and crime and address their underlying causes. The government of Chihuahua drafted a plan of action in a participatory process that directly involved communities, the education sector, the media, the business sector, the police, and civil society organizations.





## The law and its plan of action meet the requirements for Health in All Policies.

✦ **Political commitment.** The law and its plan of action enjoy a political commitment at the highest levels of the State of Chihuahua. The Executive Branch drafted the bill pursuant to a national mandate and the Legislature enacted Law No. 2012.04.18/No. 31 in 2012.

✦ **Separate structure.** The recently created State Attorney General's Office implements the initiative, which falls under the purview of the State Public Security Council comprised of representatives from all levels of government, the legislature, and civil society, including local universities, parents associations, and entrepreneurs.

✦ **Separate budget.** The program is financed by federal allocations earmarked for security policy. It also receives state and municipal budget allocations and support from civil society organizations.

✦ **Participation of other sectors.** A range of sectors and groups are involved in implementing this initiative, including: state and municipal institutions (regional councils, the National System for Integral Family Development (DIF), addiction treatment centers, institute for women, the secretariats of urban development and ecology, social development, public safety, education and culture; urban services, and civic

## Social violence and crime prevention with citizen participation

associations; neighborhood associations; faith based organizations, the business sector, and the general public.

✦ **Focus on reducing inequity.** While the program focuses primarily on youth, it also targets seniors and children in urban areas, where rising violence is associated with social and geographical inequalities created by urban development, inadequate social integration policy, and the perceived increase in organized crime.

✦ **Intersectoral action.** –The State Center for Violence and Crime is currently drafting a social violence and crime prevention program and plan of action with citizen participation. It will conduct monitoring to ensure that cross-cutting activities in the area of public security are included in all programs established in the 2010-2016 State Plan. The latter includes key sectors that will be responsible for including these activities in the operating programs and budgets. An intersectoral entity has yet to be created by the state secretariats (economy, urban development and ecology, social development, SEDESOL) and municipal secretariats (public safety, citizen services).

✦ **Public policy.** The plan sets out conditions for strengthening the health sector, including eleven strategic objectives related to health that fall under the Ministry of Health's purview related to violence and crime.

✦ **Evidence of results.** The law was recently adopted and as yet there is no scientific evidence of its results.

✦ **Social participation.** Participatory assessments of the social and economic context of violence in participating municipalities informed the collective development municipal plans for prevention and/or intervention. Formal opportunities for public participation include sitting on state and regional councils and committees, as well as civil society organizations, neighborhood associations, and intersectoral roundtables, etc. Informal opportunities include forums, thematic roundtables, and direct interaction with community leaders and the target populations.



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

This agreement aims to reduce the prevalence of overweight and obesity through integrated, intersectoral efforts to change family diets, eating habits, and physical activity levels. Its child-centered strategy for addressing this increasingly serious public health problem includes improving the availability and accessibility of healthy foods and beverages and, promoting regular physical activity. The agreement sets out a comprehensive approach that includes regulating production, marketing, and advertising, and public education to encourage healthy food choices and lifestyles. It has a strong awareness and training component for teachers, health care providers, and other members of the community.







This program meets the criteria for Health in All Policies.

✦ **Political commitment.** The Agreement has political support from the highest levels of the federal government, which appointed the Secretary of Health as the implementing entity.

✦ **Separate structure.** A National Council for the Prevention and Control of Chronic Noncommunicable Diseases (CONACRO) coordinates government activities. The Secretary of Health serves as president of the Council, and the Undersecretary for Disease Prevention and Health Promotion, as vice president. The Secretary of Health appoints a coordinator, and the members include the heads of 15 federal government agencies.

✦ **Separate budget.** Although it does not have its own budget, the Agreement is funded through budget allocations from all the relevant agencies.

✦ **Participation of other sectors.** Participating agencies include: the Secretariats of the Treasury, Social Development, Economy, Education, Labor, and Social Welfare and the Secretariat of Agriculture, Livestock, Rural Development, Fisheries and Food; the Social Security Institute, the Workplace Safety and Social Services divisions; the Office of Innovation and Quality, Office of Administration and Finances; and the National Institutes of Health and High Specialty Regional Hospitals Coordinating Commission, the Federal Commission for Protection against Health Risks, the National Commission on Social Protection in Health, and the National Health Council, all under the Secretariat of Health.

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

✦ **Focus on reducing inequity.** The program mainly addresses prevalence of overweight and obesity in children and tends to focus on low-income populations, where prevalence is higher. It also serves groups such as indigenous communities, nursing mothers, etc.

✦ **Intersectoral action.** The Agreement assigns each government agency specific activities within its sphere of responsibilities, based on 10 objectives: (1) physical activity; (2) pure drinking water; (3) reduced intake of sugar and fat in beverages; (4) consumption of fruits and vegetables, legumes, whole grains, and fiber; (5) appropriate labeling and nutritional literacy; (6) breastfeeding; (7) reduced sugars and sweeteners added to foods; (8) reduced intake of saturated and trans fats; (9) reduced serving sizes; (10) control of salt intake.

✦ **Public policy.** The Secretary of Labor has promoted a law to promote healthy food in the workplace. The Secretary of Education developed a national school-based action plan that promotes physical activity, nutritious food, and nutritional literacy and issued general guidelines for the sale or distribution of food and beverages in schools. The Secretary of Health established guidelines for strengthening public policy related to breastfeeding.

✦ **Evidence of results.** Research showed that 41% of the messages created by 80% of companies that advertise in the media promote healthy lifestyles. The Secretary of Education issued general guidelines for the sale or distribution of food and beverages in schools. A total of 98% of schools include regular physical activity in their curricula and 78% of primary schools provide safe drinking water. The website created to register recommended products based on their nutritional value includes more than 2,850 products that meet nutritional criteria. The Secretariat of Education produced and distributed educational support materials. Schools set up committees with active community participation to promote and monitor actions to ensure the availability of healthy food in schools.

✦ **Social participation.** The initiative encourages active participation through public consultations, formal alliances, and workshops.



Paraguay

Paraguay presented a case study of intersectoral coordination and a whole-of-government approach to address the specific needs of people living in extreme poverty. The National Plan for Food and Nutritional Sovereignty and Security includes policies and actions to address the causes of food insecurity in an integrated, holistic way, going beyond traditional approaches limited to increasing agricultural production. It seeks to overcome existing fragmented efforts through the implementation of a global governance strategy to improve the efficiency of government interventions. Finally it aims to address the underlying problem of unequal distribution of resources.



## Plan Nacional de Soberanía y Seguridad Alimentaria y Nutricional del Paraguay – PLANAL

### National Plan for Food and Nutritional Sovereignty and Security

In 2007, Paraguay launched its National Plan for Food and Nutritional Sovereignty and Security (PLANAL, for its Spanish acronym) to tackle on the challenge of food insecurity, a commitment undertaken at the World Food Summit (Rome, 1996) and reaffirmed in the Millennium Declaration, among others. The Plan includes: (1) development of products and markets in the areas of environmental services, ecotourism, art and crafts, forestry, organic products, and ethno-pharmacology; (2) promotion of agro-product value chains and marketing, including technology and storage systems; food processing and preparation; market development, production management and integral trade; (3) productive and commercial partnerships; (4) a fund to subsidize food production expenses and investments and small industrial infrastructure, and financing to improve access to basic services; (5) promotion of the professionalization of the labor force and comprehensive training and employment promotion for youth, in partnership with the private sector. Programs under PLANAL were implemented with a systemic, comprehensive, territorial, participatory, and intercultural approach at the local, departmental and national levels of government.



## PLANAL meets many of the criteria for Health in All Policies, such as:

- ✦ **Political commitment.** PLANAL enjoys a political commitment at the highest level of national government. The Office of the Presidency of the Republic, through its Social Cabinet, supports and oversees this initiative. The departmental governments and local authorities are also actively involved.
- ✦ **Separate structure.** While it does not have its own structure, the Social Cabinet—which includes representatives from the national Parliament, government ministries and state secretariats, and academia—was strengthened with the appointment of an Executive Secretary and the establishment of a highly trained technical office created to oversee PLANAL at the central level. Two additional levels of participation and consultation were established within the Social Cabinet: the Inter-Institutional Committee and the Public Hearings Office.
- ✦ **Separate budget.** While it does not have its own budget, PLANAL is funded by allocations from the relevant ministries. PLANAL has streamlined the organization and coordination of projects and programs in different sectors to optimize those resources and their impact on families.
- ✦ **Participation of other sectors.** PLANAL is premised on government involvement at the central, departmental, and local levels. Over 30 government agencies and nongovernmental and international institutions are involved: the Technical Planning Secretariat; the Ministries of Agriculture and Livestock, Justice, Labor, Public Health and Social Welfare, Education and Culture, and Finance; the Secretariat of Social Action, the Department of Statistics, Surveys and Censuses; PAHO/WHO; UNICEF; UNDP, AECID, etc. PLANAL also established channels for social participation to gather input from cooperatives, trade unions, and the private sector, indigenous and agrarian organizations, NGOs, and others, through social participation channels.

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

- ✦ **Focus on reducing inequity.** PLANAL works with households living in poverty and vulnerability and identifies indigenous peoples and rural and urban vulnerable populations as priority groups.
- ✦ **Intersectoral action.** PLANAL requires coordination among various sectors of government, the private sector, and civil society stakeholders to reach its objectives. Through effective coordination, it has reduced the fragmentation that hampers governmental development efforts and policy-making. It rationalized public spending by approving budgets for programs selected through a results-based process and strengthened public-private coordination.
- ✦ **Public policy.** Under PLANAL, institutional regulations were modified and new programs were created, and the effectiveness and efficiency of social and nutrition programs improved.
- ✦ **Evidence of results.** PLANAL instituted an Information System and Observatory to facilitate access to information that improves the efficiency of management, evaluation, and decision-making processes related to food and nutrition policy. The Technical Planning Secretariat created a platform to consolidate a national monitoring and evaluation system for PLANAL's interventions nationwide. PLANAL's main accomplishments include: increased comprehensive health coverage; higher demand for financing for community social investment, in particular to improve the food and nutritional sovereignty and security of groups living in extreme poverty in 66 of the poorest districts; a better supply of basic foodstuffs, drinking water, and health training in indigenous communities; improved family diet, diversification through vegetable gardens, better eating habits, and the application of acquired know-how on food and nutrition in everyday life.
- ✦ **Social participation.** The main instrument for achieving PLANAL programs is territorial management. Each municipal government established mechanisms for citizen engagement in the development of strategic land use plans. Citizens are actively engaged in the process through their designated representatives. This participatory planning method strengthened individual and community capacity to follow-up on local plans, which contributes to their sustainability.



## Andalucía, Spain

The Network for Local Action in Health (RELAS, for its Spanish acronym) is an example of the important role local networks play in addressing health issues from various perspectives. While in general RELAS reflects intersectoral action at the coordination level, it also occurs at the integration level in the target municipalities. The mayors, with the support of the Junta de Andalucía, bring together governmental and nongovernmental institutions to tackle issues related to inequity, education, health, labor, and the environment.

## Red de Acción Local en Salud – RELAS Pilot Network for Local Action in Health

Andalucía promoted the concept of Networks for Local Action in Health to strengthen the role of city authorities as public health agents at the local level. Professional health teams from the provincial and city governments worked across sectors, establishing a local pact to tackle issues in the areas of disease prevention and health protection and promotion. The project began with a preliminary assessment of the local health situation using a participatory methodology. Based on the findings, it set priorities for interventions within the local health plan. The assessments considered demographic, socio-economic and environmental data, as well as local health status and resources. The pilot was carried out in nine municipalities that varied in size, type of population, geographical features, and other specific characteristics.



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



### The RELAS Project meets the criteria for Health in All Policies.

- Political commitment.** The RELAS project enjoys political commitment at the highest level. It is framed in the 3rd Health Plan of Andalucía, which calls for local authorities to play an active role in designing their health plans. The Ministry of Health and Social Welfare of Andalucía has endorsed the strategy.
- Separate structure.** Local networks are organized with supervision and technical support from the Government of Andalucía. City mayors are responsible for coordinating the network and involving all relevant sectors.
- Separate budget.** Different sectors contributed resources for the pilot. The central government of Andalucía financed a line of start-up grants for the municipalities and provided funding for technical personnel to provide advisory services at the provincial level (Technicians for Local Action in Health, or TALS by their Spanish acronym).
- Participation of other sectors.** The project brought other sectors on board at the local level, especially those most relevant to health: education, the environment, housing, urban development, employment and equality.
- Focus on reducing inequity.** RELAS addresses inequity through a social determinants of health approach. Some municipalities have focused on inequity by prioritizing health actions in response to the

needs of immigrants, areas with high levels of prostitution, and people with disabilities and dependency.

- Intersectoral action.** All local activities involve intersectoral collaboration between the education, environment, housing, urban development, employment and equality sectors. This was particularly the case in the process of conducting local health assessments.
- Public policy.** The pilot was conducted from 2008 to 2010. Today, RELAS is a consolidated strategy for local action in health in Andalucía. The provincial public health law includes regulations that support its implementation in all cities of Andalucía.
- Evidence of results.** Qualitative studies reflect a shift towards a comprehensive approach to health actions in some municipalities. Activities specifically designed to promote healthy lifestyles and citizen participation have increased. In addition, 70% of the municipalities that participated in the pilot continued the project and consolidated its infrastructure.
- Social participation.** The network is premised on participation. Local residents participate in the needs assessment and in consensus-based priority-setting for health problems and high risk situations in their area. In a second phase, citizens participate in the design of specific actions that will be included in the local health plan, channeling their input through working groups in the local health network.



Suriname



The enactment of the Anti-tobacco law in Suriname is another national example of intersectoral cooperation. Like the other case studies on tobacco legislation, this experience focuses on the negotiation process leading up to the law's enactment. The health sector spearheaded this initiative, bringing together all of the relevant sectors to obtain their input and buy-in. The challenge ahead is to ensure that this intersectoral dialogue continues into the implementation phase.



A Rising Tide lifts all Boats: Forging  
Public-Private Partnerships to Create  
Momentum in the Successful Passage,  
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## Enforcement of Smoke-free Legislation in Suriname

Suriname undertook a collaborative effort involving the three branches of government and other relevant stakeholders to promote the enactment of legislation aligned with the Framework Convention on Tobacco Control (FCTC), which the country ratified in 2008. Following similar successful experiences in countries like Brazil and Uruguay, the health sector took the lead in planning and coordination, aware that it required the backing of other sectors to ensure success. The advocacy effort involved all social sectors and every district throughout the country. The National Assembly passed the anti-tobacco bill in February in a unanimous vote and it was signed into law by President Bouterse on March 6, 2013. The law includes reporting mechanisms, harsh penalties, and intersectoral collaboration for enforcement. The Ministry of Health pushed to include all levels of society in legislative oversight by educating the public on the new rules and their rights as an individual.



### The initiative meets the criteria for Health in All Policies.

**Political commitment.** The political will of key decision-makers was apparent throughout the process. President Desi Bouterse, a known smoker, publicly expressed his support for comprehensive anti-tobacco legislation with adequate enforcement mechanisms. Members of the National Assembly also consistently demonstrated support for this initiative.

**Separate structure.** The Ministry of Health and the Pan American Health Organization initiated and guided this policy initiative. An intersectoral Tobacco Commission comprised of public and private sector representatives was created and approved by the National Assembly. The Tobacco Commission—the first of its kind in Suriname—and the National Assembly became the two formal platforms for this collaborative effort.

**Separate budget.** The country did not provide information on how the law will be funded. It is scheduled to enter into effect in June 2013.

**Participation of other sectors.** This advocacy effort involved a wide array of sectors and institutions, including: PAHO/WHO; the Ministries of Health, Trade and Industry, Justice, Labor, and the Environment; The National Assembly; Anton de Kom University (School of Law for consultation on the bill); sports associations; youth organizations; district commissioners and councils; transportation organizations (bus and taxi drivers); and the Chamber of Commerce.

**Focus on reducing inequity.** The law is intended to protect vulnerable populations from the detrimental effects of secondhand smoke and protect the health of children, employees, and populations in the interior with limited access to information and services.

**Intersectoral action.** Successful passage of the law required intersectoral action by all stakeholders. Intersectoral leadership will be required to promote, implement, and enforce the law.

**Public policy.** The new law was enacted with strong support from all the relevant sectors.

**Evidence of results.** As yet, there is no scientific evidence of the results of this effort. The Tobacco Commission will monitor and evaluate implementation and adherence to the law once it takes effect. The mechanisms established to regulate tobacco have yet to be evaluated since the law will not enter into force until 7 June 2013.

**Social participation.** This advocacy effort engaged multiple sectors of society, including government agencies, the private sector, nongovernmental organizations, civic groups, and the media. Other partners joined the effort spurred by growing momentum in favor of an anti-tobacco law in Suriname. In June 2012, the Ministry of Health organized a massive Anti-Smoking Walk that drew nearly 5,000 participants. This walk played a major role in generating press coverage and raising awareness about the pending legislation and in overcoming resistance from some areas of the public sector and the hospitality industry.





Uruguay



## Mátelo de Sed Kill it with Thirst Anti-dengue Campaign

The case study from Uruguay describes the actions taken to control and reduce the prevalence of dengue in the country. This is a case of intersectoral action at the level of information sharing. While it does not meet many of the criteria to be considered a Health in All Policies approach, it is an example of a successful partnership with the National Movement of Public and Private Health Users (NMPPHU), a nongovernmental organization that addresses public health issues.


The Ministry of Public Health and the municipal government of Montevideo launched an educational campaign on dengue prevention in 2002, after detecting large mosquito populations in vulnerable socio-economic regions. Working through the print media, the campaign placed 75 advertisements in public areas and in public transportation vehicles. The slogan was "Kill the dengue mosquito with thirst." Community workers were trained, brochures were created, and mass media outlets (television, radio, written press) were used to raise awareness in the community as a whole. The National Movement of Public and Private Health Consumers (NMPPHU), a nongovernmental organization, provided telephone assistance to the public.











While the program does not meet all of the established criteria, it has certain characteristics that are relevant for Health in All Policies, such as:


-  **Political commitment.** The campaign did not have a political commitment from the highest level of national government. It did, however, have the support of the Ministry of Public Health, in collaboration with the National Emergency Agency, the Montevideo City Council, and departmental governments.


-  **Separate structure.** The campaign did not have a separate structure. It relied on the government infrastructure for implementation.


-  **Separate budget.** The government did not allocate a separate budget for the campaign. Various departments at the different levels of government provided funds for implementation.

-  **Participation of other sectors.** While the campaign does not involve other sectors besides health, collaboration takes place among the different levels of government. Departmental governments deployed brigades to eliminate larvae and mosquitoes with the available technology. The National Movement of Public and Private Health Users (NMPPHU), an NGO, offered telephone assistance to the public.

-  **Focus on reducing inequity.** The program served socially and economically vulnerable areas with a higher prevalence of dengue in order to reduce the social gradient in health.

-  **Intersectoral action.** While the campaign was not explicitly based on intersectoral action, it involved a partnership between the Ministry of Health, departmental governments, and NMPPHU to disseminate information on dengue prevention.

-  **Public policy.** It is not clear that the campaign contributed to public policies that impact health.

-  **Evidence of results.** The country did not provide scientific evidence of the results of the campaign. In 2011 it implemented an indicators methodology









## Summary of Experiences from the Americas

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