FINAL REPORT

The 1st Global Meeting of the Global Network for Health in All Policies (GNHiAP)

Nakhon Pathom Province, Thailand

2 – 3 October 2017

Reported by
Executive Committee of GNHiAP
Report Date: 15.12.2017

Government of South Australia

NATIONAL HEALTH COMMISSION OFFICE THAILAND

MINISTRY OF SOCIAL AFFAIRS AND HEALTH Finland

THE GRADUATE INSTITUTE GENEVA

GLOBAL HEALTH CENTRE

World Health Organization

Table of Contents

1. Background

The Global Network for Health in All Policies (GNHiAP) is a country-led initiative which was launched by the governments of Sudan, Finland and Thailand, the Province of Québec, and the State of South Australia at a side event during the 70th World Health Assembly (WHA) on May 24th, 2017.

A meeting was convened soon after the launch, resulting in the establishment of a Transitional Steering Committee (TSC). To support the network and plan for activities during the first months, an Executive Committee (EXCOM) was formed from the members of the TSC. The EXCOM comprises the Ministry of Public Health of Sudan, the National Health Commission Office of Thailand, the South Australian Department of Health and Ageing, the Ministry of Health and Social Affairs of Finland, the Global Health Centre at the Graduate Institute and the World Health Organization.

During the first four months, the EXCOM worked on a draft governance structure and a draft 3-year workplan, as well as a website structure, a logo design and a slogan of the network. A GNHiAP 2017 member survey on Health in All Policies was also conducted. Further invitations were sent out to expand the membership of the network. In addition, the participants of the Adelaide II Conference on Health in All Policies, who contributed to a book on Health in All Policies case studies, were invited to join the network. Moreover, the advocacy of H.E. Bahr Idriss Abu Garda, Federal Minister of Health of Sudan at the WHO Eastern Mediterranean Regional Office, the African Union, and the Statistical, Economic and Social Research and Training Centre for Islamic Countries (SESRIC) led to increased support of the Network, and strong commitment from the Regional Director of EMRO.

This report outlines the progress of the network to date, and presents the discussions had and decisions made at the first network meeting in October 2017.

2. Overview of the GNHiAP Meeting

The first meeting of GNHiAP was convened from 2-3 October 2017 in Nakhon Pathom Province, Thailand, and hosted by the National Health Commission Office of Thailand. The meeting consisted of eleven (11) sessions with the following objectives:

1) Agree on the vision, mission and slogan of the network
2) Agree on the governance structure of the network
3) Elect the Steering Committee, the Executive Committee and the Chairperson of the network
4) Develop and agree on a workplan

The complete programme of the meeting is attached in **Annex 1.**

A total 38 participants from nine countries, two academic institutes and three UN agencies attended the meeting. The participants are listed in **Annex 2**. The meeting began with a welcome speech by Dr. Poldej Pinprateep, Secretary General of the National Health Commission, Thailand. He welcomed the participants and spoke of the power of the network to

change governance patterns from bureaucracy towards partnership. He noted that in order to ensure the network's effectiveness and sustainability, it will be essential to build the capacity of individuals and organisations, create network nodes and develop a functioning structure for the network. The full welcome note is in **Annex 3.**

H.E. Bahar Idriss Abu Garda, Federal Minister of Health of Sudan gave an introductory speech in which he presented the background of GNHiAP, explaining that the seed of the Network was planted in a side event during the 69th World Health Assembly in Geneva, titled ''Health in All Policies for Sustainable Development Goals Achievement'', which was hosted by the Federal Ministry of Health of the Republic of the Sudan in coordination with the Ministries of Health of Finland and Thailand. This event led to the launch of the Network one year later during the 70th World Health Assembly in Geneva in May 2017. His full speech is included in **Annex 4**.

Dr. Daniel Kertesz, WHO representative to Thailand welcomed the network and stated that the new Director-General of WHO has a strong commitment to Health in All Policies. He reiterated how the WHO Thailand Country Cooperation Strategy with its five programmes - Non-Communicable Diseases (NCDs), Migrant Health, Road Safety, Antimicrobial Resistance and Global Health Diplomacy & Trade and Health - already applies working across multiple sectors.

After the introductory speeches, the participants were divided into smaller groups for introductions and discussion. They covered six key topics relevant to their respective countries and organisations - experiences in HiAP, key drivers for HiAP, opportunities and challenges, contributions to and expectations from GNHiAP - and reported back to the meeting. Despite of differences in HiAP experiences among the countries and actors, the participants shared similar ideas on key drivers, opportunities and challenges. They agreed that political support and citizen engagement are important drivers of HiAP implementation; and that the SDGs and their focus on wellbeing present a key opportunity to advance and institutionalise HiAP. At the same time, the participants acknowledged that challenges arising from siloed working culture and conflicts of interest between stakeholders remain.

Carmel Williams of the South Australian Department for Health and Ageing summarised the GNHiAP survey, which was completed by twenty people from seventeen jurisdictions (eight national jurisdictions and nine sub-national) and WHO. The survey included 6 sections: (1) current status of HiAP in your jurisdiction; (2) HiAP operation; (3) budget; (4) coordination and governance; (5) policy goals; (6) current knowledge, skills and capacity about both HiAP and GNHiAP. The results indicate that respondents expect GNHiAP to support the members in various forms, including case studies, direct contact with political leaders, and financial support to training. The full report of the survey can be found in **Annex 5**.

After this the discussion moved onto the workplan, focusing primarily on activities, timeframe and responsibilities. The first three activities to be prioritised were agreed to be advocacy, governance and capacity building. The conclusion of this session is in chapter 6.

The first day of the meeting concluded with an event to present and discuss a newly published book, titled "Progressing the Sustainable Development Goals through Health in All Policies: case studies from around the world", which was co-produced by the WHO and the Government of South Australia. Many of the authors of the case studies included in the book were present, and the panel, consisting of Eugenio Villar (WHO), Katina D'Onise (Government of South Australia) and Nicole Valentine (WHO), highlighted the value the book adds to those working with the HiAP approach. The book, which covers cases from thirteen (13) countries across six WHO

regions, provides an overview and reflections on the scope for action on social determinants of health, the underlying policy imperatives, drivers for change, as well as on governance mechanisms, aiming to present a practical resource for decision makers.

On the second day, the meeting continued with the discussion on the governance structure of GNHIAP and concluded with the selection of the Chairperson, the steering committee and the executive committee. The outcomes of these sessions are outlined in chapters 4 and 5.

The meeting was closed by the H.E. Bahar Idriss Abu Garda as the first elected Chairperson of GNHiAP. He expressed his appreciation on the discussion and thanked the participants for sharing their experiences and ideas throughout the meeting, and thanked the hosts for convening this important meeting. Finally, the Chair emphasised his first three priorities as the Chair, which are advocacy for HiAP, promoting the network and working together.

An optional field trip to a local farm was organised after the formal conclusion of the meeting. The hosts arranged the participants to visit a local farmer's school to learn about Health in All Policies implementation and practice in Thailand. The farmers started an initiative due to persistent health concerns over the chemicals used in their agricultural practises. By working with the provincial health assembly and its resolution on food safety the farmers' collective transferred into organic farming and mobilised the locals as a network to share and learn from each other. They have achieved more than their original goal of improving the health of the farmers, and now also raise awareness about health, diet and pesticides, as well as market the organic products to improve the local economy.

3. Vision, Mission and Slogan

Michaela Told of the Global Health Centre facilitated this session. In general, the participants wanted to keep the text as simple as possible, as the documents will be translated into the six official languages of the United Nations. At the end of this session, the participants agreed on the following:

SLOGAN:
Global Network for Health in All Policies: a partnership for integrated SDG action

VISION:
The HiAP approach is strengthened with the aim of implementing the SDGs and facilitating progress on Universal Health Coverage.

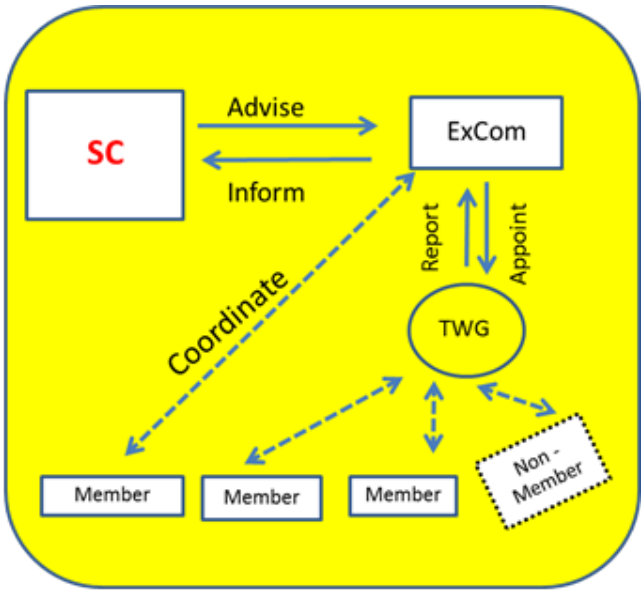
MISSION:
The Global Network for Health in All Policies (GNHiAP) will work with various governments and institutions across different sectors at all levels to address the determinants of health by strengthening the HiAP approach. The aim is to support the development of skills, to build capacity, share knowledge, and facilitate systems change towards embedding a holistic approach for sustainable development.

4. Governance Structure

Weerasak Putthasri of the National Health Commission Office, Thailand, facilitated this session. Discussion was held to refine and agree on the governance structure of the network, of which a preliminary version was circulated before the meeting. In summary, the participants agreed on

a governance structure which consists of a Chairperson, 14-18 steering committee members, 6 executive committee members, other members and potential technical working group(s). The revised governance structure document is in the **Annex 6**, and the envisioned framework is presented in the below graph.

Graph 1: Governance framework



5. Selection of the Chairperson, Steering Committee and the Executive Committee

Nanoot Mathurapote from the National Health Commission Office of Thailand facilitated this session. The participants agreed that all participants of the meeting, having expressed their strong commitment and active engagement in HiAP processes, shall form the first Steering Committee of the GNHiAP. In addition to the members present, two additional organisations who could not attend, but had expressed strong interest to be involved, namely the Ministry of Social Affairs and Health, Finland and Peter L. Reichertz Institute for Medical Informatics, University of Braunschweig, were invited to be part of the Steering Committee. Additional two institutions, People Health Movement (PHM) and EuroHealthNet, were proposed by meeting participants, and shall be formally approached to join the committee.

Following this decision the new Steering Committee approved the current Executive Committee to continue in its function for the first three years of the network, until 2020. Finally, the Steering Committee unanimously selected H.E. Bahr Idriss Abu Garda, Federal Minister of Health of Sudan as the first Chairperson of the network.

The full list of the Steering Committee members is presented in the below table.

Table 1: GNHiAP Steering Committee members, by sector

Government Sector	
1. Paddy Phillips / Katina D'Onise / Carmel Williams	Australia (South Australia) South Australia (SA Health), the State of South Australia
2. Sam Kolane	Botswana Ministry of Health and Wellness
3. Sylvie Poirier	Canada (Quebec) Ministry of Health and Social Service, the Province of Quebec
4. Jose Ruales	Ecuador Municipality of Quito
5. Taru Koivisto *Alternate: Timo Ståhl*	Finland Ministry of Social Affairs and Health *National Institute for Health and Welfare*
6. Charles Usurua	Namibia Ministry of Health and Social Services
7. Bahar Idris Abu Garda	Sudan Federal Minister of Public Health
8. Weerasak Putthasri	Thailand National Health Commission Office
9. Hela Benesmia	Tunisia Ministry of Health
10. Catherine Weatherup	United Kingdom (Wales) Public Health Wales
Academic Institutions	
11. TBC who	Peter L. Reichertz Institute for Medical Informatics, University of Braunschweig - Institute of Technology and Hannover Medical School, Germany
12. Michaela Told	Global Health Centre, the Graduate Institute of International and Development Studies, a WHO Collaborating Centre on Governance for Health and Global Health Diplomacy, Switzerland
13. TBC who	School of Health Systems and Public Health University of Pretoria, a WHO collaborating Centre for Health in All Policies and Social Determinant of Health, South Africa
United Nations Agencies	
14. TBC who	United Nations Environmental Programme (UNEP)
15. TBC who	United Nations Educational, Scientific and Cultural Organization (UNESCO)
16. TBC who	World Health Organization (WHO)

Table 2: Members of the Executive Committee, by sector:

Government Sector	
1. Carmel Williams	South Australia (SA Health), the State of South Australia, Australia
2. Taru Koivisto *Alternate: Timo Ståhl*	Ministry of Social Affairs and Health, Finland *National Institute for Health and Welfare*
3. Abdalla Osman	Federal Ministry of Public Health, Sudan
4. Nanoot Mathurapote	National Health Commission Office (NHCO), Thailand
Academic Institutions	
5. Michaela Told	Global Health Centre, the Graduate Institute, Switzerland
United Nations Agencies	
6. Nicole Valentine	World Health Organization (WHO)

6. Workplan

Nicole Valentine, WHO, and Abdalla Osman, Ministry of Health, Sudan facilitated this session, which focused on the network's workplan. Participants, divided into smaller groups, discussed individual workplan items in accordance with the proposed workplan which was circulated before the meeting.

The proposed activities were:

1. Developing advocacy mechanisms for the HiAP approach, GNHiAP, and the linkage between HiAP and SDGs
2. Conducting capacity building on HiAP approach for members and interested individuals
3. Producing routine HiAP global status reports
4. Developing and maintaining well-functioning governing bodies for the GNHiAP
5. Establishing a well-functioning EXCOM for the GNHiAP
6. Developing and facilitating operational guidance for the practice of the HiAP approach as a public knowledge good of the HiAP approach
7. Documenting and disseminating best practices and success stories of HiAP implementation
8. Mapping the bodies responsible for monitoring SDGs in all countries in order to strengthen linking HiAP to SDGs

The outcomes of the discussion are shown in the table below. The activities in the table are in the order of their priority and urgency for the network.

Table 3: Agreed GNHiAP activities

Activity	Focal Point	Steering Members
Advocacy - Mapping of key events and meetings at the global and regional levels, and seeking for opportunities to organise concurrent events about GNHiAP during these - Reaching out to Ministers of Health and/or Presidents to gain support for the network - Spreading awareness of the network and its activities among international, regional and local agencies - Developing a priority-setting guidance for the facilitation of strengthening the linkages between HiAP and SDGs - Utilising social media and big data as tools for advocacy	Sudan	WHO, Botswana, Finland
Governance - Expanding the network: Identification of new potential members, including international organisations from non-health sectors, non-governmental organisations, grass-roots organisations and academia - Organising annual/bi-annual strategic meeting. The theme and host-country of the meeting will rotate, and the focus will be on technical and political issues - Regular teleconferences: Steering Committee once every 6 months, Executive Committee once every two months - Face-to-face meetings of both SC and EXCOM on a bi-annual basis - Establishing a reliable and convenient channel of communication and information sharing, such as a website or a newsletter - Delivering an annual GNHiAP status report during the WHA each May	Thailand	WHO, Namibia, Sudan
Capacity Building - Mapping and analysing existing training programmes and materials - Creating and maintaining a database of HiAP training alumni, and sharing this with the network - Creating standard training materials which can be adapted to various levels and to different stakeholder audiences - Creating mentorship and peer-learning opportunities and frameworks for theory and practice - Establishing and monitoring quality standards of HiAP training **Operational Guidance** - Establishing a website for HiAP tools and materials, accessible for all network members, within the first 6	WHO	UNESCO, UNEP, WHO, Quebec, Wales, Tunisia, South Australia, Finland, Global Health Centre, Pretoria University-South Africa

Activity	Focal Point	Steering Members
months - Network endorsement principle applied to tools (defined expectation of tool and element of tool(s) that should be presented in 12-18 months) - Establishing active learning and peer review frameworks within the first 12-18 months, and continue this also on the 2nd year of the network - Facilitate further outreach by identifying and highlighting individuals and institutions championing in HiAP policy		
Global Status Report - Establishing a working group to develop initial criteria for the status report, and to draft a template for countries and regions, and to draft a terminology glossary for GNHiAP - The Chair of the network shall invite all members to develop the report - Preparing and presenting a briefing about the purpose of the network along with the value of the annual status report to WHO - Creating and maintaining an official list of members in order to identify their roles in working groups - Working group shall invite network members to coordinate the collection of information for the status report at national and subnational levels - Working group shall align the reporting with mapping of determinants of health and the SDGs <u>Specific activities during first year</u> - First report and proof of the concept of HiAP <u>Specific activities during second year</u> - Improving the quality of reporting - Follow-up analysis based on the global status of HiAP baseline - Analysing of best practice and HiAP benchmarks <u>Specific activities during third year</u> - Global evaluation of HiAP practices - Achieving buy-in from international agencies	South Australia	Tunisia, Ecuador, Sudan
Linkages to monitoring SDGs - Linking to National Voluntary Review reporting systems for the SDGs (not only quantitative information, looking into indicators for the principle of policy coherence (SDG 17.14)) - Highlighting and promoting HD intervention evidence indicators and linkages to SDGs and other regional reporting frameworks (e.g. Health 2020) - Supporting the creation of a research fund describing health gains and co-benefits from interventions on health determinants (in particular integrated /complex interventions)	Finland	WHO, UNESCO Tunisia, Ecuador, Pretoria University – South Africa,

7. Annex

Annex 1: The Programme of GNHiAP Meeting

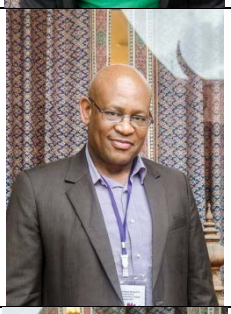
Provisional programme outline

DAY ONE: MONDAY 2 OCTOBER 2017			
Session	**Time**	**Agenda Item**	**Facilitator**
Session 1	09.00	Welcome note *Secretary General of National Health Commission, Thailand*	Thailand
Session 2	09.05 - 09.15	Introduction of the GNHiAP *Minister of Health, Sudan* • Background of the network • Objectives of the network	Sudan
Session 3	09.15 - 09.30	Introduction of Executive Committee Members • Members • Role Objectives of this meeting	Global Health Centre
Session 4	09.30 - 12.00	Self-introduction of the participants and their HiAP experience (10 minutes for each participant) • Name, Organisation, Position • Your experience in HiAP implementation • Opportunities and challenges • How a network could help progress the HiAP agenda	South Australia
Lunch Break @ 12.00			
Session 5	13.00 - 13.30	Slogan of the network	Global Health Centre

Session 6	13.30 - 17.30	GNHiAP Workplan • Activities • Timeframe • Responsibility	WHO
Session 7	18.30	Pre-launch of the HiAP Book	South Australia, WHO
Welcome Dinner @ 19.00			
DAY TWO: TUESDAY 3 OCTOBER 2017			
Session	**Time**	**Programme Outline**	**Facilitator**
Session 8	08.30 - 08.45	Recap	Sudan
Session 9	08.45 - 12.00	Discussion of Governance Structure Selection of Chairperson, Steering Committee, and Executive Committee	Thailand
Session 10	12.00 - 12.10	Brief about the Study Trip	Thailand
Lunch Break @ 12.10			
Session 11 (OPTIONAL)	13.30	Study trip on HiAP practice at the farmer's school, Thailand • Organic farming • Food safety • Poverty reduction	Thailand
Dinner @ 19.00			

Annex 2: List of Participants

List of participants
Meeting of the Global Network for Health in All Policies
Nakhon Pathom Province, Thailand
2 – 3 October 2017

No	Country	Name, Position/Organisation, contact	Photo
1.	Australia (South Australia)	**Katina D'Onise** Director, Prevention and Population Health, South Australia (SA Health) Email : katina.d`onise@sa.gov.au	
2.	Australia (South Australia)	**Carmel Williams** Manager, Health Determinants and Policy, Prevention and Population Health Branch, Department of Health and Ageing, South Australia Health (SA Health) Email : Carmel.Williams@sa.gov.au	
3.	Botswana	**Sam Kolane** Chief Health Officer Health Promotion and Education Division Ministry of Health and Wellness Government of Botswana Email: samkolane@hotmail.com , skolane@gov.bw	
4.	Canada (Quebec)	**Sylvie Poirier** Deputy Director of Public Health at Quebec Ministry of Health and Social Service (Quebec), Canada Email: sylvie.poirier@msss.gouv.qc.ca	
5.	Ecuador (Quito)	**Jose Ruales** Secretary of Health Municipality of Quito, Ecuador Email: jose.ruales@quito.gob.ec	

No	Country	Name, Position/Organisation, contact	Photo
6.	Namibia	**Charles Usurua** Ministry of Health and Social Services Windhoek, Namibia Email: usuruacharles10@gmail.com	
7.	Sudan	**Bahar Idris Abu Garda** Federal Minister of Public Health, Sudan	
8.	Sudan	**Abdalla Osman** National Institute for Public Health,Sudan Email: abdalla.sd52@gmail.com	
9.	Sudan	**Amar H. O. Abdelrahman** Head of Advocacy and Partnerships Department Public Health Institute Federal Ministry of Health, Sudan Email : amar.a@phi.edu.sd	
10.	Thailand	**Poldej Pinprateep** Secretary General National Health Commission Office (NHCO), Thailand Email : poldej@nationalhealth.or.th	

No	Country	Name, Position/Organisation, contact	Photo
11.	Thailand	**Weerasak Putthasri** Deputy Secretary-General National Health Commission Office (NHCO), Thailand Email: weerasak@nationalhealth.or.th	
12.	Thailand	**Siriwat Tiptaradol** Senior Consultant National Health Commission Office (NHCO), Thailand Email : siriwattip@gmail.com	
13.	Thailand	**Nanoot Mathurapote** Head of Global Coordination Unit National Health Commission Office (NHCO), Thailand Email: nanoot@nationalhealth.or.th	
14.	Thailand	**Tipicha Posayanonda** Head of Participatory Healthy Public Policy Development Unit, National Health Commission Office (NHCO), Thailand Email : tipicha@nationalhealth.or.th	
15.	Thailand	**Sutthipong Wasusophapol** Head of Participatory Healthy Public Policy Movement Unit, National Health Commission Office (NHCO), Thailand Email : suttipong@nationalhealth.or.th	

No	Country	Name, Position/Organisation, contact	Photo
16.	Thailand	**Sirikorn Kaophuthai** Head of Participatory Healthy Public Policy Development for Central Region of Thailand Unit, National Health Commission Office (NHCO), Thailand Email: sirikorn@nationalhealth.or.th	
17.	Thailand	**Somkiat Pitakkamonporn** Senior Expert of Participatory Healthy Public Policy Movement Unit, National Health Commission Office (NHCO), Thailand Email : somkiat@nationalhealth.or.th	
18.	Thailand	**Techid chawbangpom** Senior Technical Officer of Participatory Healthy Public Policy Development for Central Region of Thailand Unit, National Health Commission Office (NHCO), Thailand Email : techid@nationalhealth.or.th	
19.	Thailand	**Khanitta Sae-Iew** Senior Technical Officer of Global Coordination Unit National Health Commission Office (NHCO), Thailand Email: khanitta@nationalhealth.or.th	
20.	Tunisia	**Hela Benmesmia** Advisor in the Office of the Minister of Health President of the Administrative Management Unit of the Societal Dialogue for Health Ministry of Health, Tunisia Email: hela.benmesmia@tunisia.gov.tn mesmiahela@hotmail.fr	

No	Country	Name, Position/Organisation, contact	Photo
21.	United Kingdom (Wales)	**Catherine Weatherup** Strategic Lead on Health and Sustainability Welsh Government and Public Health Wales Email: catherine.weatherup@wales.nhs.uk	

No	UN Organisations	Name, Position/Organisation, contact	Photo
22.	United Nations Environmental Programme (UNEP) France	**Fanny Demassieux** Environment and Health Coordinator (Coordonnatrice Environnement et Santé) Email: fanny.demassieux@unep.org	
23.	United Nations Environmental Programme (UNEP) Thailand	**Masato Motoki, P.E.** Environmental and Head Officer United Nations Environmental Programme Asia and the Pacific Office, Thailand Email : masato.motoki@un.org	
24.	UNESCO Thailand	**Eunsang Cho** TVET Expert in the Section for Educational Innovation and Skills Development UNESCO's Asia and Pacific Regional Bureau for Education, Thailand Email: e.cho@unesco.org	
25.	UNESCO Thailand	**Kabir Singh** Senior Project Officer for HIV preventive education and Team Leader for Health Education and Well-being Team UNESCO's Asia and Pacific Regional Bureau for Education, Thailand Email: k.singh@unesco.org	

No	UN Organisations	Name, Position/Organisation, contact	Photo
26.	WHO Headquarter Switzerland	**Nicole Valentine** Technical Officer Social Determinants of Health WHO Headquarter, Switzerland Email: valentinen@who.int	
27.	WHO Headquarter Switzerland	**Eugenio Villar** Coordinator Social Determinants of Health Team Department of Public Health, Environmental and Social Determinants of Health (PHE) WHO Headquarter, Switzerland Email: villare@who.int	
28.	WHO EMRO	**Naeema Al Gasseer** WHO Representative in Sudan & Head of Mission, Sudan	
29.	WHO Thailand	**Daniel Kertesz** Head office WHO Representative Thailand Email : kerteszd@who.int	

No	Academia	Name, Position/Organisation, contact	Photo
30.	Global Health Centre Switzerland	**Michaela Told** Deputy Director & Executive Director Global Health Centre at the Graduate Institute, a WHO Collaborating Centre for Governance for Health and Global Health Diplomacy Switzerland Email: michaela.told@graduateinstitute.ch	

No	Academia	Name, Position/Organisation, contact	Photo
31.	School of Health Systems and Public Health University of Pretoria	**Deb Basu** Head of Public Health Medicine School of Health Systems and Public Health University of Pretoria, a WHO collaborating Centre for Health in All Policies and Social Determinant of Health Pretoria,South Africa Email: debashis.basu@up.ac.za	

No	Rapporteur Team	Name, Position/Organisation, contact	Photo
32.	Thailand	**Chayut Pinichka** International Health Policy Program, Thailand Email : chayut@ihpp.thaigov.net	
33.	Thailand	**Arnond Kulthanmanusorn** International Health Policy Program, Thailand Email : anond@ihpp.thaigov.net	
34.	Thailand	**Titiporn Tuangratananon** International Health Policy Program, Thailand Email : titiporn@ihpp.thaigov.net	
35.	Thailand	**Hathairat Kosiyaporn** International Health Policy Program, Thailand Email : hathairat@ihpp.thaigov.net	

No	Administrative Team	Name, Position/Organisation, contact	Photo
36.	Thailand	**Oranit Orachai** Senior Administrator**,** Global Coordination Unit National Health Commission Office (NHCO), Thailand Email : oranit@nationalhealth.or.th	
37.	Thailand	**Sunanta Pinatano** Senior Administrator of Participatory Healthy Public Policy Development for Bangkok Unit, National Health Commission Office (NHCO), Thailand Email: sunanta@nationalhealth.or.th	
38.	Thailand	**Boonyawaree Hongthong** Senior Administrator of Participatory Healthy Public Policy Development for Central Region of Thailand Unit, National Health Commission Office (NHCO), Thailand Email : peeraporn@nationalhealth.or.th	

Annex 3: Welcome addresses

Welcome Note
By Dr. Poldej Pinprateep
Secretary-General of the National Health Commission Office, Thailand
At
The Meeting of Global Network for Health in All Policies
Monday 2nd October 2017
Sampran Riverside, Nakhon Prathom Province, Thailand

Hounourable Health Minister of Sudan, Guests and Friends,

On behalf of Thailand's National Health Commission, I am very happy to co-host this meeting together with Sudan, South Australia, Geneva Global Health Centre and WHO. But I am even more happy that all of you come. Because we will learn from each other, work together and achieve SDGs together by health in all policies.

I highly value the power of network. My organisation has only 90 staff but we work across the country and also reach out the global community. We can do lots of work because we apply governance by network, not by bureaucracy.

Without the support of our network, our work cannot be progressed. And we would feel alone in the universe.

For this reason, I believe that the Global Network for Health in All Policies will make everyone here not too lonely. Because you have friends to rely on. And friends to move forward together.

And as your friend, I have a bag as a gift for all of you here. I understand that when you were invited to Thailand, apart from thinking about Health in All Policies, you also thought of shopping. So this bag is for collecting friendship, workplan and souvenirs back to your country.

Thank you.

Annex 4: Introductory address

Introductory Speech
Mr. Bahar Idriss Abu Garda
Federal Minister of Health, the Republic of Sudan

Members of the Transitional Steering Committee
Members of the Executive Committee
All Members of the Global Network for Health in All Policies

Dear Guests

It is my pleasure to welcome you all to this Steering Committee meeting for the Global Network for Health in All Policies. In particular, I would especially like to thank Mr. Poldej Pinprateep, the Secretary General of the National Health Commission of Thailand, for hosting and organising this meeting.

I would like to begin by giving a brief introduction to the Global Network for Health in All Policies and describe the background of the network as well as the main objectives behind it. The Global Network for Health in All Policies is a global initiative embarked on initially be a group of countries in order to institutionalise and facilitate the implementation of the Health in All Policies approach worldwide.

The seed of the Network was planted in a side event during the 69th World Health Assembly in Geneva, named ''Health in All Policies for Sustainable Development Goals Achievement'' which was hosted by the Federal Ministry of Health of the Republic of the Sudan, in coordination with Ministries of Health of Thailand and Finland. This event led to the launch of the Network a year after during the 70th World Health Assembly in Geneva in May 2017, along with the formulation of a Transitional Steering Committee and an Executive Committee for the Network.

The primary motivation behind this initiative was that countries were struggling to achieve the Millennium Development Goals prior to 2015, and they are also still struggling to achieve the Sustainable Development Goals. This difficulty arises from the fact that addressing social determinants of health and health inequalities requires an intersectoral approach, and that ministries of health cannot address these global challenges alone. It is evident now that without commitment, coordination, collaboration, and partnerships between different sectors and the Ministry of Health, it is almost impossible to move progressively towards Sustainable Development Goals and Universal Health Coverage.

With the aim of creating a global platform to strengthen and advance Health in All Policies approach and to Progress towards Sustainable Development Goals and Universal Health Coverage, several objectives have been set for the Global Network for Health in All Policies which are:

- To lead, facilitate, strengthen, and institutionalise the implementation of Health in All Policies in countries to support the implementation of the Sustainable Development Agenda.
- To build capacities and skills to enable the implementation of the Health in All Policies approach.

- To facilitate the development of tools and guidelines to support step by step Health in All Policies implementation, and hence moving from theory to practice through active collaborations and partnerships.
- To enable knowledge sharing and inter-countries transfer of experiences through South to South and triangular Cooperation.
- To Generate evidence on the effectiveness of the Health in All Policies approach in the progress towards Sustainable Development Goals and Universal Health Coverage.
- And finally, to create an online platform where all countries can have rich interactive discussions and share experiences.

It is necessary to take advantage of this opportunity to highlight the need for all member countries, specially Steering Committee members and Executive Committee members, to commit them self to active participation and support for the network in order to allow adequate functioning of the network.

I would also like to emphasise again my sincere appreciation for the National Health Commission of Thailand for organising and hosting this meeting, as well as for all members of the Transitional Steering Committee for their commitment and participation. And finally, on behalf of the Steering Committee, I would like to welcome you all.

Annex 5: GNHiAP Survey Report

GLOBAL NETWORK FOR HEALTH IN ALL POLICIES

GNHiAP SURVEY 2017 REPORT

BACKGROUND

The Global Network for Health in All Policies (GNHiAP) is a network of government entities (national, regional, local) and other institutions (UN, IGOs, NGOs, Academia) committed to work jointly on strengthening Health in All Policies (HiAP).

In preparation for the first formal meeting of GNHiAP in Thailand on 2-3 October 2017, the GNHiAP conducted a survey to gain an understanding of the current status of implementing the HiAP approach in different jurisdictions, contacting all country entities (government, non-government) who have been invited to the meeting in Thailand.

The aim of the survey was to assist the GNHiAP to prioritise its activities over the next 3 years (action plan) and to provide a baseline of the current status and capacity of jurisdictions in order to measure progress against GNHiAP objectives over time.

Following is an overview of the survey results.

RESPONDENTS

A total 20 people, representing 17 jurisdictions, completed the survey before 29 September 2017. This included 8 national jurisdictions and 9 sub-national jurisdictions, as well as the WHO. Below is a list of all respondents.

Name	Position Title	Organisation/Agency:	Jurisdiction
Crusivia Chilobe Hichikumba	Director - Finance and Economic Development	Policy Analysis and Coordination Division, Cabinet Office	Zambia
Jane Wolforth	Senior Policy Analyst	Vermont Dept of Health	State
Samuel Kolane	Chief Health Officer	Ministry of Health , Botswana	National
Axel	Acting deputy permanent secretary	Ministry of Health and Social Services	National
Channa Perry	Service Manager Public Health	Taranaki Regional Health Board	Taranaki New Zealand
Virginia McLaughlin	Medical Officer of Health	Northland District Health Board	Regional
Gabino Arredondo	Management Analyst II	City of Richmond, CA, USA	Subnational = City
Øyvind Giæver	Director	Norwegian Directorate of Health	National
Lesley C Usurua	Control Health Programme Officer	Ministry of Health and Social Services	National
Francisco Obando	Coordinador de estrategia de Barrios Saludables	Secretaría de Salud del Municipio del Distrito Metropolitano de Quito	Subnational
Jose Ruales	Secretary of Health	City of Quito, Ecuador	Subnational
Anna Stevenson	Public Health Specialist	Canterbury District Health Board	Subnational
Poirier Sylvie	Deputy director	Ministère de lSanté et des Services sociaux d	Québec
Timo Ståhl	Chief Specialist	National Institute for Health and Welfare	National
Nanoot Mathurapote	Head of Global Collaboration Unit	National Health Commission Office	Thailand
Louise St-Pierre		Ministry of Health and Social Services	Québec
Hela Ben Mesmia	Advisor in the office of the Minister of Health	Ministery of Health Tunisia	National
Julia Caplan	Program Director, HiAP	Public Health Institute	Subnational - State of California
Eugenio Villar Montesinos	Coordinator SDH/PHE/FWC/WHO	WHO (Geneva)	global
Carmel Williams	Manager	Prevention and Population health	South Australia

HISTORY AND CURRENT STATUS OF HiAP IN YOUR JURISDICTION

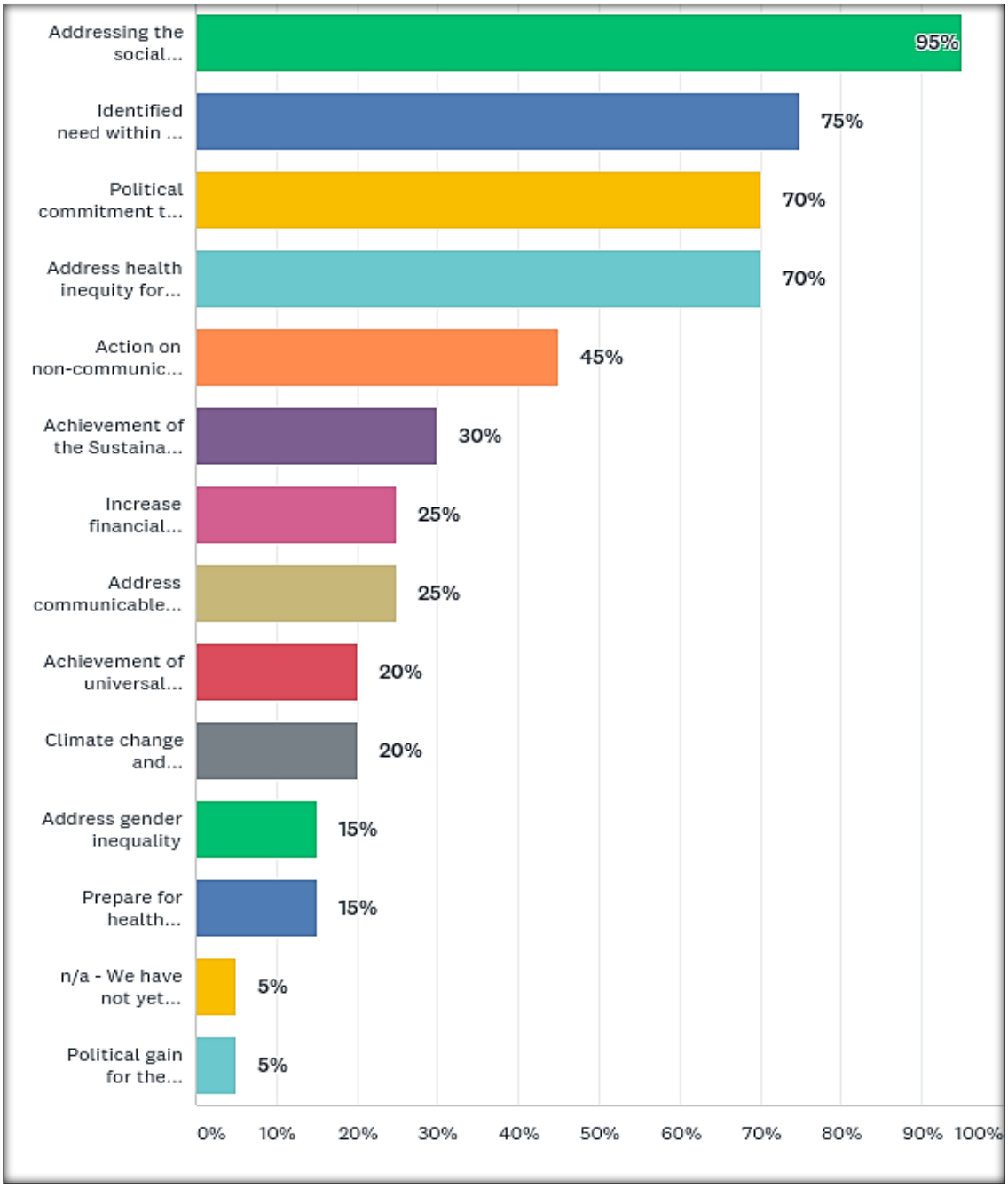
Q2. How long have you been developing and/or implementing the HiAP approach in your jurisdiction?

ANSWER CHOICES	RESPONSES	
We have not yet formally started to develop our HiAP approach	5%	1
We are in the early stages of planning our HiAP approach	25%	5
1-2 years	10%	2
2-5 years	25%	5
5-10 years	15%	3
Greater than 10-years	20%	4
TOTAL		20

Q3. What stage is your jurisdiction at in the development and delivery of the HiAP approach? Please select only one answer that best describes your stage of development.

ANSWER CHOICES	RESPONSES	
We are interested but have not yet sought formal commitment/approval to develop and implement HiAP in our jurisdiction	15%	3
We are actively working to obtain formal commitment/approval to develop and implement HiAP in our jurisdiction	0%	0
We have formal commitment/approval to proceed with development and implementation of HiAP but are just starting to work out our governance structure and implementation plan	35%	7
We have developed a formal governance structure and are in the early stages of implementation	15%	3
We have well developed formal mechanisms for governance and implementation and are making good progress	20%	4
HiAP approach is embedded as a mandatory or recognised way of working in our jurisdiction	15%	3
TOTAL		20

Q4. What were/are the key drivers in the commencement and progression of HiAP in your jurisdiction? Please select all that apply.



- Addressing the social determinants of health
- Identified need within the health sector to work across all sectors or across the whole of government to improve health
- Political commitment to joined up government or multisectoral action
- Address health inequity for disadvantaged populations
- Action on non-communicable diseases
- Achievement of the Sustainable Development Goals

- Increase financial investment in health or increase the status of health across government
- Address communicable disease prevention or eradication
- Achievement of universal health coverage
- Climate change and environmental sustainability
- Address gender inequality
- Prepare for health emergencies
- n/a - We have not yet commenced HiAP approach and activities in our jurisdiction
- Political gain for the political leaders in power

OPERATION OF HIAP IN YOUR JURISDICTION

Q5. On a scale of 1 to 5 how would you rate the level of political support (support from elected officials and/or senior government decision makers) for the implementation of HiAP in your jurisdiction?

	1 NO LEVEL OF SUPPORT	2 SMALL LEVEL OF SUPPORT. SENIOR OFFICIALS ARE AWARE OF HIAP BUT UNDECIDED ABOUT FORMAL ENDORSEMENT	3 MODERATE LEVEL OF SUPPORT. TENTATIVE 'IN PRINCIPLE' SUPPORT BUT NO FORMAL MECHANISMS IN PLACE	4 GOOD LEVEL OF SUPPORT. FORMAL MECHANISMS ARE IN PLACE BUT HIAP IS NOT YET SYSTEMATICALLY EMBEDDED	5 FULL SUPPORT. OUR POLITICAL LEADERS HAVE FULLY ENDORSED THE HIAP APPROACH AS GOVERNMENT POLICY	TOTAL	WEIGHTED AVERAGE
Level of Political Support	0% 0	5% 1	21% 4	47% 9	26% 5	19	3.95

Q7. How many staff do you have working extensively in the development and delivery of HiAP in your jurisdiction? In answering this question include staff who have HiAP as a significant part of their job role.

ANSWER CHOICES	RESPONSES	
1 Staff	11%	2
2 Staff	0%	0
3 Staff	37%	7
4 Staff	5%	1
5 Staff	21%	4
Other amount of staff (please enter the number)	26%	5
TOTAL		19

Other amount comments

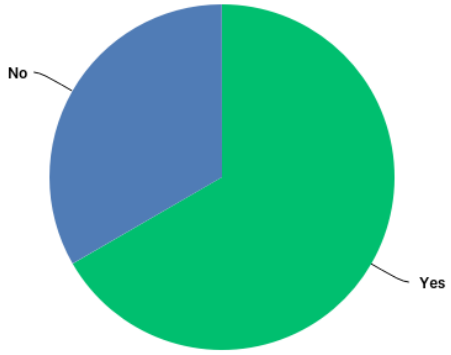
- 7 plus our health department has 4 staff who work on climate change & health equity, which is basically HiAP as well.
- 90 staff because HiAP is embedded in our organizational work
- At Ministry of Health there is a Department of Social Determinants of Health
- 10+
- HiAP as a way of working is embedded in the work of many of the staff members. The question is impossible to answer from THL's perspective

Q8. Which organisation/agency/government department takes the lead role for the development and delivery of HiAP in your jurisdiction? Please provide the name of the agency/department and the role or function of the agency/department

Name of organisation, agency or department	Function of organisation, agency or department
Social Determinants of Health at Ministry of Health	Health Wellbeing
Vermont Dept of Health	
Health Promotion Division, Dept of Public Health	Advocacy, Mobilisation and Public Education
Ministry of Health and Social Services	Public Health
Taranaki Public Health Unit	Public Health Unit, part of District Health Board
City Manager's Office, City of Richmond, CA, USA	Implementing City Council Policy, Directing departments and the City's administrative functions, Providing day-to-day leadership in policy development and implementation, Overseeing the annual budget process
Dept. of social determinants of health (in the Directorate of Health)	
Ministry of Health and Social Services	Directorate of Policy Planning and Human Resource Development
Jose Ruales	Secretario de Salud de Quito
Secretariat of Heath	Directio of health policy and healthy city
Canterbury District Health Board	Delivers health services including health promotion
Health Ministry	Public health
Ministry of Social Affairs and Health, department of wellbeing and services	
National Health Commission Office	NHCO provides a platform and a process, namely health assembly, HIA and health charter to develop HiAP at the national, regional and provincial levels.
Public health directorate at the Ministry of health and Social services	Leadership, coordination
Ministry of Health	Office of the Minister and the Primary Health care department
California Strategic Growth Council - a committee of the state cabinet	
Dept Health and Ageing and Dept Premier and Cabinet	Health care and central governance

HiAP BUDGET

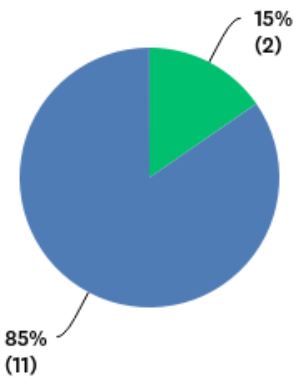
Q9. Do you have a budget for conducting your HiAP activities?



Q10. What is the amount of your HiAP Budget?

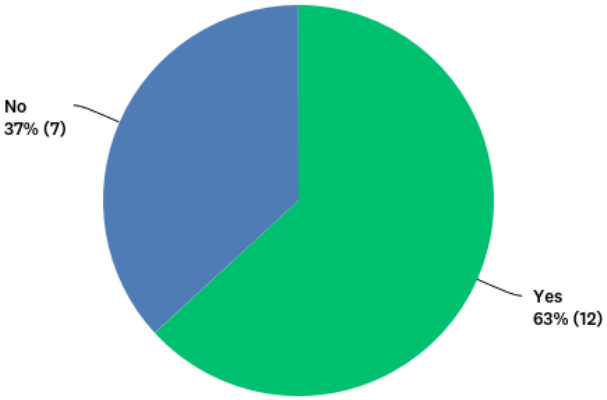
Jurisdiction	Budget
Zambia	I do not but in Zambia the Ministry of Health is among the top five high spending Ministries
Taranaki District Health Board	$NZ 30,000 approx.
City of Richmond, California	$USD 150,000
Secretaría de Salud del Municipio del Distrito Metropolitano de Quito	$5,000
City of Quito, Ecuador	$40,000
Canterbury District Health Board	in the FTE's
National Health Commission Office, Thailand	$USD 4.5 million
Ministry of Health and Social Services, Quebec	$CAN 20 million per year x 10 years
Public Health Institute, State of California	This is a difficult question. The health department employs 4 HiAP staff, so that budget is approx $400,000. The Public Health Institute employs 4 additional HiAP staff, with a budget of approximately $600,000/year.
WHO Geneva	$USD 100,000 approx
South Australia	$AUD 400,000

Q11. Is your HiAP budget adequate to fund your HiAP Activities?



HiAP COORDINATION AND GOVERNANCE

Q12. Do you have a HiAP Coordinating and/or governance committee?



Q13. Who are the members of your coordinating/governance committee i.e. which departments, sectors, organisations are on the committee?

There is a Director, Social Determinants of Health and Team
Inter-governmental task force comprised of leadership (commissioner, deputy) from each state agency
Offices of prime minister, planning commission, ministry of health
City staff from multiple City Departments up to 19: such as Engineering, Police, Library, Information Technology, Planning and Building, Fire, Wastewater, Employment and Training, Finance, etc. We also convene community based organizations.
8 or 9 ministries
Office of the Prime Minister; National Planning Commission; Ministry of Health and Social Services; Ministry of Urban and Rural Development and City of Windhoek
Departments of the Municipality of the Metropolitan District of Quito responsible for provision of water, parks, infrastructure and those working on the environment, health and social inclusion.
DHB, City Council, Regional Council, Local iwi, Ministry of Social Development,
15 ministries and government agencies
National Health Commission have 39 members consisting government sectors (6 ministries and local government), health and non-health professional and academia, and people sector (CSO and private sector)
high level managers from 15 departments and government organisations
Public health, Transportation, Social services, Fire and forestry, Parks, Land use planning, Corrections and rehabilitation, General services (state contracts), Environmental protection, Air quality, Education, Housing, Workforce development.

Q14. Which department/sector/organisation chairs the coordinating/governance committee?

Social Determinants of Health Department	Dirección de Politicas y Pleaneamiento de Salud de la Secretaría de Salud del Municipio del Distrito Metropolitano de Quito
Department of Health	District Health Board
Office of the Prime Minister and Ministry of Health and Social Service	Ministry of health - Public health department
City Manager's Office	Prime Minister chairs the National Health Commission
Ministry of Health	Public health
Department of Social Welfare Policy	Strategic Growth Council & Public Health

POLICY GOALS

Q15. What are the 3 most significant policy outcomes/goals that your jurisdiction's HiAP approach is aiming to address or has addressed?

Making Households the entry point to good health instead of the health facilities	Making Zambia a nation of healthy and productive people	Caring for the environment in which communities lived
Implementing evidence-based best practices for population health		
Formation of HiAP National Coordinating Structure	Awareness Creation on HiAP	Active uptake of Health issues by other sectors
Coordinated approach	Health lenses for different sectors	Improvement of health comes through interventions of other sectors
Joint planning using health impact assessment	Developing shared outcomes on public health issues such as reducing alcohol related harm	Collaborative initiative implementation addressing determinants of health such as poor quality rental housing
Built Environment	Full Service and Safe Communities (addressing Gun Violence)	Environment Health and Justice
Reduced social inequalities in health	Raised life expectancy	Cross-sectoral cooperation

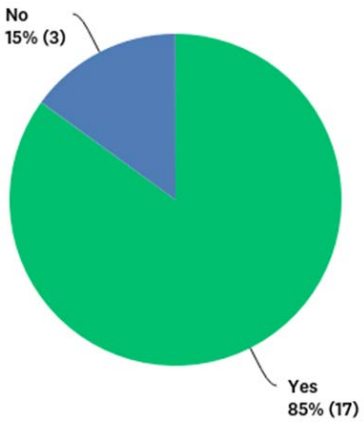
Creating a shared understanding of the driving (upstream) determinants of health	Promoting mechanisms that improve shared responsibility and joint action for addressing the determinants of health	Strengthen the ability of the health sector and broader government, including parliaments and other spheres of public influence, to influence decisions, policies and laws, and their implementation, across sectors to favour their health and health equity impacts.
Intersectoral support in the implementation of health plans developed by the community.	Working on obtaining the certification from the Ministry of Public Health of Ecuador of Quito as a Healthy City	
Intersectorial approach	Healthy neighborhoods	Social participation in health
Working relationships	Collaborative working	Implementing determinants of health projects e.g. transport, alcohol, housing
Health inequities	Population health and well-being	Determinants of health
Reduction of health inequality	Tackle NCD's	Prevent social exclusion
Chemical free agriculture	Trade and health	Healthy food in schools and surrounding areas
Improve the health of the population by working on determinants of health	Reducing health inequality	Improve governance coherence and accountability for the health of the population
Non communicable disease strategy	Prevention strategy for communicable disease	Societal dialogue to elaborate the national health policy
Increasing walking (double), biking (triple), and use of public transit (double) by 2020.	Increasing access to parks and green space in low-income and disadvantaged areas.	Incorporating health and equity criteria into allocation of state grant funds for work in areas such as active transportation, housing development, parks and greening, etc.
Developed global political consensus on HiAP	Developed training tools and processes	Developed evidence and documented experiences, globally
Improve population health and reduce Health inequities	Increase cross government action on SDH	Build behaviours across the public sector that make collaboration easy and successful

CURRENT KNOWLEDGE, SKILLS AND CAPACITY IN THE HiAP APPROACH

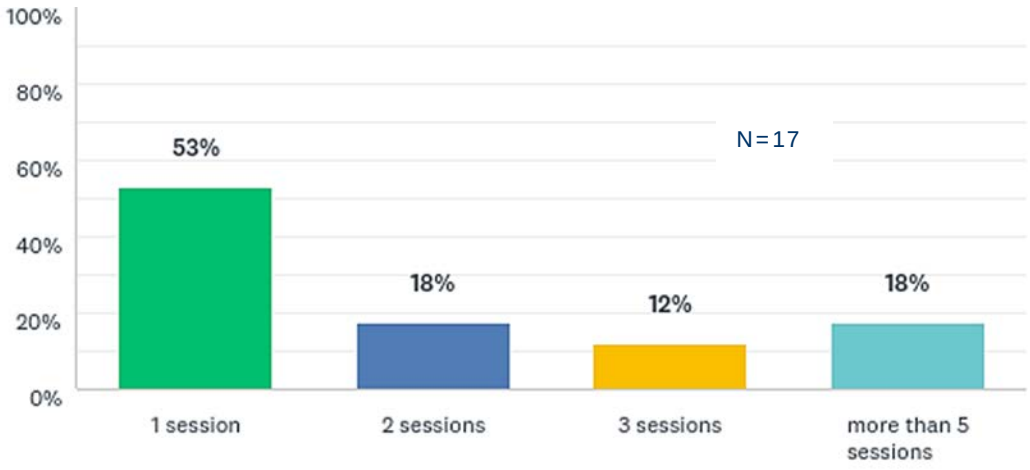
Q16. Please rate both your own and your wider jurisdiction's level of knowledge, skills and capacity to implement the HiAP approach. When thinking about your wider jurisdiction consider the combined capacity of your other colleagues and the workforce employed across the other sectors, government departments and organisations in your jurisdiction.

	No or limited	Some	Moderate	Very Good	Very High	Avg. on scale of 1-5
Your own level of capacity	0%	11%	32%	37%	21%	3.68
Your jurisdiction's level of capacity	10%	42%	37%	5%	5%	2.53

Q17. Have you ever attended any training workshops, seminars or conferences on how to implement HiAP?



Q18. How many HiAP training sessions have you attended?

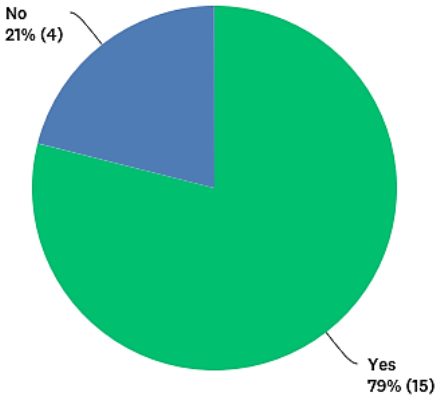


Q19. What was the name, location and date of the last HiAP training session YOU attended?

Name of last training session attended	Location of last training session attended	Date of last training session attended (month/year)
International HiAP Conference II,	Adelaide, South Australia	30-31 March, 2017
Participation at the CA HiAP Task Force		
HiAP trainers course	Geneva, Switzerland	2014
Presentation by Anna Stevenson from Cantebury Community Public Health	New Plympton	
HiAP Workshop	Dunedin, NZ	June 2017
Health in All Policies Government and Community Collaboration for Change workshop	Los Angeles, CA, USA	April 2016
EU Joint action work package	Berlin	10/2012?
Health in All policies Training of Trainers workshop for MOH and Training Institutions	Johannesburg, South Africa	30 November - 4 December 2015
International conference in Health in All policies	Adelaide, Australia	March 2017
Broadly Speaking - in-house bespoke training	Christchurch	August 2017
HiAP manual Trainers training	Geneva	2015, this is the only one really focusing on HiAP only; I've been training several groups on how to implement HiAP from 2 hours up
Health in All Policies' Training for Trainers	Geneva	24 - 26 March 2015
HiAP what it is (I was the tutor)	National collaborating centre	2015
"Applying Health in All Policies Approach to Achieve Sustainable Development Goals in the Eastern Mediterranean	World Health Organization (WHO) Regional Office for the Eastern	26-28 February 2017

Region"	Mediterranean in Cairo	
HiAP master class	Adelaide, South Australia	March 2017
Swiss development Cooperation summer training on HiAP	Lugano, Switzerland	Sep-17
HiAP Master Class 2017	Adelaide South Australia	March 2017

Q20. Have any of your other colleagues or staff in your jurisdiction ever attended any training workshops, seminars or conferences on how to implement HiAP?



Q21. Do you think there are opportunities to increase or improve the implementation of HiAP within your jurisdiction?

100% of respondents indicated that there were opportunities to increase or improve the implementation of HiAP in their jurisdictions. Following are their responses on the opportunities available.

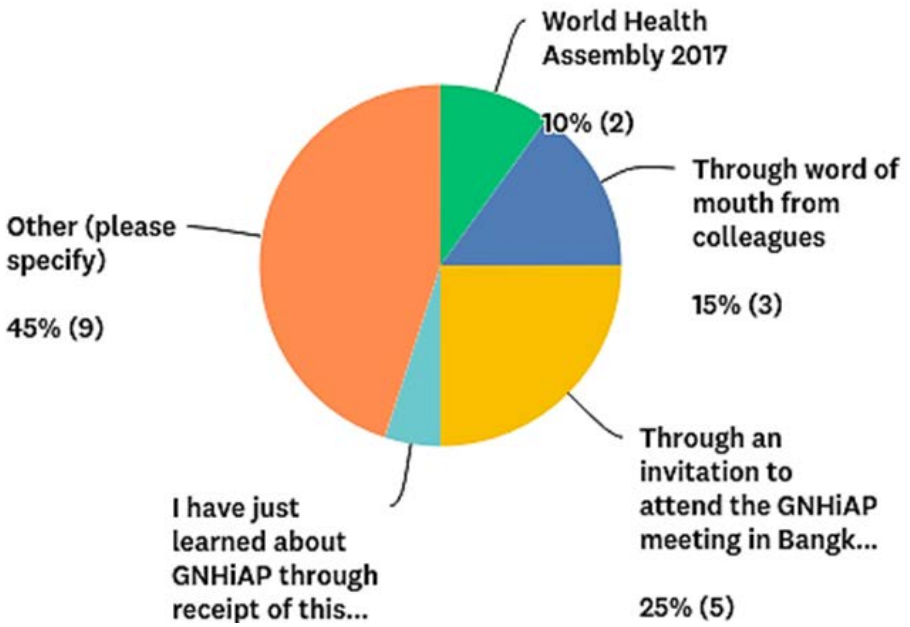
In ensuring that all staff in my jurisdiction appreciate the importance of mainstreaming HiAP as they coordinate sector Ministries in policy formulation and implementation.
Communication around how population health extends beyond the health department; making health a shared value and commitment.
With the setting up of the envisaged National Coordinating structure, there would be room to train more people for effective implementation.
Political commitment is in place and the is motivation an justification
More training and develop formal relationship agreements
Training, formal approval to reorient to HiAP direction within organisation, strengthening relationships internally and externally
Opportunity to train and disseminate HiAP to all workers for the City of Richmond.
The level of implementation in different parts of my organisation varies greatly
Sectors responsible for implementing different sections of the development plan can jointly evaluate likely impacts of their work and therefore aspects that can be improved through taking a health and equity lens. A range of existing collaborative and coordination mechanisms exist
The sustained participation of actors from other sectors of the municipal administration has a demonstrative and multiplier effect, requires greater diffusion and communication of the principles and expected results of HiAP
formalisation of governance and institutionalisation of HiAP practice
Sustained governance, political endorsement, increased budget
Strengthen the structures and processes of HiAP, better quality of the work done e.g. better IA of the legislative proposals etc.
Using SDGs as a door to work with non-health sector more and closer and also introduce them HiAP.
Strong mobilisation at the local level to see government level working more strongly and collaboratively for prevention in health
There are some people who are very convinced of the approach of HiAP but they need training to enhance their competencies. This approach is spreading in the other department of the government but we need mechanisms to help us to implement it.
I would like to increase the government commitment to HiAP, to fully embed it into government operations. This may require legislation or new action by the Governor.
SDGs and inequity action bring interest and opportunities
For HiAP to be more systematised and extended beyond the HiAP Team

Q22. What do you see as the biggest challenges in implementing the HiAP approach in your jurisdiction?

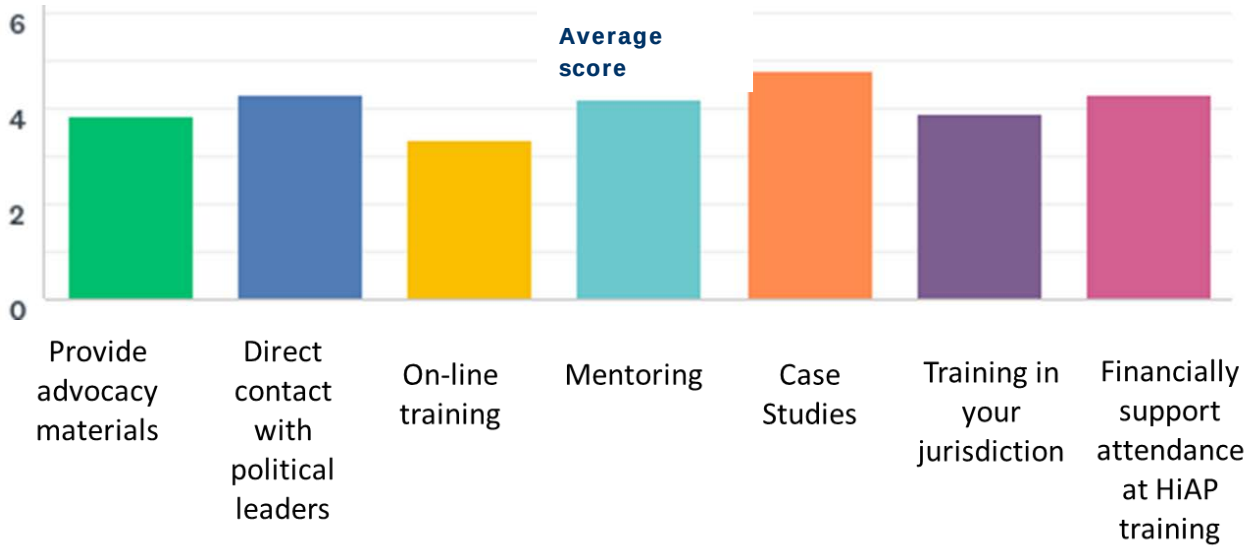
Temptation to work in silos
Lack of staff
Lack of adequate funding and resource duplication due to silo mentality by other agencies
Stakeholder engagement
Buy in from senior management (CEO) of the district and regional councils and buy in from governance (e.g. mayors and councillors)
Capacity
Data collection and analysis and funding.
Skills in negotiation and communication
Non-legislative mechanisms are frequently supported by memoranda of understanding and inter-ministerial committees. These mechanisms are not functioning optimally given that intersectoral representation is frequently absent or, when present, sectors are represented by more junior
Top level political support
That the summation of improvements in the population health and determinants be higher than if we work individually outside the Health in all policies paradigm
Time/work-force pressure, the benefits of working across sectors are not seen
I think Thailand have well understood HiAP in terms of concept and approach, but implementation is still the challenge due to conflicting laws and regulations between health and non-health organizations. Asbestos case can be exemplified. Banning asbestos is a National Health Assembly 's resolution with strong political support from Ministry of Public Health, asbestos still cannot be banned because banning is a responsibility of Ministry of Industry. We have talked with Ministry of Industry almost 5 years but the progress has not been made.
Continuing support from the political level
implication of other sectors to consider the health as a priority in their policies
At this point, we already have solid relationships and trust. Departments want to do health and health equity work, and they want us to provide quite technical expertise on things like how to quantify the health benefits of specific policy interventions. Unfortunately our team does not have the skill set nor time/resources to provide this level of expertise. Also, things are moving so very fast in our jurisdiction right now because we are near the end of our Governor's term (one more year).

Everyone is scrambling, and it's hard to get people to think about the future beyond about one year.
Saturation on their own work
Small number of staff- too many opportunities and not capacity to realise them all

Q23. How/when did you first hear about the Global Network for Health in All Policies (GNHiAP)?



Q24. How can the GNHiAP support you to progress the HiAP approach in your jurisdiction? Please rank from 1 to 7 in order of importance to your jurisdiction. 1 is the most important form of support and 7 is the least important form of support.



Q25. Please tell us if there are any other forms of support that GNHiAP can provide to your jurisdiction to help in the implementation of the HiAP approach.

Training, financial support to attend HiAP training opportunities
Sponsoring training of the initiative drivers (2 members)
Technical support locally for drafting strategy and action plan
The main thing would be to deliver some good quality training in NZ!!!
Multilingual materials explaining HiAP and Training, seeking funding opportunities
Raising the issue on agendas in international networks
Facilitate in-country training or sensitization meetings with relevant stakeholders
Promote HiAP in high-level international decision-maker meetings
Sharing our stories
Benchmarking the state of affairs with similar countries - learn for their experiences; Globally, resist the development that directs action into "silos"
After having case study books, training courses and etc., it will be helpful if the network help connecting my organization /jurisdiction to other organizations/ jurisdictions through an annual meeting or a twining programme. A face to face meeting can inspire an idea an provoke implementation than a book or a training.
Provide example of indicators to evaluate progress in terms of intersectoral governance
It would be excellent to arrange a phone call or video meeting between GNHiAP leaders and our jurisdictional leaders in California, to help us advance this to a higher level.
Political advocacy and lobby to WHO's governing bodies
Monitoring the global progress of HiAP practice

Q26. If you or your organisation or jurisdiction has the capacity to provide input and support to the GNHiAP please indicate the type of support that can be provided. Please select all that apply.

Note: This survey question was flawed in its design as it did not allow respondents to select more than one response, thus the responses are not usable.

Q28. Are there any other comments, suggestions or ideas you would like to provide in regards to the GNHiAP?

- We would like opportunities to discuss and use the SDGs for furthering the HiAP agenda
- We support it and look forward to any opportunities to be involved
- This approach is a very important approach to achieve sustainable goals that Tunisia are engaged in. We need a support to convince our government and I think that our involvement in this network could help us very much.

Annex 6: Governance Structure

Governance Structure of the Global Network for Health in All Policies (GNHiAP)

1. GNHiAP

The Global Network for Health in All Policies (GNHiAP) is a country-led initiative which was launched by the governments of Sudan, Finland and Thailand, the Province of Québec, and the State of South Australia at a side event during the 70th World Health Assembly (WHA) on May 24, 2017.

A meeting was convened soon after the launch, resulting in the establishment of a Transitional Steering Committee (TSC). To support the network and plan for activities during the first months, an Executive Committee (EXCOM) was formed from the members of the TSC. The EXCOM comprises Ministry of Public Health of Sudan, National Health Commission Office of Thailand, the South Australian Department of Health and Ageing, Ministry of Health and Social Affairs of Finland, the Global Health Centre at the Graduate Institute and the World Health Organization headquarters in Geneva.

The GNHiAP governance structure is based on multi-stakeholder engagement with the aim of ensuring effective coordination and tangible outputs. GNHiAP is managed by the Executive Committee with the supervision of the Steering Committee. All committee members work pro bono.

1.1 Vision

The HiAP approach is strengthened with the aim of implementing the SDGs and facilitating progress on Universal Health Coverage.

1.2 Mission

The Global Network for Health in All Policies (GNHiAP) will work with various governments and institutions across different sectors at all levels to address the determinants of health by strengthening the HiAP approach. The aim is to support the development of skills, to build capacity, share knowledge, and facilitate systems change towards embedding a holistic approach for sustainable development.

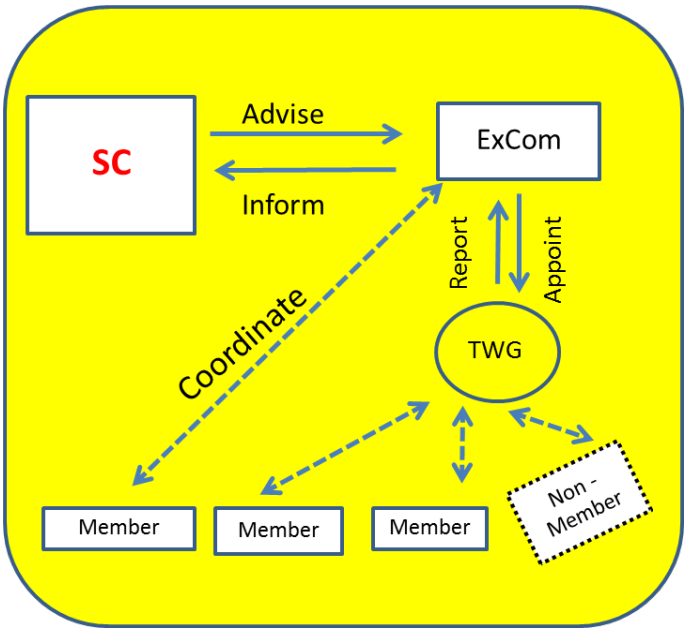
1.3 Network Activities

The below section outlines the objectives of the network, which arise from the vision and mission of the network.

The Global Network for Health in All Policies aims:

1. To advocate for HiAP;
2. To lead, provide and facilitate HiAP implementation at the regional, national and sub-national levels to support the implementation of the SDG agenda;
3. To strengthen and institutionalise HiAP as a whole-of-government and whole-of-society approach;
4. To facilitate the development of tools and guidelines, and to support step-by-step HIAP implementation "from theory to practice" with the benefit of global expertise, in collaboration with the WHO and other partners;
5. To enable knowledge-sharing and learning from country experiences, reflecting cultural diversity and context through South to South and Triangular Cooperation;
6. To enhance research and evidence generation on the effectiveness of the HiAP approach in supporting the implementation of the SDGs and UHC;
7. To provide countries and jurisdictions an online platform where they have access to a range of support materials, and the opportunity to engage in rich interactive discussions and share experiences, and;
8. To build capacity and skills to enable implementation of Health in All Policies and facilitate system change towards embedding sustainable development in the regional, national and sub-national governance systems and operations.

2. GNHiAP Structure



2.1 Steering Committee (SC)

2.1.1 Composition

The membership should not exceed 14 - 18 persons, representing institutions from different sectors as presented below:

Member, by sector	Amount
a) Government agencies from national and sub-national levels covering six regions and all income levels	50%
b) Academic institutions (rotating across 6 regions)	20%
c) Non-governmental organisations (NGOs), civil society organisations (CSOs) or networks at regional or global levels	15%
d) United Nations agencies	15%

2.1.2 Role and Responsibilities

a) Set the direction for and oversee the implementation of GNHiAP
b) Advocate for and mobilise political support for the mission and activities of GNHiAP, including the expansion of the network
c) Responsibility over treasury, including fundraising and mobilising resources for GNHiAP activities
d) Convene and attend a teleconference meeting regularly, at least twice a year
e) Select and appoint the Executive Committee
f) Represent and give a voice to the network

2.1.3 Term of Service

The term of service is 3 years, and the current term is from 2018 – 2020.

The Steering Committee members may be reappointed for a maximum of two consecutive terms. No more than 2/3 of the outgoing Steering Committee can be reappointed at the same time in order to ensure diverse representation across sectors and regions.

2.1.4 Quorum

The Quorum required to convene an official meeting is 50% plus one of the Steering Committee members.

2.1.5 Criteria for joining the Steering Committee

a) The institution has to be a member of the network
b) Both the institution and the individual nominated have to have a good understanding of and commitment to HiAP work
c) The individual has to be committed to and available for the Steering Committee meetings and able to finance their participation

2.1.6 Selection Process

a) The Steering Committee members and other network members can nominate a selected representative or alternate representative to the Steering Committee by sending either an informal or formal letter of support to the Executive Committee
b) The Executive Committee circulates a shortlist of candidates to the Steering Committee for approval

c) In case no nominations are received to satisfy the composition of the Steering Committee, the Transitional Steering Committee or the existing Steering Committee can propose institution and a representative individual for the consideration of the Executive Committee, which will invite the institution to join the Steering Committee

2.2 Chair

2.2.1 Role and Responsibilities

a) Conducting and chairing the Steering Committee meetings and other meetings
b) Chairing the Executive Committee and facilitating consistency of work
c) Leading the fundraising and advocacy for GNHiAP and its activities

2.2.2 Term of Service

The term of service of the Chair is 3 years. The current term is from 2018 – 2020.
The Chair may be reappointed, and can serve a maximum of two consecutive terms.

2.2.3 Criteria for being the Chairperson

a) Demonstrated high commitment to HiAP
b) International recognition and good connections to donors and stakeholders
c) Effective leadership and chairing skills and abilities

2.2.4 Selection Process

a) Steering committee members can propose candidates for the role
b) All members of the Steering Committee will agree on a nominee best suited for the role and matching the requirements of the role
c) The Chair will also be the Chair of EXCOM

2.3 Executive Committee (EXCOM)

The EXCOM provides leadership under the supervision of SC, as well as performs a secretariat function to the SC

2.3.1 Composition

Members comprise the following:

a) Maximum of 6 institutions
b) If possible, different sectors, namely national and sub-national governments, academia, UN agencies and NGOs/CSOs, should be included in the EXCOM to ensure diverse and broad representation
c) One of the EXCOM members is always the SC Chair
d) The EXCOM will be elected from the Steering Committee members

2.3.2 Role and Responsibilities

a) Developing the workplan and budget of the network
b) Monitoring the progress of the workplan, approved by the Steering Committee
c) Producing annual reports for the recording of activities and communication purposes

d) Coordination and facilitation of the Steering Committee, network's members and technical working groups
e) Serving as the Secretariat of the network

2.3.3 Term of Service

The term of service is 3 years. The current term is from 2018 – 2020.

2.3.4 Criteria for selection to the Executive Committee

a) Demonstrated experience and knowledge in the area of HiAP
b) Commitment to and availability for the work of the Executive Committee, including ability to financially support themselves to work as EC member
c) The World Health Organization is a Standing Executive Committee member

2.3.5 Selection Process

a) The Executive Committee is elected from and by the Steering Committee membership
b) The Steering Committee members nominate their representatives to serve on the Executive Committee at the last meeting of the Steering Committee before the service term ends (the next time will be in 2020)
c) A focal point for the Executive Committee is selected among the members of the Executive Committee

Note: *For the first 3 years of GNHiAP, the founders of the network will automatically be the Executive Committee. When the term ends, the Executive Committee will be selected according to the above composition ad procedure.*

2.4 Member

2.4.1 Role and Responsibilities

a) Commitment to use HiAP approach to achieve SDGs
b) Contribution of in-kind or financial resources to support the work of the network

2.4.2 Term of Service

The term of service is 3 years. Membership is automatically renewed at the end of the term.

2.4.3 Criteria for becoming a member

a) Institutions located in the following sectors: government agencies at all levels, CSOs, NGOs, UN agencies and international organisations, private sector, academic institutions, universities, media (this list is not exhaustive)
b) Institutions from both health and non-health sectors are welcome
c) Strong interest or prior experience in HiAP is required

2.4.4 Selection Process

a) Interested institutions should send a Letter of Intention to the Executive Committee

b) The Executive Committee endorses the requests and informs the Steering Committee for acknowledgement and approval

2.5 Technical Working Group (TWG)

If deemed necessary and appropriate, the members can request establishment of a technical working group(s) in line with the workplan by sending an informal or formal letter together with suggested Terms of Reference to the Executive Committee. The TWG will be endorsed by the Executive Committee and dissolved when the task is completed.