GLOBAL STATUS REPORT ON HEALTH IN ALL POLICIES

Global Network for Health in All Policies

Government of South Australia

CONTENTS

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Foreword by the Director-General of the World Health Organization

Improving the health and wellbeing of people around the world and achieving the Sustainable Development Goals takes commitment and collaboration from all sectors and actors. The Sustainable Development Goals affect all countries – whether low, middle or high income. Health is not only a critical outcome of the Sustainable Development Goals, it is also an important tool for achieving them.

The WHO Thirteenth General Programme of Work 2019–2023 (GPW 13), launched in 2018, is based on the Sustainable Development Goals and structured around three strategic priorities to *ensure healthy lives and wellbeing for all at all ages:*

- achieving universal health coverage – 1 billion more people benefitting from universal health coverage;
- addressing health emergencies – 1 billion more people better protected from health emergencies; and
- promoting healthier populations – 1 billion more people enjoying better health and wellbeing.

One of the most effective ways to achieve both the Sustainable Development Goals and GPW 13 is through Health in All Policies, an approach which systematically takes into account the health implications of decisions in all sectors. Health in All Policies involves intersectoral action which deals with all determinants of health.

Understanding the nature, strengths and challenges of current Health in All Policies practice is vital to strengthen the capacity of countries to take action on the Sustainable Development Goals and GPW 13.

Health in All Policies practice emphasises working together and understanding what makes for good governance, leadership and effective mechanisms for working across sectors. It also involves strong guidance and committed people and resources, to ensure health is considered in all policies.

It gives me great pleasure to introduce this, the first Global Status Report on Health in All Polices. The Report presents a picture of Health in All Policies approaches and the diversity of practice from 41 jurisdictions across the world. It contributes to the growing evidence base demonstrating a consistent set of conditions for success in the establishment, implementation and sustainability of Health in All Policies.

The Report was prepared on behalf of, and in collaboration with, the Global Network for Health in All Policies (GNHiAP). I commend the GNHiAP for their commitment to work collaboratively to strengthen Health in All Policies practice internationally.

This Report, along with future iterations, will help to shape the development of Health in All Policies globally and contribute to the achievement of the Sustainable Development Goals and GPW 13.

Dr Tedros Adhanom Ghebreyesus
WHO Director-General

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Acknowledgements

This first Global Status Report on Health in All Policies 2019 has been prepared on behalf of, and in collaboration with, the Global Network for Health in All Policies (GNHiAP). Membership of the GNHiAP is listed in Appendix 1.

The GNHiAP would firstly like to thank the respondents for taking the time to share their experiences of HiAP practice, and for sharing the Global Network for Health in All Policies Survey with HiAP practitioners in other jurisdictions. The GNHiAP extends even further appreciation to the three jurisdictions which also provided snapshots of their HiAP practice.

The GNHiAP would also like to thank the Global Status Report Data Analysis Team from the South Australian Department for Health and Wellbeing for their leadership, coordination and delivery of the report - Carmel Williams (conceptual and technical oversight), Beth Keough (primary data analyst and primary author), Deb Wildgoose (data analysis and report author), Claudia Galicki and Katherine Pontifex (supporting authors). The Team lead the survey design and data analysis, and authored this final report.

This work has benefitted from the continual advocacy by WHO on the use of the Health in All Policies approach, in particular since hosting the Second Adelaide meeting with the Government of South Australia, and supporting the Global Network to establish itself and its activities.

This exercise was supported by a number of people to whom we also express our thanks:

The GNHiAP Executive Committee (ExComm) – consisting of Abdalla Osman (Sudan), Carmel Williams (South Australia), Taru Koivisto and Timo Ståh (Finland), Nanoot Mathurapote (Thailand), Michaela Told and Sara-Oona Matilda Pentikainen (Switzerland) Nicole Valentine (Switzerland) - provided input into the development of the survey, as well as the data analysis and the final report.

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And also recognised are Michele Herriot, Director, Health Promotion Consulting, South Australia, as editorial advisor, and Jessica Mckinlay for project support.

EXECUTIVE SUMMARY

Shanghai, China

Background

This is the first Global Status Report on Health in All Policies (HiAP), an important development in the advancement of HiAP. It presents a picture of HiAP approaches and the diversity of HiAP practice based on the responses of 41 jurisdictions across the world.

The World Health Organization (WHO) defines HiAP as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity."[a] In particular HiAP involves the use of formalised governance structures to facilitate multisectoral action; this feature distinguishes HiAP from other forms of collaborative action.

The United Nations Sustainable Development Goals (SDGs) provide a renewed impetus for joined-up action to address complex, contemporary problems and for the achievement of health and good governance. The achievement of the 17 SDGs relies on strong collaboration across sectors. HiAP can help facilitate improved holistic and multi-stakeholder action to achieve the SDGs and to improve health and wellbeing, whilst also advancing the goals of all sectors through shared responsibility. The importance of partnerships is explicitly recognised through Goal 17.

It is envisaged that this report will help raise the profile of HiAP as a rigorous methodology to support the implementation of the SDGs and other cross-sector collaborative approaches; shape the development of HiAP on a broader scale and continue to stimulate discussion about the value of the approach.

This report was prepared on behalf of, and in collaboration with, the Global Network for Health in All Policies (GNHiAP). The GNHiAP is a network of government entities (national, regional, local) and other institutions (UN, inter-government and non-government organisations, academia) committed to working collaboratively to strengthen HiAP practice internationally.

The report documents the status of HiAP practice across the world in order to establish an account of HiAP models, to examine current progress, identify key challenges and share lessons in HiAP action. It presents an analysis of how HiAP operates in different jurisdictions, including by different levels of government and by stages of maturation. It is hoped that this will improve understandings of HiAP among policy-makers and partners and inform capacity building activities (including training and courses) to strengthen and sustain global HiAP practice. As the first extensive survey of its kind it informs the future development of methods and indicators for HiAP action.

[a] World Health Organization (2013a). Helsinki Statement on Health in All Policies. 8th Global Conference on Health Promotion, Helsinki, 10-14 June. Geneva (CH): WHO; 2013. Available at: http://www.who.int/iris/handle/10665/112636

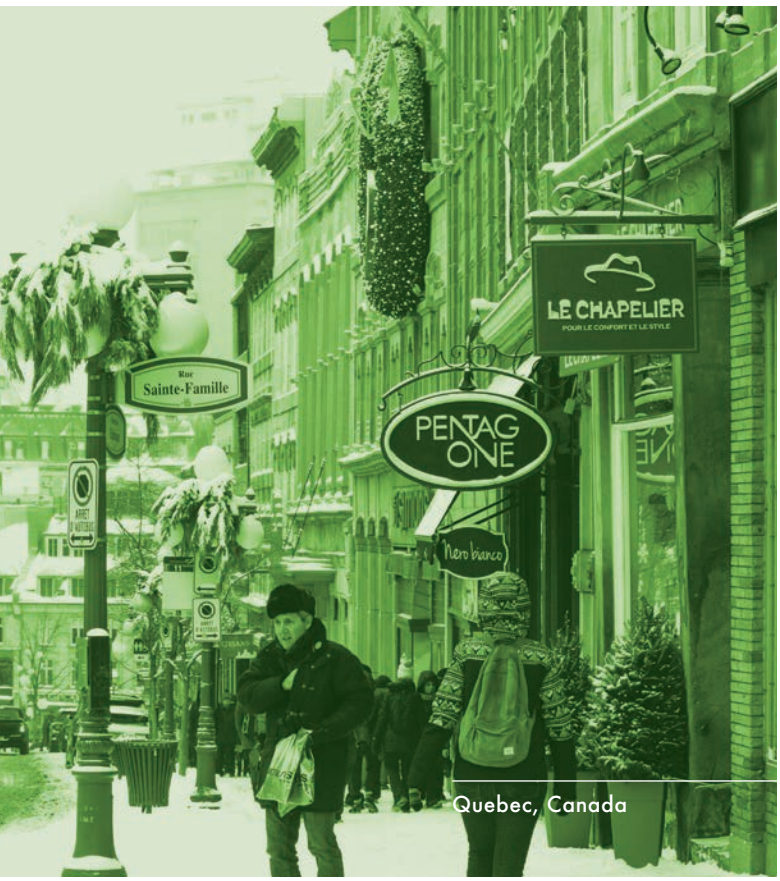
Methodology

The 48 question, on-line Global Network for Health in All Policies Survey was distributed in October 2018 to national, subnational and local entities implementing a HiAP approach in their jurisdiction. After assessment there were 41 suitable responses for analysis. The Technical Group of the GNHiAP and additional experts advised on the methods for analysis.

There is no formal register of jurisdictions using the HiAP approach meaning a snowball sampling method was used to maximise the number of respondents and achieve the best possible diversity of respondents. Jurisdictions were asked to respond only if they identified as HiAP practitioners based on the WHO definition of HiAP (rather than practitioners of general intersectoral or multisectoral action for health). There were respondents from all continents and 22 countries. Some countries included responses from different levels of government.

Findings

The results were analysed by two key factors: phases of maturity (emerging, progressing and established) and, where appropriate by level of government (local, subnational and national). Analysis by maturation elicited stronger themes, whereas analysis by level of government proved less useful overall.



Quebec, Canada

There is a growing evidence base demonstrating a consistent set of conditions for success that support the establishment, implementation and sustainability of HiAP within jurisdictions. This evidence base builds on the large body of theory and evidence in relation to intersectoral action for health and was used to establish the themes for the analysis of the survey results. Key preconditions are:

Governance and Leadership: the survey data show that the more established the HiAP practice, the more likely a jurisdiction is to have a strong authorising environment with political support, as well as governance mechanisms or formal structures in place to oversee HiAP in their jurisdiction. The majority of jurisdictions have some level of governance arrangements or formal structures. Further clarification of the terms formal and informal governance will be important in the future.

Resources for HiAP (personnel and monetary): resources are required to support and sustain good HiAP practice and in particular dedicated personnel are key given the importance of building strong collaborative relationships for successful HiAP practice. However, results show that HiAP implementation is possible with minimum budgets, regardless of HiAP practice maturity. Dedicated resources, whether staffing and/or budgets, are most common at the subnational level of government, and in the established phase of practice.

Entry Points: there is no single way to get HiAP on the agenda as it is context specific. Action needs to reflect and leverage current cross-cutting issues, potentially drawing on both the local and international context. These can include health system and health protection related factors, specific health issues (e.g. obesity or infectious diseases). Common actions for initiation of HiAP are action plans, events and high-level strategies. Addressing health inequity is an ambition although it is not always reported as a way of working. Entry points vary with stage of maturity. For example emerging jurisdictions are more likely to act on "top down" drivers, possibly reflecting the SDGs imperative.

Capabilities (Individual and Organisational): the results confirm the literature that shows HiAP practice requires complex and comprehensive negotiation and diplomacy skills and the ability to navigate and be responsive to changes in the political, administrative, cultural and/or environmental context. Skills levels are reported as less competent in the progressing phase of practice than the emerging, which may be due to reflection about the true, breadth and complexity of skills required for HiAP that comes with growing experience. The results also suggest that skills and experience working with other sectors are developed and strengthened as HiAP practice evolves.

Ways of Working: the results show that respondents with more established practice report a more comprehensive range of current, or intended approaches to implementing HiAP in their jurisdiction than those with less experience. *'Delivery of strategic or "big P" policy...'* is the most common policy-related focus for HiAP practice which is encouraging given policy impact is widely considered the ultimate goal of a comprehensive and sustained HiAP approach. Having a dedicated team is more common in supporting *"big P"* policy approaches than having a dedicated budget – it takes people skills and time more than it does specific budgets. Other ways of working covered include: the presence of informal structures to support the implementation of HiAP; use of evidence and tools such as "Health Lens Analysis"; use of meetings and events for sharing information and engaging key HiAP influencers and networking. There seems to be limited action on environmental determinants and climate change at present through HiAP practice however.

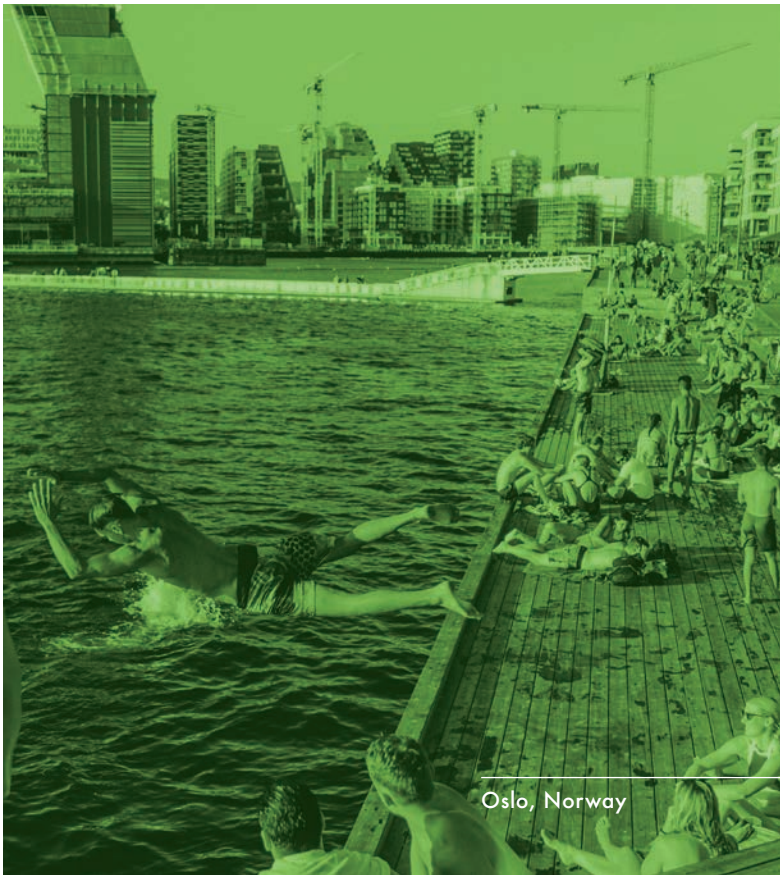
Monitoring, Reporting and Evaluation: the report shows clear linkages between the maturity of HiAP practice and any reporting and evaluation mechanisms in place, as well as a positive relationship between formal governance structures and monitoring, reporting and evaluation. Further definition of terms in this area will be important as results indicate that monitoring, reporting and evaluation are defined differently across global jurisdictions.

HiAP Priorities and Outcomes: The survey results show that priority setting is important in all phases of maturity; the nature of these priorities is however influenced by the level of government and the political climate. Jurisdictions reported on priorities related to evolving their practice and processes as well as specific health issues they intend to tackle in the next two to five years. Demonstrating short and longer terms outcomes will be important in the future. Outcomes reported tend to span across a number of categories, from an increase in political commitment, multisectoral action on health and social determinants of health issues, to introduction of legislation and policy to support the systematisation of HiAP.

Summary

It is envisaged that the report will stimulate discussion about the opportunities and challenges of HiAP implementation and its place in supporting the achievement of the SDGs as well as aid in improving our understandings of how to initiate, implement and sustain HiAP.

Positive developments show that HiAP provides a sustainable model for working across sectors to deliver health outcomes and progress the goals of other sectors, but advances so far remain uneven across regions. The consolidation of evidence on HiAP practice presented in this report allows us to take stock of where we are now, reflect on the challenges, and progress HiAP development in a more informed way that will ultimately support actions to deliver on the 2030 Development Agenda. This consolidation of evidence will inform and strengthen future survey iterations and analysis of the status of Global HiAP practice.



Oslo, Norway

1.0 INTRODUCTION

Bombwe, Zambia

Welcome to the first Global Status Report on Health in All Policies (HiAP).

This report aims to capture the current state of HiAP approaches and the diversity of HiAP practice across the world. It is envisaged that this report, along with future iterations, will help shape the development of HiAP on a broader scale and continue to stimulate discussion about the value of the approach.

This report was prepared on behalf of the Global Network for Health in All Policies (GNHiAP); a network of government entities (national, regional, local) and other institutions (United Nations, international governmental organisations, NGOs, academia) dedicated to working collaboratively to strengthen international HiAP practice. Several pieces of work have been prepared by the GNHiAP since the network was first established in 2017. This includes a survey of GNHiAP members regarding aspects of their HiAP practice,[1] which informed the design of this survey. The full membership of the GNHiAP is outlined in Appendix 1.

1.1 Context of the report

In the era of the United Nations Sustainable Development Goals (SDGs),[2] there is a renewed impetus for joined-up action to address complex, contemporary problems. The 2030 Development Agenda and its SDGs provide a new platform for the achievement of health and good governance. Many of the 17 SDGs intersect and their achievement relies on strong collaboration across sectors. Indeed, health is at the core of many of the SDGs. Seizing on that momentum, HiAP can help facilitate improved holistic and multi-stakeholder action to achieve the SDGs and to improve health and wellbeing, whilst also advancing the goals of all sectors through shared responsibility.

Action across sectors (in government and society) to protect and promote health can take many forms. The World Health Organization (WHO) defines HiAP as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity."[3] HiAP can be seen as a continuum of intersectoral action for health that often involves systematisation, formalisation and/or institutionalisation of the approach. HiAP involves the use of formalised governance structures to facilitate multisectoral action, setting it apart from other forms of collaborative action.

HiAP continues to attract the attention of policy-makers worldwide, yet its uptake has been variable and experiences diverse.[4] More and more jurisdictions are progressing HiAP, but garnering greater participation in policy-making and implementation, and strengthening governance for health are still challenging. Many jurisdictions face difficulties in translating the evidence for HiAP into practice through policies and actions that are relevant to their needs. Understanding and addressing the determinants of health and health inequities is also difficult because they are complex, multi-faceted and dynamic. Furthermore, systematic change, such as HiAP takes time in order for sustainable outcomes to become apparent. In organisational cultures and political climates where quick-wins, short-term gains and fast-acting processes are favoured, taking the time to apply HiAP can seem onerous. Greater effort is therefore required to encourage and support HiAP implementation.

California, USA

HiAP action is also context specific; what works in one jurisdiction will not necessarily work in another. For over a decade, as HiAP practice has advanced consistent factors for success have begun to emerge, as well as interesting points of difference that all contribute to building the HiAP knowledge base.[4,5] This report provides an opportunity to consolidate our understanding of how HiAP operates in different countries and localities as well as different contexts.

Gaining a better understanding of how HiAP models function at different levels of government and at different stages of maturation will support improved progress on HiAP globally, regionally and locally and help to fully realise the transformative agenda envisioned by the SDGs. It is timely to gain a broader understanding on how HiAP is being implemented, to inform its development around the world, and to strengthen partnerships and governance for health.

This first global report on the status of HiAP collates information from 41 jurisdictions implementing HiAP around the world providing robust information about current HiAP practice and giving insight into the diversity of approaches. It allows lessons to be drawn from the different models to facilitate tracking of worldwide progress on implementation; and will support future reporting.

This report is not intended to be a scorecard or rating of progress across different implementing regions or countries. Rather it considers key thematic trends for HiAP action, including enablers and barriers to implementation and is intended to catalyse collaborative policy-making and advocate for HiAP as a critical policy-making strategy and tool. It is envisaged that the report will stimulate discussion about the opportunities and challenges of HiAP implementation and unpack its place in supporting the achievement of the SDGs. The report aims to improve our understandings of how to initiate, implement and sustain HiAP.

Positive developments show that HiAP provides a sustainable model for working across sectors to deliver health outcomes and progress the goals of other sectors, but advances so far remain uneven across regions. The HiAP approach offers a useful strategy and tool-kit for brokering and facilitating not only partnerships but embedding governance into intersectoral collaboration. The implementation of all 17 SDGs is dependent on coherent and integrated action, which requires a shift towards whole-of-government and whole-of-society approaches that take account of the most disadvantaged and marginalised groups. HiAP provides a mechanism to support and deliver on this transformative agenda. The consolidation of evidence on HiAP practice presented in this report allows us to take stock of where we are now, reflect on the challenges, and progress HiAP development in a more informed way that will ultimately support actions to deliver on the 2030 Development Agenda.

1.2 Report objectives

The specific objectives of this report are to:

- Document the status of HiAP practice across the world in order to establish an account of HiAP models, to examine current progress, identify key challenges and share lessons in HiAP action;
- Present an analysis of how HiAP operates in different jurisdictions, including by different levels of government and by stages of maturation;
- Improve understanding among relevant policy-makers and partners of HiAP approaches;
- Inform capacity building activities to strengthen and sustain global HiAP practice;
- Support the work program of the Global Network for Health in All Policies in identifying gaps to improve HiAP training and courses;
- Develop viable cost-effective methods and indicators for identifying HiAP action;
- Raise the profile of HiAP as a rigorous methodology to support the implementation of the SDGs and general cross sector collaborative approaches.

1.3 Target audience

The primary target audience of this report is the health sector. Whilst HiAP is a mutual agenda for all sectors, it is usually the role of the health sector to help initiate and facilitate HiAP and provide a foundation to support its implementation. Increased consideration and investment is needed by ministries of health and local level health initiatives to integrate intersectoral action as part of core business, to magnify health benefits and advance the goals of other sectors. Leading by example, the health sector can promote and broker the integration of HiAP across different systems and build a concerted network of HiAP champions.

The role of central government is also important in the discussion of HiAP practice as it provides the high-level governance framework to legitimise HiAP across government; therefore central government is also a critical audience for this report. Furthermore, the findings will also be of interest to policy-makers in sectors outside of health, non-government organisations, academia, development agencies and civil society.

1.4 Key concepts

The survey methodology is described in Chapter Two and the results in Chapter Three however there are two key features to consider whilst reading this report, these include:

1.4.1 Jurisdiction

The term jurisdiction is used in conjunction with the level of government at which the respondent is implementing HiAP practice i.e. a jurisdiction may refer to a local, subnational, or national level of government. Finland for example, provided responses from both local level and national level of government; both are in this case referred to as a jurisdiction.

1.4.2 Phase of maturity of practice

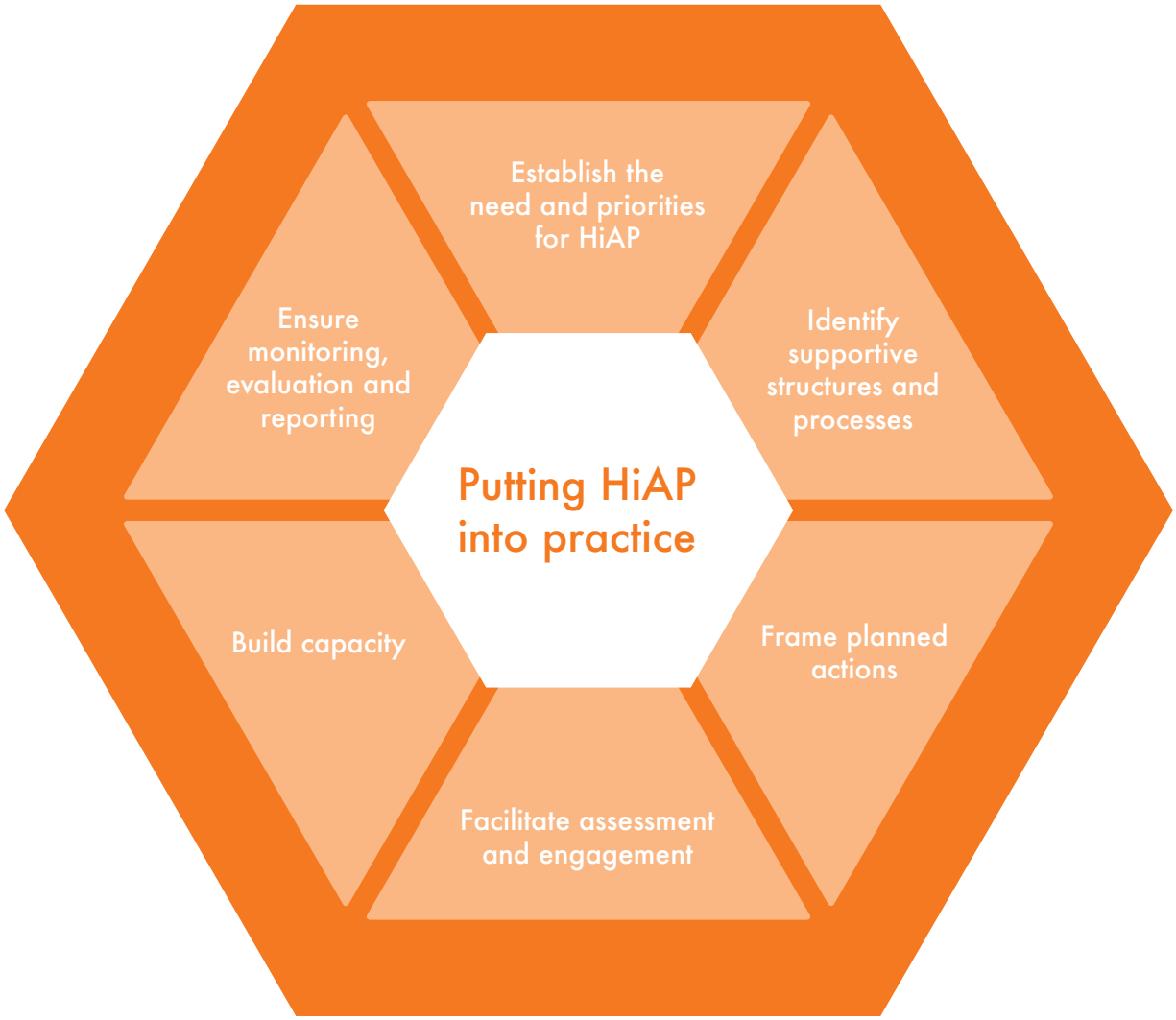
Respondents were asked to identify the stage of development and delivery of their HiAP practice, by choosing one of seven responses which drew on key features of HiAP practice. During data analysis, these seven responses were grouped into three categories - Emerging, Progressing and Established. These are known as the "phases of maturity" throughout the report.

- Respondents identified as being in the **Emerging** phase have an interest in developing HiAP, may or may not be working in partnership with other sectors, and currently have no formal commitment to progress a HiAP approach.
- Respondents identified as being in the **Progressing** phase have formal commitment to proceed, and acknowledge that they are in the early stages of planning or implementation.
- Respondents identified as being in the **Established** phase have well developed formal mechanisms, with some having HiAP as embedded practice.

While respondents were also asked about the length of time (number of years) they had been developing or implementing systematic work across sectors, length of time was not a consistent indicator of maturity of practice.

FIGURE 1–1

Key components of implementing health action across sectors



Source: Adapted from the Health in All Policies: Framework for Country Action WHO 2014[18]

1.5 A conceptual framework for the Survey

HiAP is a recognised approach to intersectoral action for health.[6] The call for cross sectoral action for health has a long history, from the *Alma Ata Declaration 1978*,[7] and the *Ottawa Charter for Health Promotion 1986*.[8]

The WHO refers to intersectoral action for health as *"actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector on health or health equity outcomes or on the determinants of health or health equity"*.[9]

Intersectoral action for health recognises and seeks to address the complexity of interactions and intersections of the social determinants of health and wellbeing. HiAP is seen to extend intersectoral action by *"facilitating sectors outside of Health to routinely consider and account for the health impact of their policies, plans and implementation"*.[10]

The greatest opportunity to impact the social determinants of health is through the creation of healthy public policy, policy being a key driver of funding decisions for programs and service delivery across government.[11] The growth of the HiAP approach globally has occurred at the same time as the growing acknowledgement that policy development is not linear, as it is often presented, but is complex and "messy".[12,13]

Pawson et al describe social interventions as *"complex systems thrust amidst complex systems"*,[14] a concept that also applies to policy interventions for action on the determinants of health.[11] HiAP takes a complex systems approach to addressing health equity and the determinants of health through healthy public policy.[15-17] In taking action within this complexity, HiAP draws on a variety of different theories and frameworks, from different disciplines to help shape practice.

These concepts are further explored in relation to the Survey results in Chapter Four.

1.5.1 Conditions for success

There is a growing evidence base that shows a consistent set of conditions required for success that support the establishment, implementation and sustainability of HiAP within jurisdictions.[4,18-20] This evidence base builds on the large body of theory and evidence that exists in relation to intersectoral action for health.[5]

These conditions for success have been recognised and embedded in key WHO publications on HiAP, including the:

- Adelaide Statement on Health in All Policies (2010)[11]
- Helsinki Statement on Health in All Policies (2013)[3]
- Health in All Policies Framework for Country Action (2014)[18]
- Adelaide Statement II –Implementing the Sustainable Development Agenda through good governance for health and wellbeing: building on the experience of Health in All Policies (2017).[22]

They have also been recognised and explored through the foundational work of the *GNHiAP*[1] and *Progressing the Sustainable Development Goals through Health in All Policies: Case studies from around the world*,[4] as well as a number of recent peer reviewed publications - Gase et al,[20] Baum et al,[10] and Shankardass et al[19] to name a few.

The *Health in All Policies Framework for Country Action (the FCA)*,[18] outlined in Figure 1-1, was adapted from the Helsinki Statement 2013.[3] It was developed as a "starter kit", detailing key components to be addressed in developing a sustainable HiAP approach. It was advanced with a particular focus on supporting the initiation of HiAP in a jurisdiction.

The GNHiAP agreed to explore a number of conditions for success through the Survey, incorporating key elements from the FCA and from the WHO Statements highlighted above. These conditions (and associated symbols) are:

The Survey sought to explore how these conditions for success are being operationalised in different jurisdictions from across the world, to understand more about current HiAP practice, and to consider the implications of these experiences for future HiAP action more broadly.

It must be recognised that these conditions are not distinct or separate from each other; rather they are interconnected and overlapping. The data in this report are largely presented in relation to these conditions for success. Cross-thematic analysis, insights into the significance of the level of government at which HiAP practice is implemented, and insights into the implications of the phase of practice maturity for these conditions are reported throughout.

1.5.2 Governance and Leadership

HiAP action is supported by high-level leadership and governance mechanisms which provide oversight for the HiAP approach, and formal structures to facilitate the implementation of HiAP practice. These structures are a distinguishing feature of HiAP, and are often important to the sustainability of HiAP practice.[23]

Political and executive leadership provides the authorising environment, the mandate for action and strategic vision. Leadership at the highest level helps to mobilise the whole government, create an environment of accountability, and support the sustainability of the HiAP approach. Leadership and formal governance structures at all levels are recognised as supporting the implementation of HiAP practice.[22,24,25]

1.5.3 Resources for HiAP

Appropriate resources and investment (both personnel and monetary) are important to support and sustain HiAP efforts.[5,10,20, 26]

Sound partnerships based on co-design, co-delivery and co-benefits are a crucial feature of HiAP.[4] As such, people are critical to the successful delivery of HiAP action. People play different but critical roles in creating a sustainable HiAP approach. Dedicated HiAP personnel often act as an engine for progressing HiAP action, facilitating the HiAP practice and navigating the complexity of collaboration.[10,13,27] The concept of the advocacy coalition framework[28] recognises that the policy process involves (and can benefit from) the formation and maintenance of complex coalitions (networks) of interest, and that these networks play a critical role in supporting and progressing policy change. Informal support staff (people who participate in and support HiAP activities but are not part of a core HiAP team) are vital both in supporting the implementation of activities, and in advocating for ongoing HiAP action.[10,28]

Financial resources, such as a dedicated HiAP budget, are recognised as a key factor that can enhance the implementation of HiAP activities when funding is available, or limit them if it's not.[5,27,30]

1.5.4 Entry Points

Entry points for the initiation of HiAP within a jurisdiction are understood to be context specific.[5,21,22] There are many drivers which can be used to initiate HiAP, depending on the windows of opportunity, engaged policy actors, and existing local, national and international agendas and priorities that can be leveraged. Understanding the political and policy environment helps to guide where to target effort to initiate HiAP, and the types of activities to undertake.[5,21,22]

1.5.5 Ways of Working

While there are key principles and strategies fundamental to the HiAP approach (including taking action on the social determinants of health, considerations of equity, a co-design approach and a focus on policy, particularly *"big P"* policy) there is no single or simple model for the implementation of HiAP.[4,5] Rather, the components of the approach are tailored to and by the jurisdiction, – to the political, organisational and situational context.[5,18]

The evidence shows that formal and informal structures and processes, flexible methods and tools and the sound use of evidence all contribute to effective HiAP practice.[5,10,18]

The creation of a broader, often informal, supportive network of policy actors who engage with and champion HiAP plays a vital role in supporting its implementation and sustainability.[10,13,28] This wider network often includes staff outside of the health sector who can be strong advocates for collaboration and multi-sectoral action.[10]

One key aspect of HiAP practice that is not explored in great detail in this survey is the nature, functioning and outcomes of partnerships and relationships in the jurisdictions. This was a deliberate decision, given the complexity of unpacking the critical elements of partnerships and relationships through this type of survey. This challenge is amplified when trying to gather this information across different cultures and languages. This is acknowledged in the recommendations.

1.5.6 Capabilities (Individual and Organisational)

Knowledge, skills and experience to support HiAP practice, such as negotiation and diplomacy, are critical for HiAP practitioners, as is understanding and being respectful of the needs and demands that drive sectors outside of health.[9,10,32] These HiAP capabilities often become as important as technical skills, such as evidence and policy analysis to help achieve policy coherence, especially when addressing very complex policy problems.[32,33]

1.5.7 Monitoring, Reporting and Evaluation

Monitoring and evaluating HiAP progress is complex, but is important to better understand what has worked and why, and to identify challenges and best practice.[18,20,34] Process, impact and outcome evaluation together can demonstrate the value of investment for health and wellbeing and policy collaborations. Reporting requirements (with or without evaluation) are often an accountability mechanism and are also recognised as an opportunity to showcase activity and influence future HiAP action.

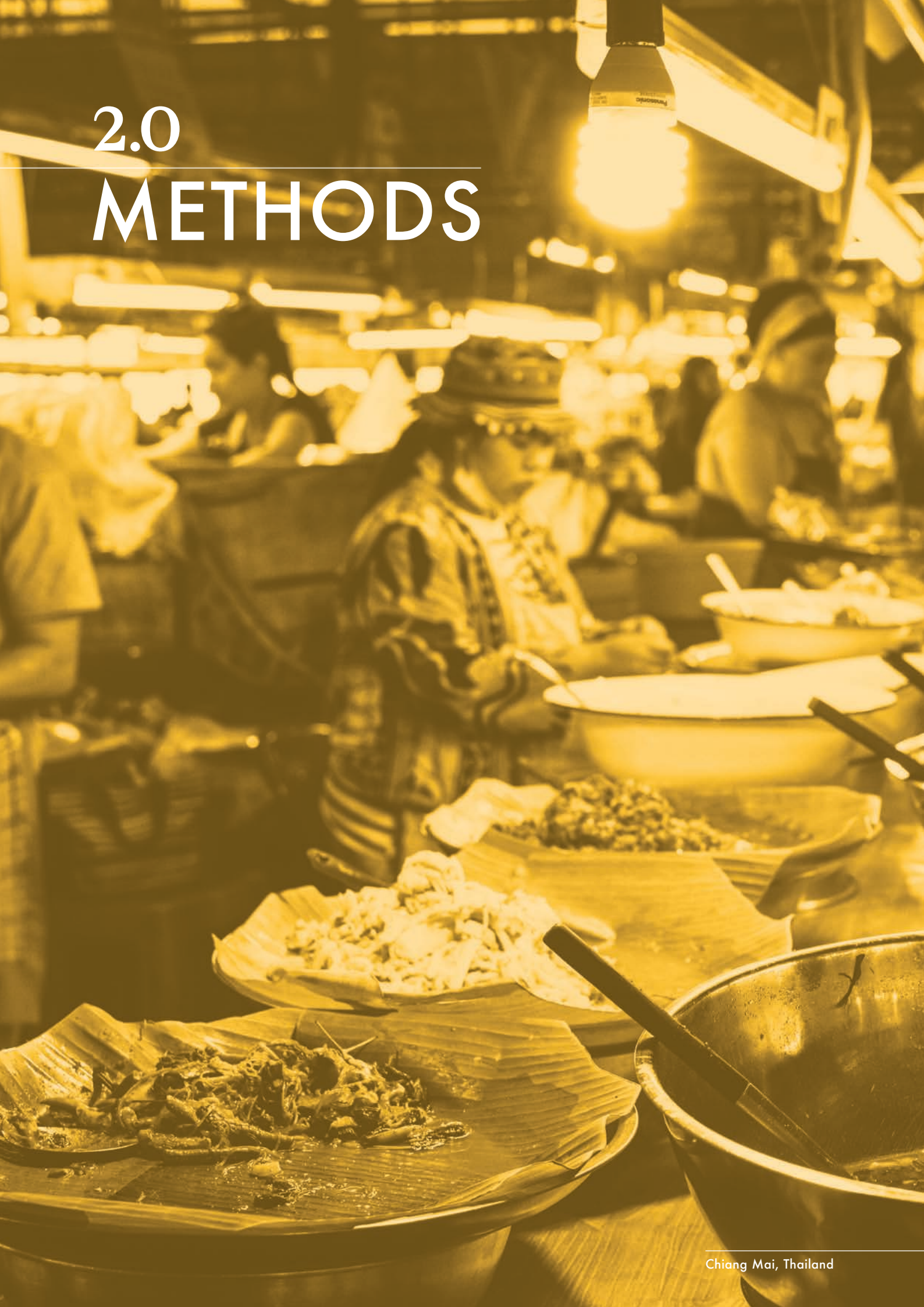
1.5.8 HiAP Priorities and Outcomes

Establishing priorities for HiAP action provides clear strategic direction and identifies significant issues for HiAP in particular contexts. HiAP priorities can be based on a variety of considerations, including the significance of the issues to health, alignment with government priorities, the feasibility of strategies to address a particular issue, and opportunities for collaboration.

The prioritisation process also helps identify entry points for HiAP and future policy action, and a collaborative priority setting process can help set the tone for joint action.

Rennes, France

2.0 METHODS



Chiang Mai, Thailand

This chapter describes the methods used in preparing the Survey, the sampling process and data analysis techniques, and reflects on the methodology.

2.1 Survey overview

Data for this report was collected between October 2018 and January 2019 from national, subnational and local entities implementing a HiAP approach in their jurisdiction. The collection instrument, the *Global Network for Health in All Policies Survey* (the Survey), is a 48 question, on-line survey (see Appendix 2). The survey design was informed by, and corresponds to the conditions outlined in Section 1.5 of this report.

In early 2018, the GNHiAP Steering Committee established a Technical Group to oversee the development of the survey and this report. The Technical Group comprised of members of the GNHiAP Executive Committee (a sub-group of the Steering Committee – see Appendix 1) and additional Steering Committee members.

The survey was designed in stages. One member organisation of the Executive Committee/ Technical Group (South Australia) developed a draft outline based on conditions and themes of interest identified in contemporary HiAP documents as discussed in Section 1.5. The Executive Committee and additional interested members of the Steering Committee provided input to the draft survey and reached consensus on a final endorsed version. South Australia played the lead role in conducting and analysing the survey responses.

The online survey was released on 17 October 2018 with an initial closing date of 14 November 2018. On 26 November 2018, the Technical Group agreed to extend the closing date to increase the opportunity for additional responses. The survey was officially closed on 7 January 2019. Respondents were required to complete the survey on-line and in one session taking approximately 20 minutes.

2.2 Sampling

There is no formal register of all national, subnational and local jurisdictions using the HiAP approach. A snowball sampling method was used to maximise the number of survey responses and achieve the best possible diversity of respondents - both geographically and in relation to level of government (national, subnational and local level HiAP approaches).

The survey was circulated to all jurisdictions known by the GNHiAP to be implementing a HiAP approach; those described in the 2017 *Case Studies report*[4] and respondents to the *GNHiAP Survey 2017* which acted as a pilot for this survey.[1] In addition, the survey was circulated through networks known to: the World Health Organization's Social Determinants of Health contacts, the GNHiAP Steering Committee and the GNHiAP Executive Committee. These networks' members forwarded the survey to jurisdictions they knew or believed to be implementing a HiAP approach. These jurisdictions were also invited to complete the survey and were asked to forward the invitation to any additional jurisdictions known to them, to be implementing a HiAP approach.

Jurisdictions were asked to respond only if they identified as HiAP practitioners based on the WHO definition of HiAP (rather than practitioners of general intersectoral or multisectoral action for health).[22]

Essaouira, Morocco

2.3 Technical Group meeting

On 26 and 27 November 2018, the South Australian Government hosted a meeting of the GNHiAP Technical Group in Adelaide, South Australia. The focus of the meeting was to identify a process for analysing the survey data, and agree on emerging themes and a structure for this report, based on the data available at the time. Due to other commitments, some international members of the Technical Group were unable to attend. Representatives from two Australian jurisdictions (Australian Capital Territory and Tasmania) and one New Zealand jurisdiction with HiAP expertise were invited to observe and contribute. An independent facilitator with HiAP expertise led the meeting discussions.

The Technical Group endorsed the data management methods proposed by the SA Health, Health Determinants and Policy Team (the Analysis Team). The discussions across the two-day meeting were recorded and summarised to inform subsequent data analysis. The Technical Group also provided advice on opportunities for improvements in any future surveys based on the 2018 experience.

The Technical Group examined the data grouped under the categories of the known conditions that support HiAP (outlined in section 1.5) in small group discussions. The GNHiAP had provided prior endorsement of the process (of grouping data on the basis of these conditions) at a Health in All Policies Sub-Committee meeting in May 2018. The Technical Group, through consensus, provided guidance on which data should inform the Global Status Report on HiAP and where analysis might be strengthened by cross-analysis of data from related survey questions. Guidance was also provided on the recoding of "other" responses into existing categories, where deemed appropriate.

It became apparent on the first day of the Technical Group meeting that the most meaningful themes emerging were in relation to the "level of maturity" of the HiAP approach. As such, three categories of maturation were identified based on responses to survey question 11 (see Appendix 3): "Emerging", "Progressing" and "Established". Categories of "level of government", based on responses to survey question 2, were also agreed to be a meaningful approach to comparing data related to certain conditions.

The Analysis Team summarised the outcomes of the Technical Group meeting, and subsequently proposed a structure for this report to the Technical Group. Minor amendments to the structure were also suggested and have been incorporated.

2.4 Survey responses

A total of 70 survey responses were received by the initial closing date (14 November 2018) with an additional 12 responses received by the extended closing date of 7 January 2019 giving a total of 82 responses.

Of the 82 responses, **41 valid responses were included for analysis**, and 41 were excluded including:

- 9 duplicative responses
- 13 incomplete responses
- 19 incomplete and duplicative responses.

The 41 surveys were excluded from the final sample for reasons as follows:

- Survey responses deemed to be materially incomplete were excluded (those excluded were, at a maximum, 30 percent complete).
- In addition, survey responses deemed duplicative for a given national, subnational or local respondent were excluded; the (single) most complete version for a given respondent was accepted for analysis. The survey design required that responses were done in one sitting, which explains the high number of duplicative and incomplete survey responses.
- Survey responses deemed to be from respondents not undertaking (or planning on undertaking) a HiAP approach, as defined in the survey, were excluded. These were also often incomplete.
    - Survey Questions 4 and 5 were used as a basis for validating HiAP practice (however responses to other questions were also considered to cross check these).
    - Question 4 asked respondents to describe their HiAP work and engagement with other sectors. Where respondents selected Option a (occasional collaborations to address one issue or determinant of health with a single partner) or Option b (occasional collaborations to address a range of issues or determinants of health with various partners), they were directed to Question 5.
    - Question 5 asked respondents to confirm if they had plans to include a more systematic approach to their collaborative work.

A number of responses from the same country have been included in the final data set. For example, for China, one national level and two subnational level responses have been included, and for Finland, one national and two local level responses have been included.

In addition, one response though incomplete was close to completion and thus deemed valid for inclusion.

The 41 valid survey responses were analysed and endorsed by the Technical Group, and form the basis for this report.

Table 2-1 shows the respondent jurisdictions.

2.5 Data analysis

Data from the final 41 valid survey responses were exported from the Survey Monkey website into Microsoft Excel V.14. A process of deductive thematic analysis has been applied to the data, where coding and theming is directed by existing concepts or ideas underpinning HiAP practice, based on existing literature.[3,4,9,21,22,32,35]

Data was organised for each survey question as follows:

- For questions with a closed set of responses, the proportion of respondents selecting each response has been calculated and displayed in tabular or graphical format.
- For questions where the closed set of responses included an "other" category, "other" responses were recoded to existing categories (by the Analysis Team), or were reported verbatim for the consideration of the Technical Group.
- For Question 2 (level of government), some responses were observed to be reported inconsistently by jurisdictions. Two jurisdictions responded as "multiple local" level of government, but were observed to be reporting on one local area. As a result, the category of "multiple local" was removed from subsequent analysis and the two categories of "individual local" and "multiple local" were combined with a new "local" label.
- For questions with open responses: data were recorded verbatim for the consideration of the Technical Group.

Data from questions were sorted into groupings based on the following conditions:

- Governance and leadership
- Resources for HiAP (personnel and monetary)
- Entry points
- Ways of working
- Capabilities (individual and organisational)
- HiAP priorities and outcomes, and
- Monitoring, reporting and evaluation.

2.6 Strengths and weaknesses – survey design, sampling and analysis

The Technical Group and Analysis Team identified the following strengths in the survey design, sampling and analysis:

- Purposive sampling has captured a range of HiAP models given this is the first global HiAP survey to be undertaken.
- The survey was fully completed by 40 of the 41 survey respondents with the remaining one completing the majority of questions.
- The collaborative survey design process ensured a sound cross-section of key themes, based on the conditions known to support HiAP that were covered in the survey. These themes and conditions are evidence-based and demonstrate the complexities of HiAP practice.

The Technical Group and Analysis Team identified the following limitations in the survey design, sampling and analysis:

- There is no complete or up-to-date list of jurisdictions implementing HiAP. This led to the need to undertake snowball sampling which, when combined with a limited data collection period, limited the breadth of circulation to the global communities of practice working on different issues in relation to HiAP.
- There are known missing HiAP models in the final response count; therefore the data in this report are not representative of all examples of HiAP practice across the globe.
- A relatively small sample size has meant that when grouping the data into even smaller categories (i.e. by level of government and phase of practice maturation), there are some groups that have low representation. This creates potential for skewing or biasing of results.
- Some responses may not fully represent the activity within jurisdictions. The responding individual themselves is likely to have influenced the responses provided, due to language and cultural differences, and the nature of their relationship with the HiAP practice occurring i.e. are they immersed in it, or observing it from an academic perspective; are they a senior decision maker or is their role more operational?
- There is potential for response bias, as respondents would naturally want to present their HiAP practice in the most favourable way. Respondents may also have a subjective or biased view from their own experience which does not objectively reflect the complete picture of what is occurring.
- Details of the contextual nuances critical to HiAP could not be elucidated through the data collected in response to the survey, where questions were in some cases, worded bluntly.
- HiAP terminology is context specific. This was considered during the survey design phase however, and common terminology was settled on by the Technical Group. Nonetheless it may have had an impact on responses.
- Open-ended questions and inconsistencies in responses, indicated discrepancies in question interpretation. For example, when asked to describe budget allocation estimates, some respondents may have included staff in these estimates, where others may not have, rendering responses incomparable. For these reasons, a number of open-ended responses have been excluded from analysis.

Namibia

TABLE 2-1

Location of all respondents)

1	China
2	Bangladesh
3	Canada
4	Bhutan
5	Tunisia
6	Morocco
7	Namibia
8	Wales (UK)
9	Zambia
10	France
11	Finland
12	Suriname
13	Sudan
14	Thailand
15	Norway
16	Scotland (UK)
17	Prince Edward Island (Canada)
18	Nabeul (Tunisia)
19	Gabes (Tunisia)
20	Touzeur (Tunisia)
21	Pomurje (Slovenia)
22	Kebili (Tunisia)
23	Nelson (New Zealand)
24	Shanghai (China)
25	Waikato (New Zealand)
26	Shandong (China)
27	ACT (Australia)
28	Québec (Canada)
29	Tasmania (Australia)
30	Araba (Spain)
31	Oujda (Morocco)
32	Tennessee (USA)
33	South Australia (Australia)
34	Canterbury (New Zealand)
35	California (USA)
36	Quito/Pichincha (Ecuador)
37	Bizerte (Tunisia)
38	Irvine/California (USA)
39	Rennes (France)
40	Pirkanmaa/Tampere (Finland)
41	Tampere (Finland)

3.0 RESULTS

The 41 responses have been divided and presented in three groups, based on the maturation of HiAP practice (determined by responses to survey question 11, see Appendix 3): Emerging (n=18), Progressing (n=10) and Established (n=13). Results are presented here in subsections based on the key categories outlined in Chapter One.

In some instances, where appropriate, responses have been analysed by the level of government at which the HiAP approach is being implemented (based on responses to survey question 2, see Appendix 2. These categories include: national (n=16), subnational (n=19) and local (n=6).[b] Figure 3-1 shows a map of all responding jurisdictions, and indicates both the practice maturity, and level of government for that jurisdiction.

3.1 Governance and Leadership

Strong governance and leadership provides an authorising environment for HiAP, and drives and supports the development and implementation of HiAP work across sectors.[22] Understanding this authorising environment involves unpacking the different types and purposes of governance and leadership arrangements; the nature of the authorising environment, including political support and governance mechanisms and structures in place to provide oversight of the HiAP approach in jurisdictions; and the formal and informal structures to support the *implementation of HiAP practice.*

[b] When considering local level responses throughout this Results Chapter, it should be noted that this is a small number and therefore responses may seem more significant than they are in reality. For example, if 100 percent of local level reported, this is only six jurisdictions.

FIGURE | 3-1

Location of respondents - maturity of practice and level of government


Emerging (n=18)
Progressing (n=10)
Established (n=13)
National Level (n=16)
Subnational Level (n=19)
Local Level (n=6)[1]
Shandong
Bhutan
Bangladesh
Shanghai
China
Thailand
ACT
Tasmania
South Australia
Canterbury
Waikato
Nelson

3.1.1 Political support for HiAP

Political support for HiAP is reported by 68 percent of the 41 respondents.[c] Of the respondents without political support (20 percent), or those that do not know (12 percent) if they have political support for the HiAP agenda in their jurisdiction, 69 percent intend to seek it (n=9), and 31 percent (n=4) do not or are unsure.

All respondents in the Established phase and 90 percent of respondents in the Progressing phase, appear to have political support for HiAP (Figure 3-2).

3.1.2 Formal governance arrangements to oversee HiAP

Formal governance arrangements appear to be in place to *oversee* HiAP for 44 percent of respondents (n=18). Figure 3-3 shows that the more established the HiAP practice, the more likely a jurisdiction is to have such formal governance arrangements in place.

The single respondent categorised as having Emerging HiAP practice but with formal governance arrangements in place to oversee HiAP, implements HiAP at the national level. Given that establishing formal governance arrangements is contrary to the activities generally prioritised in the Emerging phase of HiAP practice,[26] this result could be indicative of the intention to take a top down approach to overseeing HiAP across the country as a whole.

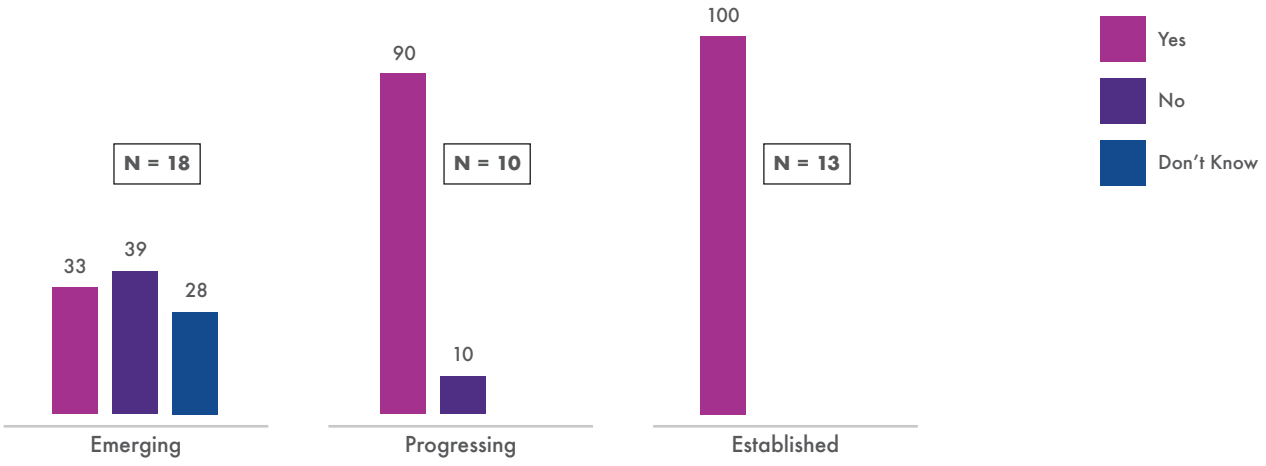
The majority of respondents (n=23) report that they do not have (46 percent) or are unsure if they have (10 percent) formal governance arrangements in place to oversee HiAP in their jurisdiction.

Of those respondents who do not have formal governance arrangements in place, 46 percent (n=11) intend to set up a formal governance arrangement for HiAP in the next 12-24 months, however 17 percent (n=3) do not and 38 percent (n=9) are unsure.

Of the three respondents with no known governance arrangement in place to oversee HiAP and who are not intending to set up formal governance arrangements for HiAP in the next 12-24 months, two are categorised as Emerging and one as Established. This decision may be because the HiAP program is progressing well without formal oversight governance (possibly with a combination of political support and support for HiAP practice), or because there is no support for the establishment of formal governance arrangements to oversee HiAP in their jurisdiction.

FIGURE 3-2

Political support for HiAP in respondent's jurisdiction by maturity of practice (percentage)

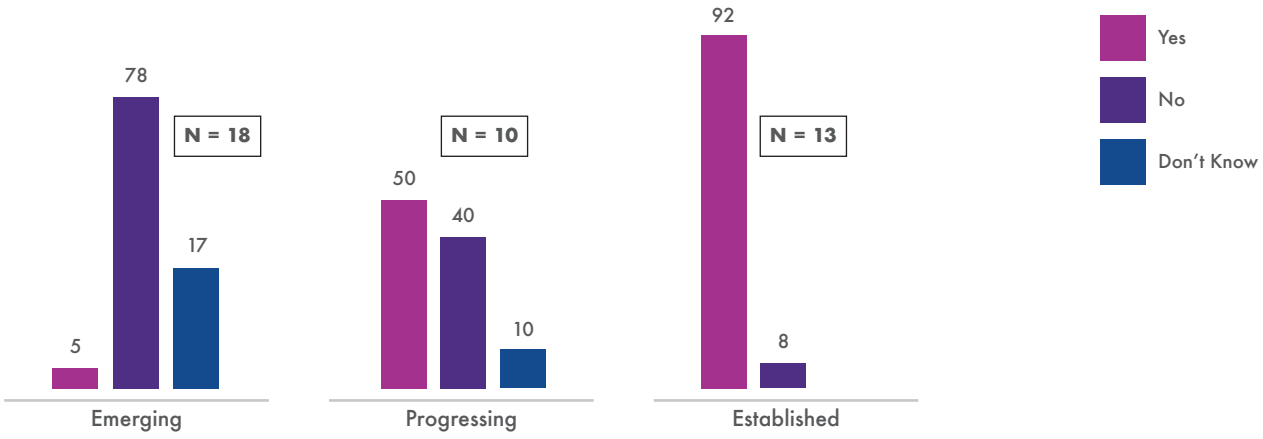


[c] The data reported in section 3.1 are from survey questions that relate to the Governance and Leadership category, these include questions: 7,11,16,17,18,19,20,21,22,23,24,25 (see Appendix 2 for a full copy of the Survey Questions).

Bangkok, Thailand

FIGURE | 3-3

Formal governance arrangements to oversee HiAP in a jurisdiction by maturity of practice (percentage)



Bhutan (National)
Emerging

As a jurisdiction with emerging HiAP practice, Bhutan is exploring applying a HiAP approach through the governance and processes of their Gross National Happiness (GNH) strategy. Through the GNH Strategy, Bhutan has embraced progressive, systematic, decentralised policy development. The GNH has four pillars: Good Governance, Sustainable Socio-Economic Development, Preservation and Promotion of Culture and Environmental Conservation. The HiAP conditions are embedded within the GNH metrics through a comprehensive approach to health and happiness.

In Bhutan, happiness is viewed as a public good and the government is mandated to create an environment conducive to happiness. This is enshrined in the constitution of the Kingdom of Bhutan, where it states *"the state shall strive to promote those conditions that will enable the pursuit of Gross National Happiness"*.

The GNH survey occurs periodically and the results are used to monitor and provide accountability for government performance every five years. Further, all policy documents are screened through the GNH lens by the Gross National Happiness Commission; a peak body that oversees the country's policies, strategies, annual plan, five year plan, and the budget. Any policies, plans and projects that negatively impact the GNH are not approved or prioritised. Examples of government policies that have emerged through the GNH approach are: banning tobacco sales, banning the use of plastic bags, and maintaining a carbon negative country status by protecting the more than 60% forest coverage across the country of Bhutan.

TABLE 3-1

Governance arrangements that best describe the oversight structure of HiAP

	Local	Subnational	National	TOTAL
Inter-departmental committee	0	5	0	5
Other, please specify	0	2	3	5
Governing board	1	0	2	3
Municipal committee	2	0	0	2
Cabinet committee	0	0	1	1
Presidential/Ministerial/Governor oversight	0	0	1	1
Local health board	0	1	0	1
Inter-departmental unit	0	0	0	0
Parliamentary committee	0	0	0	0
	3	**8**	**7**	**18**

The 18 respondents who report having formal governance arrangements, also indicated the type of governance arrangement in their jurisdiction. Table 3-1 identifies them by level of government; there is no obvious relationship demonstrated between maturity of HiAP practice and the type of governance arrangements in place, suggesting that this decision is more context specific.

An *"Inter-departmental committee"* is the most commonly identified governance arrangement (n=5), with all five respondents identifying this arrangement at the subnational level. A *"Governing board"* (n=3) and a *"Municipal committee"* (n=2) are the next most common governance arrangements.

The responses in the *"Other"* (n=5) category varied. Two responses included reference to public health legislation. The other responses included: *"Independent Advisory Council to the Premier"*; *"Key project under Government's program with a committee"*; and a *"Monitoring Strategy Steering Group"*.

High-level leadership affords a strong authorising environment, providing legitimacy and leverage for HiAP practice and the development of a shared vision. This is important for navigating blockages. The 18 respondents who reported oversight governance arrangements were invited to provide the details of the position title of the person who provides the mandate and authorising environment for HiAP. The responses show that this tends to be very senior officials in each jurisdiction. These range from the Prime Minister to government agency Chief Executives and Mayors.

For 10 respondents, the officials providing the mandate and authorising environment are in the health sector, and seven of the officials are in central government. A high-level committee (as opposed to a senior official) provides the authorising environment and mandate for one respondent.

Respondents were also asked which organisation/agency/department takes the lead role for the development and delivery of HiAP in their jurisdiction. Almost all agencies taking the lead are part of the health sector, with only three respondents reporting that a central or non-health agency takes the lead role.

As expected, in most cases respondents listed officials who are at a lower level than those providing the mandate and authorising environment – usually managers or senior officers – when reporting on the position title of the person who oversees and manages HiAP in their jurisdiction.

3.1.3 Formal governance arrangements to support the implementation of HiAP practice

The majority of all respondents (74 percent) report that governance mechanisms or formal structures are in place to support the implementation of HiAP practice in their jurisdiction, responding with either; "*Strong governance mechanisms are in place to support HiAP implementation*" (15 percent) or "*Some governance mechanisms are in place but there is room for improvement*" (59 percent).

Eleven respondents (27 percent) report that no governance mechanisms or formal structures are in place to support the implementation of HiAP in their jurisdiction with the following responses: "*Discussion and planning about governance mechanisms to support HiAP implementation is underway, however, none are operating as yet*" (20 percent) or "*There are no governance mechanisms in place to support HiAP implementation*" (7 percent).

As Figure 3-4 demonstrates, respondents with more Established HiAP practice are more likely to have governance mechanisms or formal structures in place to support the implementation of HiAP in that jurisdiction. Of the 13 respondents, 12 reported having some or strong governance mechanisms or formal structures in place to support HiAP implementation in their jurisdiction.

Overall, a higher proportion of local and subnational respondents (Figure 3-5) report having governance mechanisms or formal structures in place to support implementation of HiAP in their jurisdiction, than national respondents. This suggests that it may be easier to establish such governance structures at these levels of government.

The survey also explored the informal structures or groups that support HiAP implementation. These results are presented in Section 3.4 Ways of Working.

FIGURE 3-4

Level of governance mechanisms or formal structures in place to support the implementation of HiAP by maturity of practice (percentage)

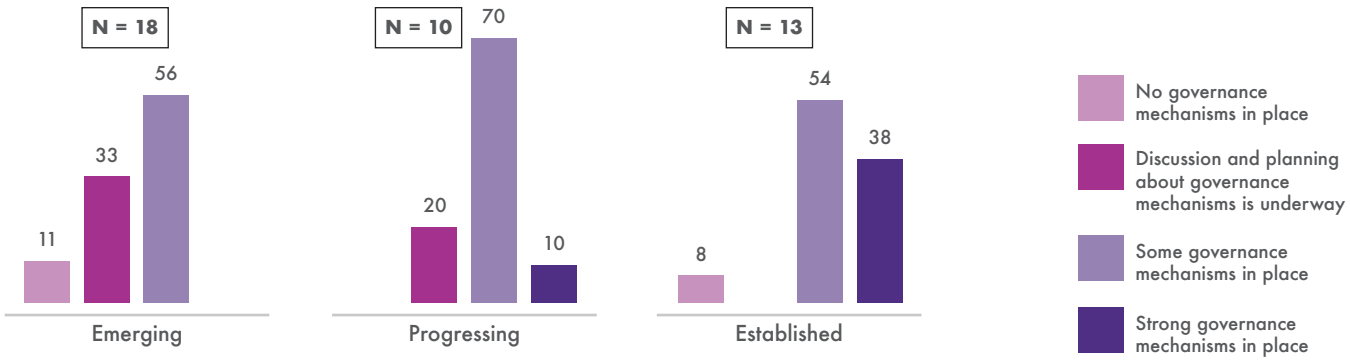
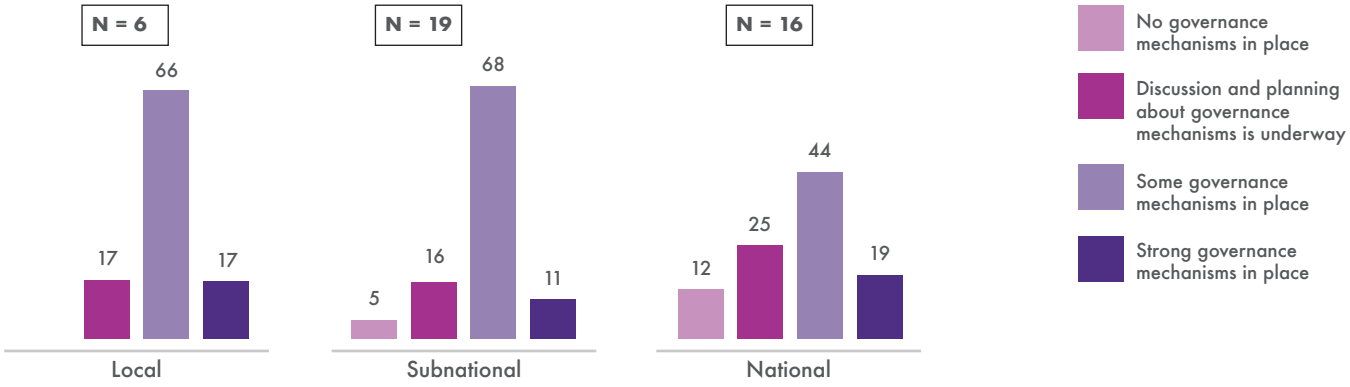


FIGURE 3-5

Level of governance mechanisms or formal structures in place to support the implementation of HiAP in jurisdictions by level of government (percentage)



56%

of all respondents have a dedicated HiAP team that supports HiAP action.

Quito, Ecuador

3.2 Resources for HiAP

In order to sustain HiAP efforts, both dedicated monetary and personnel investment is required. The data[d] show a relationship between staffing and budgetary resource commitment, and the level of government at which the HiAP practice occurs, as well as the maturity of the practice.

Over half of all survey respondents (56 percent) have a dedicated HiAP team that supports HiAP action (dedicated team). A dedicated team is most common for Established repondents. Of the 13 survey respondents in this phase, 12 report that a dedicated team is in place. Seven of the Emerging respondents (n=18) also have a dedicated team, as do four of the Progressing respondents (n=10). Figure 3.6 shows these results. There are a high number of *"don't know"* responses among the Emerging respondents, which could indicate that in the early stages of practice, support to establish a dedicated team is still being sought.

A total of 14 respondents (34 percent) have both a dedicated team and formal governance structures in place. Of those respondents with a dedicated team, 60 percent also report having formal governance structures; whereas 78 percent of those with formal governance report having a dedicated team.

Eleven of the thirteen Established respondents report having both a dedicated team, and formal governance arrangements. None of the Emerging respondents with a dedicated team have formal governance arrangements; whereas three of the Progressing respondents with a dedicated team, also have formal oversight governance arrangements.

[d]The data reported in section 3.2 are from survey questions that relate to the Resources for HiAP category, these include questions: 26, 27, 28, 29, 30, 31, and 32 (see Appendix 2 for a full copy of the Survey Questions).

FIGURE 3-6

Percentage of respondents with a dedicated HiAP team by maturity of practice

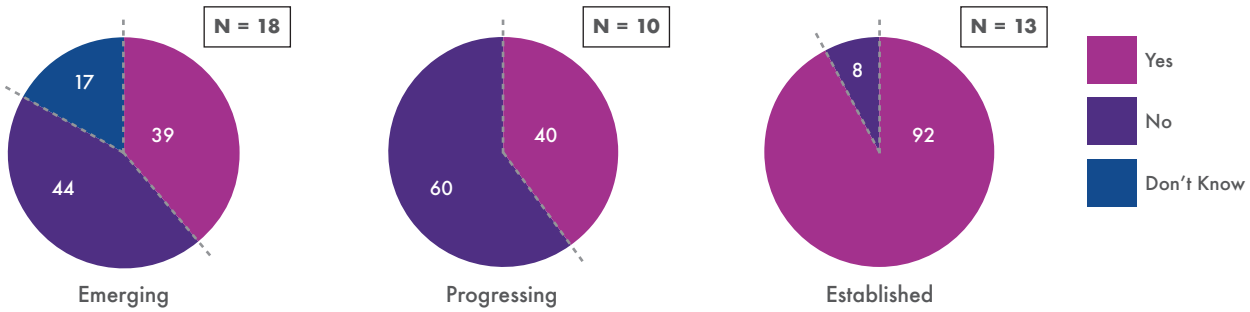


FIGURE 3-7

Percentage of respondents with staff that participate in and support HiAP (not part of the core HiAP team) by maturity of practice

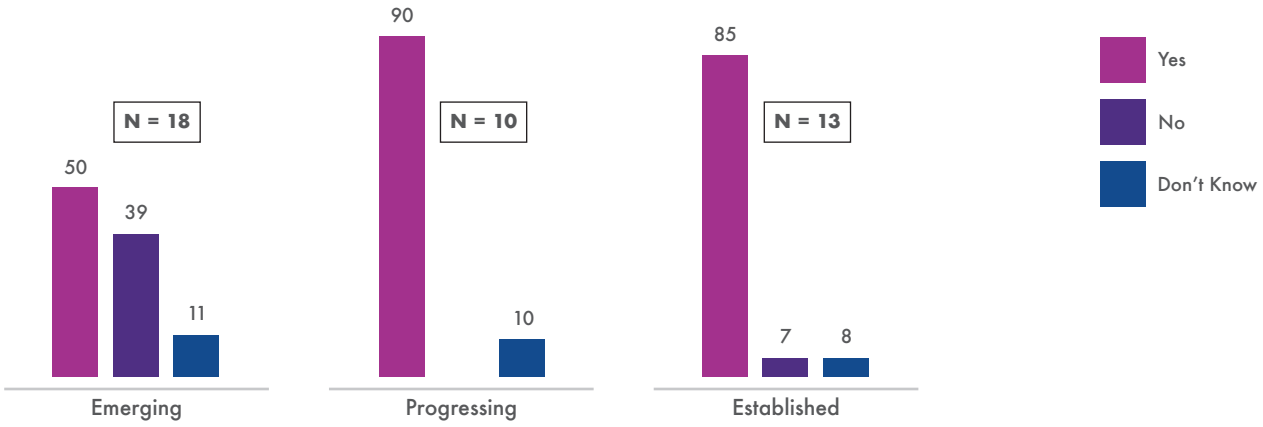
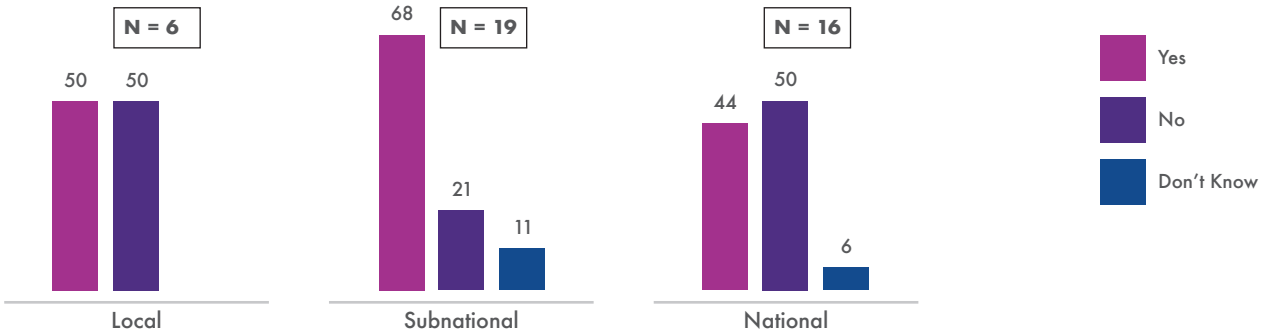
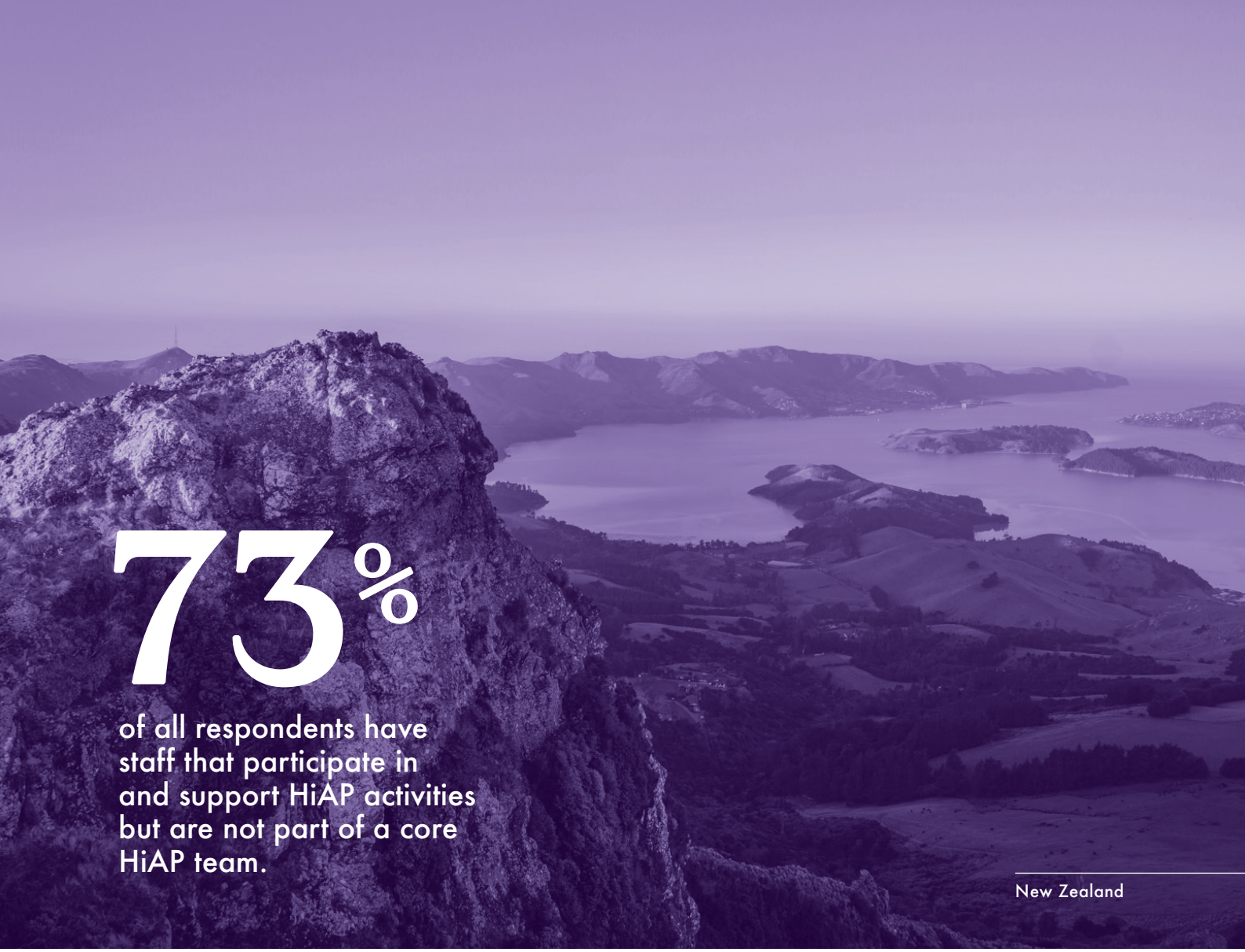


FIGURE 3-8

Percentage of respondents with a dedicated HiAP team that support HiAP action by level of government





An even greater majority (73 percent) of respondents report having staff that participate in and support HiAP activities that are not part of a core HiAP team (informal support staff). In the Established phase, a similar number of respondents report having both a dedicated team and informal support staff (85 percent). However, as shown in Figure 3-7, there is a stronger presence of informal support staff compared to dedicated teams in the jurisdictions in both the Emerging and Progressing phases. These results will be further unpacked with some cross analysis against the Section 3.4 Ways of Working results.

When considering the allocation and commitment of HiAP personnel, the level of government at which the practice occurs is also important. As shown in Figure 3-8 the highest commitment occurs at the subnational level of government where 68 percent of respondents have a dedicated team. In the Established phase, those jurisdictions without a dedicated team are all operating at the national level.

Of the nine Emerging respondents operating at the subnational level of government, five report having a dedicated team. Noting again that the numbers are small, these results suggest that a dedicated team is most common at the subnational and national level of government, and in the Established phase. Interestingly, the only relatively higher number of Emerging respondents with a dedicated team, are operating at the subnational level of government. These results indicate that as expected, the greatest dedication of resources occurs for those who have the most established HiAP practice, and for those operating at the subnational level of government.

Six respondents indicate that they have neither a dedicated team, nor any informal support staff for HiAP; which implies that no one in that organisation is responsible for implementing HiAP. Four of these jurisdictions are in the Emerging phase however. This suggests that it may be difficult, particularly in the Emerging phase, to identify the point at which HiAP practice becomes formal - there is no distinct indicator of this and it is likely that there are divergent views, in different jurisdictions, about the technical definition of *formal* HiAP practice. It's also possible that the wording of resource-related survey questions may have caused some response discrepancies.

FIGURE 3-9

Percentage of respondents with a dedicated budget for HiAP activities by level of government

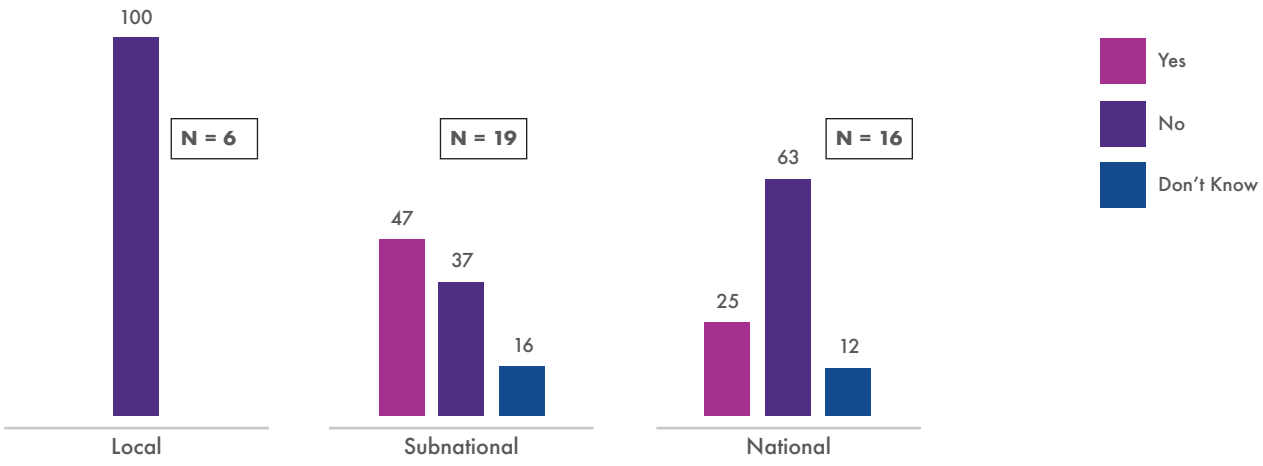
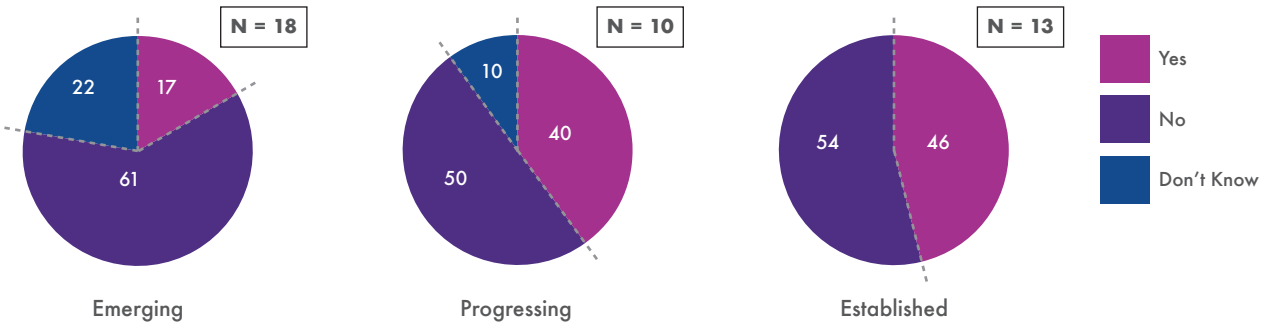


FIGURE 3-10

Percentage of respondents with a dedicated budget for HiAP activities by maturity of practice



One third of all respondents has a dedicated budget and close to two thirds do not. Again, having a dedicated budget is not a measure of the quality or commitment of HiAP practice and these responses are considered further in Section 3.4 Ways of Working.

As with a dedicated team, a dedicated budget is most common (47 percent) at the subnational level (Figure 3-9) and in the Established phase (46 percent) (Figure 3-10). No local level respondents have dedicated budgets and very few national level (4 of 16) and Emerging (3 of 18) respondents have dedicated budgets.

A greater number of respondents at the subnational level and in the Progressing phase report having a dedicated budget (four of these five respondents). Furthermore, three of the five respondents in both the Established phase and operating at the subnational level have a dedicated budget, as do three of the total six in the Established phase at the national level.

A total of 13 respondents described the agencies and organisations with responsibility for the allocation and spending of their HiAP budget. The responses can be categorised under three themes: central government, the health agency or a shared responsibility. *"Health agency/health department or Ministry of Health"* is the most common responsible agency, followed by *"central government/cabinet office"*. Those in the Emerging phase of practice all selected the Health Agency/Department, which in each instance was their own agency.

Responses are more diverse with each level of practice maturity. At the subnational level, central government/cabinet office appears to be more common; split/shared funding was reported by one subnational and one national level respondent. The juisdictions that do have split funding, both indicated that the health department drives their practice, however, one *"other"* respondent reported, *"Funding is split between a non-profit agency and 2 government departments"*.

3.3 Entry Points

There are many drivers which can be used to initiate HiAP. These present depending on windows of opportunity, the political environment, the engaged policy actors, and existing agendas that can be leveraged. Survey respondents were invited to nominate from a list of statements, those that best describe the driving factors for initiating and adopting their HiAP practice.[e] All statements listed required a *"yes"*, *"no"*, or *"don't know"* response. There were 22 factors listed (including an *"other"* response).

These factors broadly fit within the following categories:

- Health sector/major health issues/increasing burden of disease
- Health protection (e.g. Anti-microbial resistance)
- Political drivers/opportunities (e.g. major structural or political reform)
- Social equity and human rights (e.g. universal health care, gender equality)
- International influences (noting that in some cases this could be the influence of a donor agency, and in other cases survey responents may have interpreted this option as leveraging international evidence).

The survey data shows that the most common driving factors are "*Identified need within the health sector to work across all sectors or across the whole of government to improve health*" ("*Identified need...*") and "*Reducing Health Inequities*". Both of these factors received an 88 percent "*yes*" response when reviewing the data for all (n=41) respondents.

The top three most common driving factors, by level of government are included in Table 3-2. The results show that an "*Identified need...*" is the most common driver for initiating and adopting HiAP at both the local and subnational level of government. This response is the third most common driver at the national level however, where "*Reducing health inequities*" is the top driving factor.

At the subnational level "*Addressing the social determinants of health – structural and intermediary*", "*Action on non-communicable diseases", and "Reducing health inequities*", all received the same number of "*yes*" responses, as the second most common driving factors. The same top three responses were common at both the local and subnational levels of government, with the addition of "*Addressing the social determinants of health-structural and intermediary*" at the subnational level.

Health system and health protection related drivers appear to be more common at the local and subnational level whereas social equity, social determinants related and political drivers are more common at the national level. As expected, the sustainable development agenda is also a common driving factor at the national level. Whilst the Sustainable Development Goals[2] could be an ongoing driver for HiAP, it should be noted that these haven't existed for long enough to be an initiating force in the jurisdictions where HiAP practice is more mature.

The least important driving factors for initiating and adopting HiAP practice ("*No*" responses) at both the local and subnational level appear to be "*A major structural/political reform" and "Achievement of Universal Health Coverage*". "*A major structural/political reform*", also received the most "*No*" responses at the national level, followed by "*Research or study findings on benefits of HiAP*".

The data for the entry points questions have also been compared by age of practice (using responses to survey question 10[f]); the only notable difference is that "*political commitment to joined-up multi-sectoral action*" scores higher for the more recent approaches. The evidence base on HiAP, as an effective tool for multi-sectoral action has grown over time and it is possible that this has influenced an increase in top-down, rather than bottom-up HiAP initiation.

Three respondents provided an "*other*" response; two related to national legislation as a driving factor, at the national level. The third indicated that demand to strengthen "*work with local government/local and regional municipalities on the social determinants of health*" was a driving factor.

[e] The data reported in section 3.3 are from survey questions that relate to the Entry Points category; these include questions 12 and 13 (see Appendix 2 for a full copy of the Survey Questions).

[f] Question 10 - How long have you been developing and/or implementing the systematic work across sectors (HiAP approach) in your jurisdiction? Select only one answer.
a. We have not yet formally started to develop our HiAP approach b. We are in the early stages of planning our HiAP approach
c. 1-2 years d. 3-5 years e. 6-9 years f. 10 or more years

TABLE 3-2

Most common driving factors for initiating HiAP by level of government – percentage of "Yes" responses.

Local Level (n=6)	
Identified need within the health sector to work across all sectors or across the whole of government to improve health	100%
Action on non-communicable diseases	100%
Reducing health inequities	100%
Subnational Level (n=19)	
Identified need within the health sector to work across all sectors or across the whole of government to improve health	89%
Addressing the social determinants of health – structural and intermediary	79%
Action on non-communicable diseases	79%
Reducing health inequities	79%
National Level (n=16)	
Reducing health inequities	94%
Addressing the social determinants of health – structural and intermediary	88%
Identified need within the health sector to work across all sectors or across the whole of government to improve health	81%
Political commitment to joined-up government or multi-sectoral action	81%
Progressing the Sustainable Development Agenda	81%

Punakha, Bhutan

3.3.1 Actions taken to progress HiAP

Respondents reported (from a list of 14 actions) the actions taken to progress HiAP, once initiation had been agreed on and supported in their jurisdiction. A *"yes"*, *"no"*, or *"don't know"* response was required for each of the actions. The most common action taken (51 percent *"yes"* response rate) appears to be *"High-level strategy (e.g. national public health policy)"*, closely followed by *"Action plan"* (46 percent) and *"Running an event"* (44 percent).

As Table 3-3 shows, when divided by level of government, the responses are quite varied and appear to be context specific. The combination of developing a strategy, action plan or resource, and a networking meeting or event appears to be a common approach for initiation at both the local and subnational level of government.

At the local level, the most common approach (4 of the 6 respondents) is to run an event (e.g. conference or a training course). At the subnational level, three actions - a "*Regional consultation meeting*", "*Action plan*", and the "*Development of a report or formal recommendations to assist in progressing HiAP*" - received the same number of "*yes*" responses, second to "*Running an event*". A "*High-level strategy (e.g. National public health policy)*" is the most common action at the national level. Other top responses are "*Action Plan*", and the "*Development or use of legislation*".

When reviewing the data by age of practice the only notable difference is that for those jurisdictions that have been practicing HiAP for more than 10 years, "*Development and dissemination of manuals or tools on HiAP implementation*", "*Development or use of legislation*", and "*Development of a report or formal recommendations to assist in progressing HiAP*", all appear in the top three responses. These did not appear high on the list for any respondents practicing HiAP for less than ten years. "*Support from a human catalyst to progress the HiAP agenda (i.e. politician, mayor or local leader, academic, thinker in Residence)*" appeared high on the list for those who had been practicing for between three and nine years, but not for the very recent starters, or for those who had been practicing for over ten years.

A number of "*other*" responses were provided for this question. In some cases respondents used this opportunity to build on their selection(s) from the list of actions. Some "*other*" responses include actions that are not as easily defined under the categories listed, such as "*mainstreaming HiAP*", "*formal commitment*", "*targeted engagement strategy and work programme*", or reference to actions taken on specific issues, for example a Healthy Weight initiative. One response indicated that, rather than the development or use of legislation, embedding HiAP, or making it visible in updates to existing public health legislation, has been a key action taken.

TABLE 3-3

Most common actions taken to initiate HiAP by level of government – percentage of "Yes" responses.

Local Level (n=6)	
Running of an event (e.g. conference, training course)	67%
Regional consultation meeting	50%
A funded pilot	50%
Action plan	50%
High-level strategy (e.g. national public health policy)	50%
Support from a human catalyst to progress the HiAP agenda (i.e. politician, mayor or local leader, academic, 'thinker in residence')	50%
Subnational Level (n=19)	
Regional consultation meeting	47%
Action plan	47%
Development of a report or formal recommendations to assist in progressing HiAP	47%
Running of an event (e.g. conference, training course)	42%
Development and dissemination of manuals or tools on HiAP implementation	42%
National Level (n=16)	
High-level strategy (e.g. national public health policy)	69%
Action plan	44%
Development or use of legislation	44%
Running of an event (e.g. conference, training course)	38%
Development and dissemination of manuals or tools on HiAP implementation	31%

3.4 Ways of Working

In order to be sustainable, HiAP practice needs to be responsive to change in the political, administrative and cultural environment in which it operates.[g] This highlights how context-specific the ways of working in HiAP practice are. The data reported in this section are largely divided by the maturity of the practice. Whilst the level of government has important implications for the Ways of Working, these are often complex and context specific.

3.4.1 Current or intended HiAP approaches

Respondents selected (from a list of ten options) the statements that align with their current or intended approach to applying HiAP. A "*yes*", "*no*", or "*don't know*" response was required for each of the statements listed.

All except one respondent selected *"yes"* in response to "*Integrates health considerations into policy-making across sectors*", *"Addresses the social determinants of health"*, and "*Promotes health and equity*".

Figure 3-11 shows the percentage of respondents in each phase of maturation who selected "*yes*" for each statement. As expected, of the Established respondents, 100 percent selected "*yes*" for all statements except for "*Addresses health inequities*", and "*Addresses environmental determinants and climate change*".

Four of the statements received 100 percent "*yes*" responses in both the Progressing and Established phases; "*Promotes health and equity*", "*Addresses the social determinants of health*", "*Works at the population level rather than at the individual level*", and "*Integrates health considerations into policy-making across sectors*". "*Promotes health and equity*" and "*Integrates health considerations into policy-making across sectors*" are the two most common statements to align with current or intended HiAP approaches across all stages of maturation.

"*Addresses environmental determinants and climate change*", and "*Addresses health inequities*", score low for all phases of practice maturity, and are less aligned with the current or intended HiAP practice for Progressing respondents as compared to Emerging respondents. This could indicate that in relation to these factors, jurisdictions in the Emerging phase are more ambitious about what they might plan to achieve in the future, whereas in the Progressing phase, learnings around what could be realistically or practically achieved may begin to surface.

"Addressing the environmental determinants and climate change" is quite specific in comparison to many of the other statement options provided, this may explain why this statement also received low responses.

Overall, these responses show that as expected, most jurisdictions are applying the practices considered integral to HiAP and that Established respondents apply both the principles that underpin HiAP as well as deliver on the key practices in their approaches.

As discussed in Section 3.1 Governance and leadership, 18 of the 41 (44 percent) respondents report having formal governance arrangements to oversee HiAP. The following statements (of those listed in Figure 3-11) all received a 100 percent *"yes"* response, by all respondents with formal governance arrangements in place:

- *"Integrates health considerations into policy-making across sectors"*
- *"Supports cross sector collaboration"*
- *"Works at the population level rather than at the individual level"*
- *"Creates "co-benefits" or "win-wins" for multiple partners (i.e. the work simultaneously addresses the goals of the health sector and other agencies to benefit more than one end)"*
- *"Addresses the social determinants of health"*, and
- *"Promotes health and equity"*.

3.4.2 Targeted aspects of policy delivery for HiAP

Respondents also indicated the aspects of policy delivery at which HiAP is targeted in their jurisdiction. Four options were provided and multiple responses could be selected. The most common aspect for all respondents (68 percent) is "*Delivery of strategic or "big P" policy...*".[h] Following that "*Delivery of organisational or operational "little p" policy...*"[i] and "*Policies supporting program delivery*" both received a 46 percent response rate.

When reviewing the responses for each phase of maturation (Figure 3-12) the most common response in every phase was also "*Delivery of strategic or "big P" policy...*"; 85 percent of Established, 80 percent of Progressing, and 50 percent of Emerging respondents selected this option. Of the Established respondents, 91 percent (10 of 11) reporting "*Delivery of strategic or "big P" policy...*" also have dedicated HiAP teams, whereas only 38 percent of the Progressing respondents (3 of 8), and 56 percent of Emerging respondents (5 of 9) who report "*Delivery of strategic or "big P" policy...*" have a dedicated HiAP team.

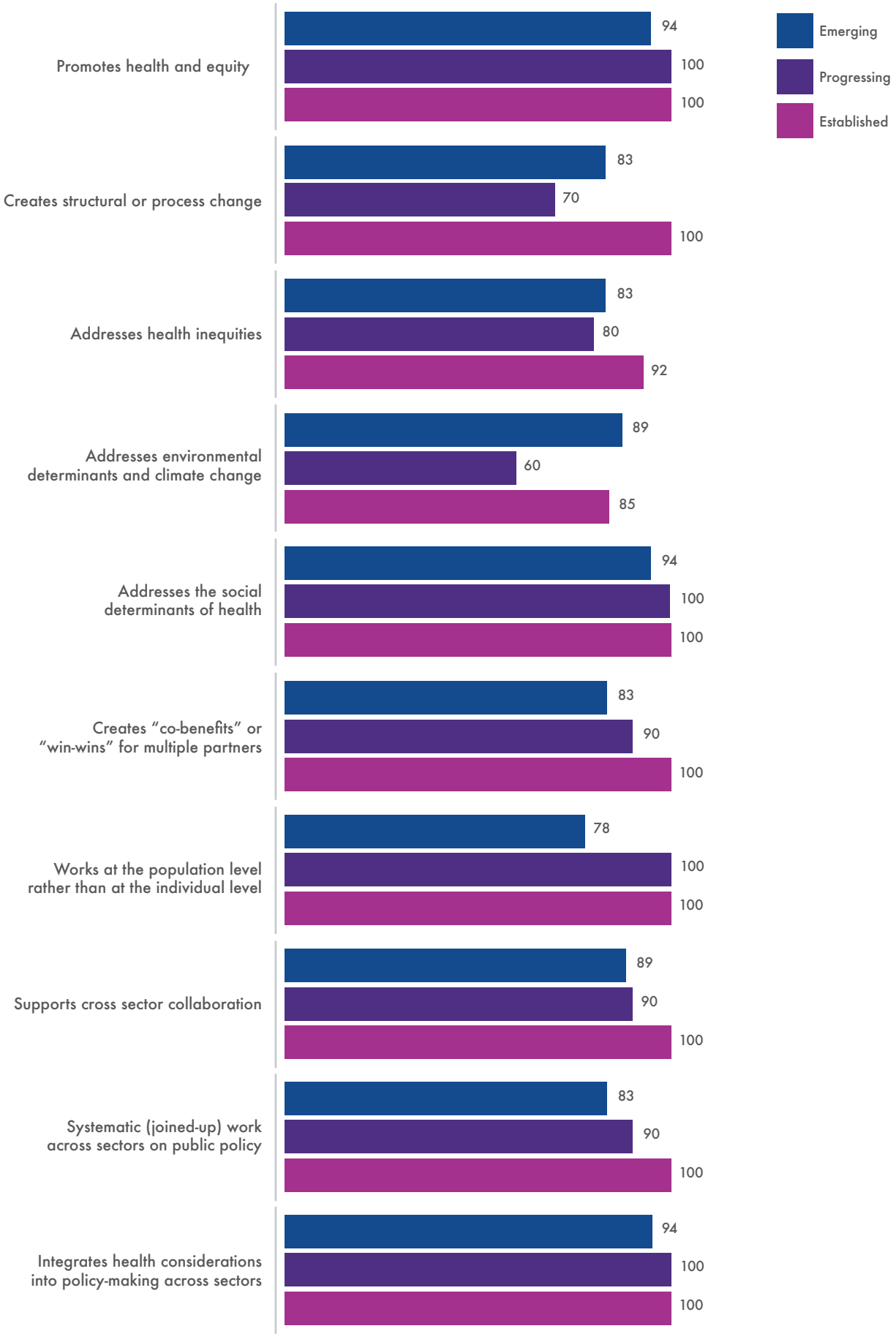
[g] The data reported in section 3.4 are from survey questions that relate to the Ways of Working category, these include: 4, 5, 6, 8, 11, 15, 24, 25, 35, 36, 37, 38 (see Appendix 2 for a full copy of the Survey Questions).

[h] Strategic or "big P" policy includes national or state/provincial/regional law, city ordinances and comprehensive plans, typically needing elected officials' approval. The implications for change can be far reaching – affecting a much larger population rather than just one organisation, department or sub-group.

[i] Organisational or operational or "little p" policy is typically delivered at an institution, department or agency level and generally influences organisational practices. These types of policy changes can create quick wins and can sometimes lead to larger changes that typically are not as labour-intensive as "big P" policy changes.

FIGURE 3-11

Statements that align with current or intended HiAP approach by maturity of practice – percentage of respondents who selected "Yes"



For the Established respondents, "*Policies supporting programme delivery*" is the second most common response (62 percent), followed by "*Delivery of organisational or operational or "little p" policy*".

The response rate for all of the remaining options was low for the Progressing respondents, (30 percent for each). For the Emerging respondents "*little p"* policy and "*policies supporting programme delivery*" appear ro be more common than "*policies supporting service delivery*".

These results are reflective of the progression that may occur in a bottom-up approach to policy delivery.

Whilst generally those who didn't respond with "*little p*" or "*big P*" as a response, may not be considered to be technically implementing a HiAP approach, it is possible that in a number of jurisdictions this question has been interpreted differently. Some of the service or program delivery policies referred to, could be categorised as "*little p*" or "*big P*" policy.

Generally the focus on strategic and "*big P*" issues becomes greater as maturity of practice increases. It is encouraging to see that across all phases there is a strong focus on "*big P*" changes and delivery, as this is the ultimate goal for HiAP practice. Theoretically, those only working on "*little p*" policy are taking a bottom-up approach, and should have ambitions to "*big P*" policy into the future.

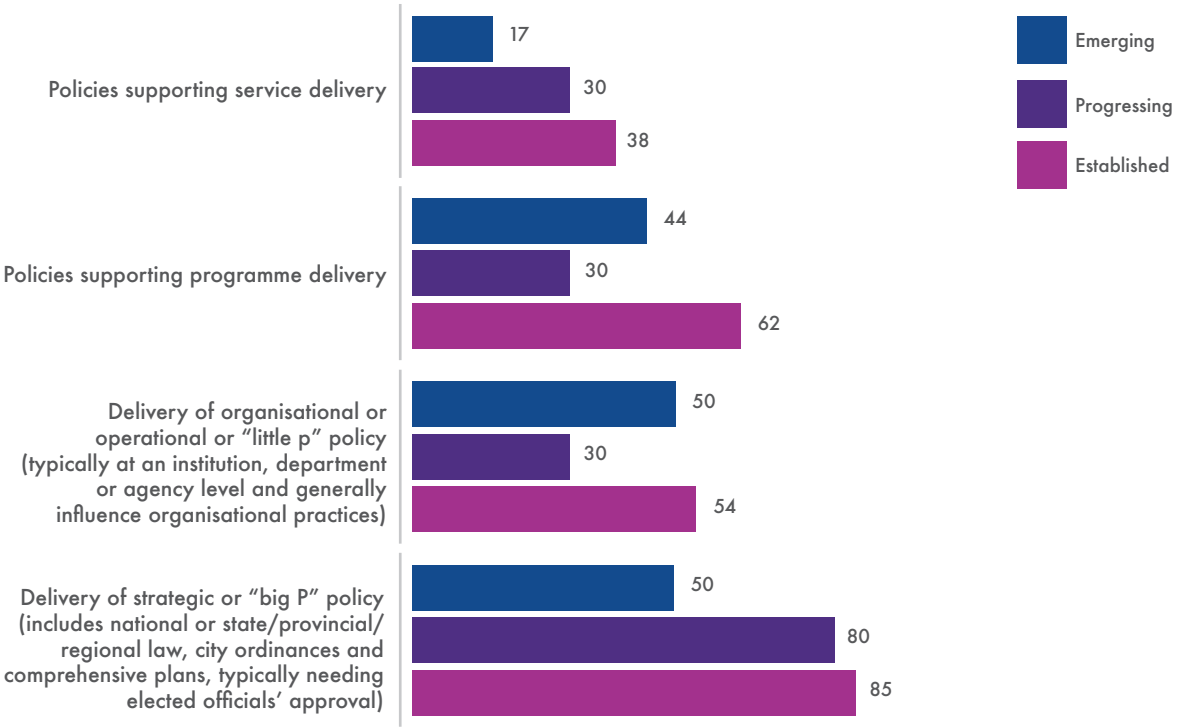
Level of government is also an important consideration for these responses, as different policy levers and opportunities for policy implementation typically occur at different levels. The most significant and expected finding is that more "big P" policy approaches happen at the national level of government.

An "*other*" category also received three detailed responses; each of these respondents had also selected at least one of the prescribed responses, therefore these other comments appear to be intended to elaborate on responses selected:

- *"Key identified success strategies which form the basis of our HiAP approach and work programme include: Developing and structuring cross-sector relationships; incorporating health into decision making processes; Enhancing workforce capacity; Integrating research, evaluation and data systems; Synchronising communications and messaging; and implementing accountability structures".*
- *"Developing baseline data to inform and support the work of other sectors; collaborative cross sector research, leveraging a common data to generate evidence to support win-win approaches".*
- *"Policy decisions ultimately impact policies supporting programme and service delivery".*

FIGURE 3-12

Percentage of respondents who report particular aspects of policy delivery for HiAP in their jurisdiction by maturity of practice



3.4.3 Informal structures or groups that support HiAP implementation

All respondents (n=41) were invited to report on informal structures or groups that support the implementation of HiAP in their jurisdiction; 30 respondents (73 percent) have informal structures or groups, 6 respondents do not, and 5 reported that they do not know of any informal structures or groups in their jurisdiction. Formal structures to support HiAP are covered in 3.1.3 above.

As shown in Figure 3-13, those with Established practice are more likely to have informal structures or groups which support HiAP implementation.

Figure 3-14 demonstrates a relationship between the level of government and the presence of informal structures and groups to support the implementation of HiAP. Respondents at the national level appear to be less likely than those at the subnational or local level, to report such structures or groups.

Respondents were invited to briefly describe the informal structures or groups that support the implementation of HiAP in their jurisdiction, to articulate the significance of groups such as communities of practice and social networks in HiAP practice. The types of informal structures or groups described varied widely - from senior level cross-departmental committees on key issues, to multi-sector project working groups, and groups that include local level community engagement. Some of the structures reported are quite formal, even those reported by Emerging respondents.

FIGURE 3-13

Jurisdictions reporting informal structures or groups that support the implementation of HiAP by maturity of practice (percentage)

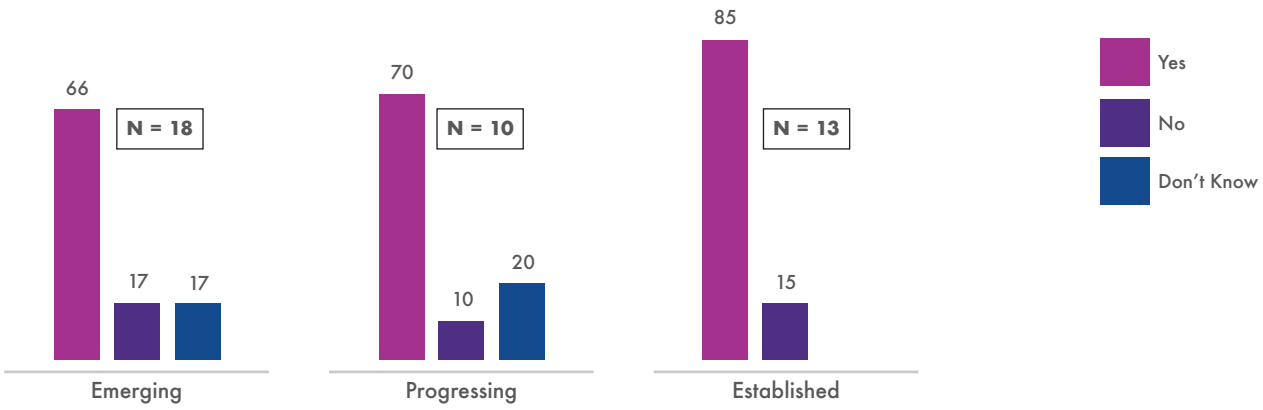
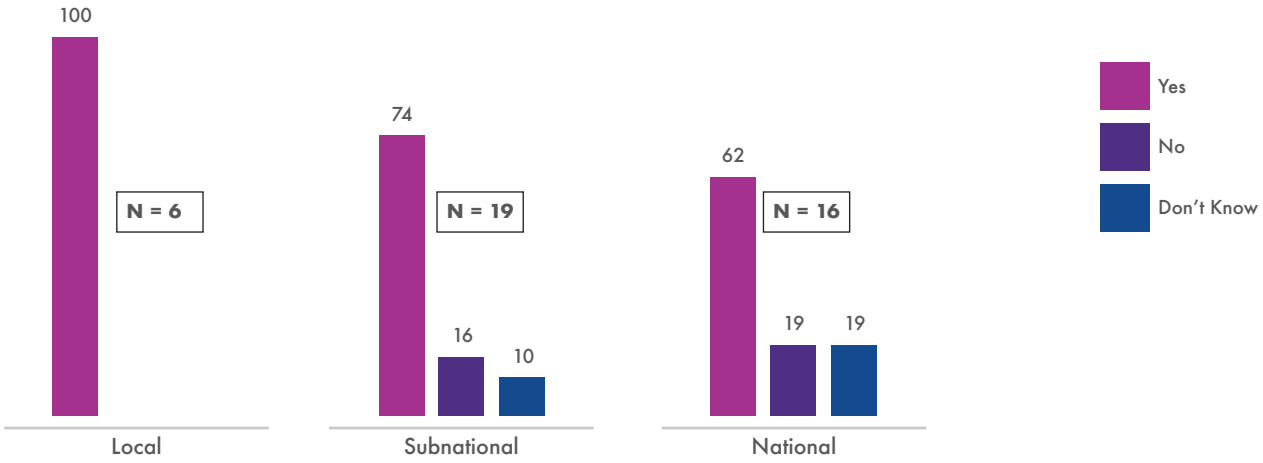


FIGURE 3-14

Informal structures or groups that support the implementation of HiAP in respondent's jurisdiction by level of government (percentage)



The nature of the groups described indicates variation in the interpretation of the question and in the definition of informal and formal structures and/or groups. It is possible that some respondents listed formal structures and groups because these groups do not have a formal responsibility for supporting the implementation of HiAP, but do provide support on an issue that is being addressed through a HiAP approach.

Support from informal groups and structures, appears to be important in enabling HiAP practice to evolve to the Established phase. The structures and operational style of these informal networks vary markedly however, and whilst they may not be formal HiAP networks, many of them appear to be formal in nature, for example, one respondent described a "*Tobacco Coalition and intention to form an Active Living Coalition*" as informal. A number of responses however do represent what would be considered informal networks as well, such as: "*Community gardening, local level groups, health promotion local groups*".

3.4.4 Key contributors for implementing HiAP

The "*Government*" is reported as the key contributor to the development and implementation of HiAP for 95 percent of respondents (90 percent in the Emerging phase and 100 percent in both the Progressing and Established phases). The top five key contributors are very similar at each phase of maturation, with "*Non-government organisations, Community/civil society*" and "*Professional bodies, Universities/Academia*" appearing in the top five for the Progressing and Established phases, but not in the Emerging phase.

Other contributors cited by respondents include: "*Non-government organisations and researchers/academics provide evidence to support HIAP/intersectoral action, but are not directly involved*" and *"...Government organisations and local government organisations work together with health on matters of mutual interest related to health and wellbeing*".

3.4.5 Key strategies for implementing HiAP

The strategies used to support HiAP implementation were also a focus of the survey.

Strategies for identifying the links between health and other policy outcomes vary significantly and appear to be very context specific. For 40 respondents who reported on these strategies, the top response (55 percent) is "*Health Lens Analysis*" followed by "*Health Impact Assessment*" (52 percent) and "*Research*" (52 percent).

There is no clear trend in these responses by maturity of practice or by level of government. For example, the most common response in the Emerging phase is "*Health Lens Analysis*" followed by "*Health Impact Assessment*"; in the Progressing phase the top response is "*Literature Reviews*", and in the Established phase it is "*Research (qualitative and quantitative)*". "*Health Lens Analysis*" and "*Health Impact Assessment*" are also common responses in the Established phase, but not in the Progressing phase, where "*Joint problem definition*" and "*Research*" are more common. *"Other"* responses provided include:

- *"...piloting an integrated impact assessment to reflect contribution to ... wellbeing goals (and wider SDG agenda)"*
- *"systems mapping"*
- *"A wide variety of approaches are taken ... depending on where the policy cycle is. It may be inputting data and evidence to inform strategy development, helping to implement strategy effectively, setting the agenda with research/data etc., supporting decision-making with tools...undertaking policy reviews (e.g. on health inequalities), etc".*
- *"90 day projects - short- term, intensive and collaborative co-design methodology; Public Health Partner Authorities - partnerships formalised under the Public Health Act".*
- *"Identify political will, co-benefits, and win-wins".*

When reporting on how information is shared with key decision makers to help shape and influence policy outcomes, at every phase of maturity and every level of government, "meetings" are the most common response.

At the national level of government *"policy briefs"* were equally as common as *"meetings"* however, and "*events*" and "*project reports*" were also common.

Respondents indicated from a list, "*all that apply*", it is interesting to note that overall responses were much higher in the Established phase; 92 percent share information through *"meetings"*, and 85 percent through *"events"*. In the Progressing phase however, only 67 percent of respondents share information through *"meetings"* and 56 percent through *"events"*.

Some "*other*" responses include: "*Informal updates or agenda items at joint meetings*"; "*position statement on key health determinants ... to support advocacy and HiAP implementation*"; "*program and evaluation reports*"; "*policy briefs*" and "*peer reviewed articles*".

FIGURE 3-15

Importance of evidence to identify links between health and other government priorities by maturity of practice (percentage)

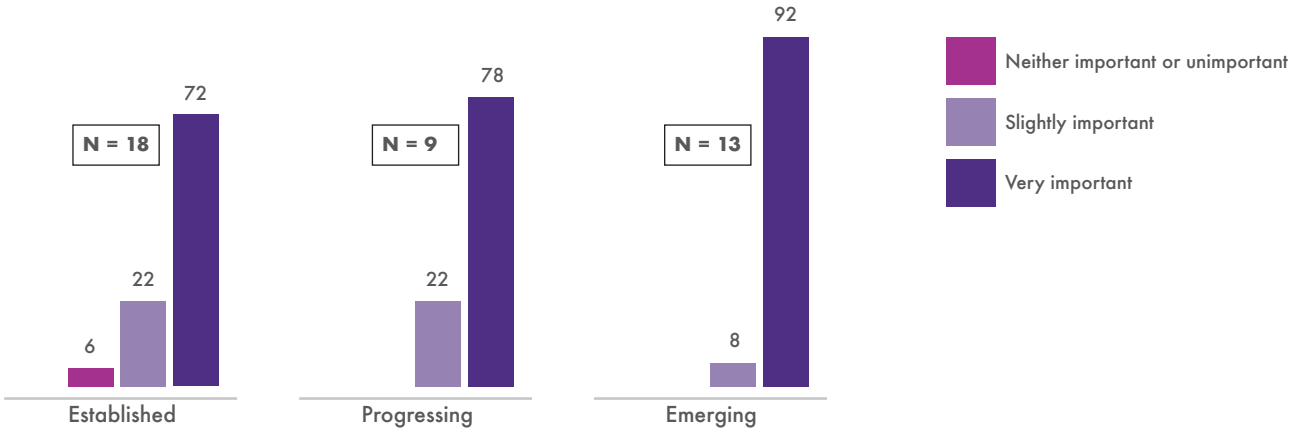
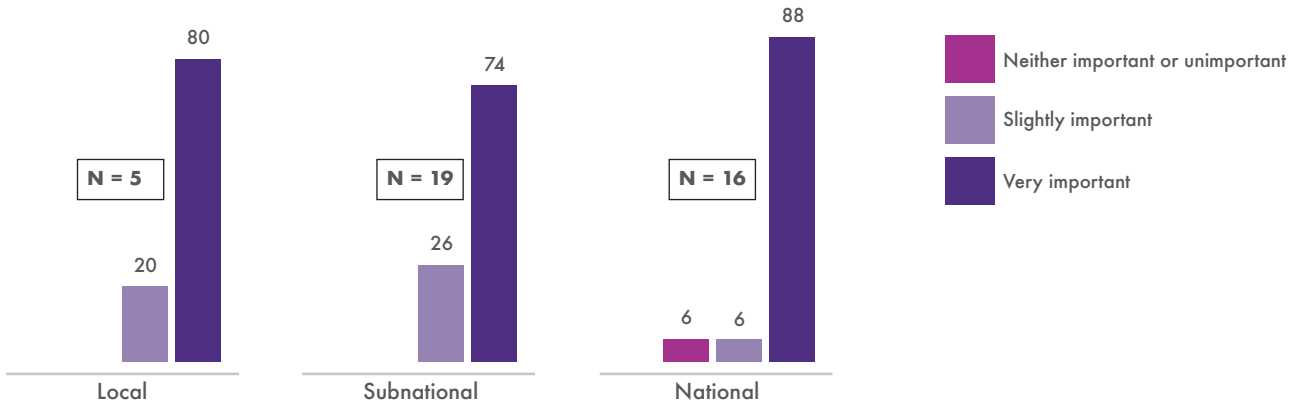


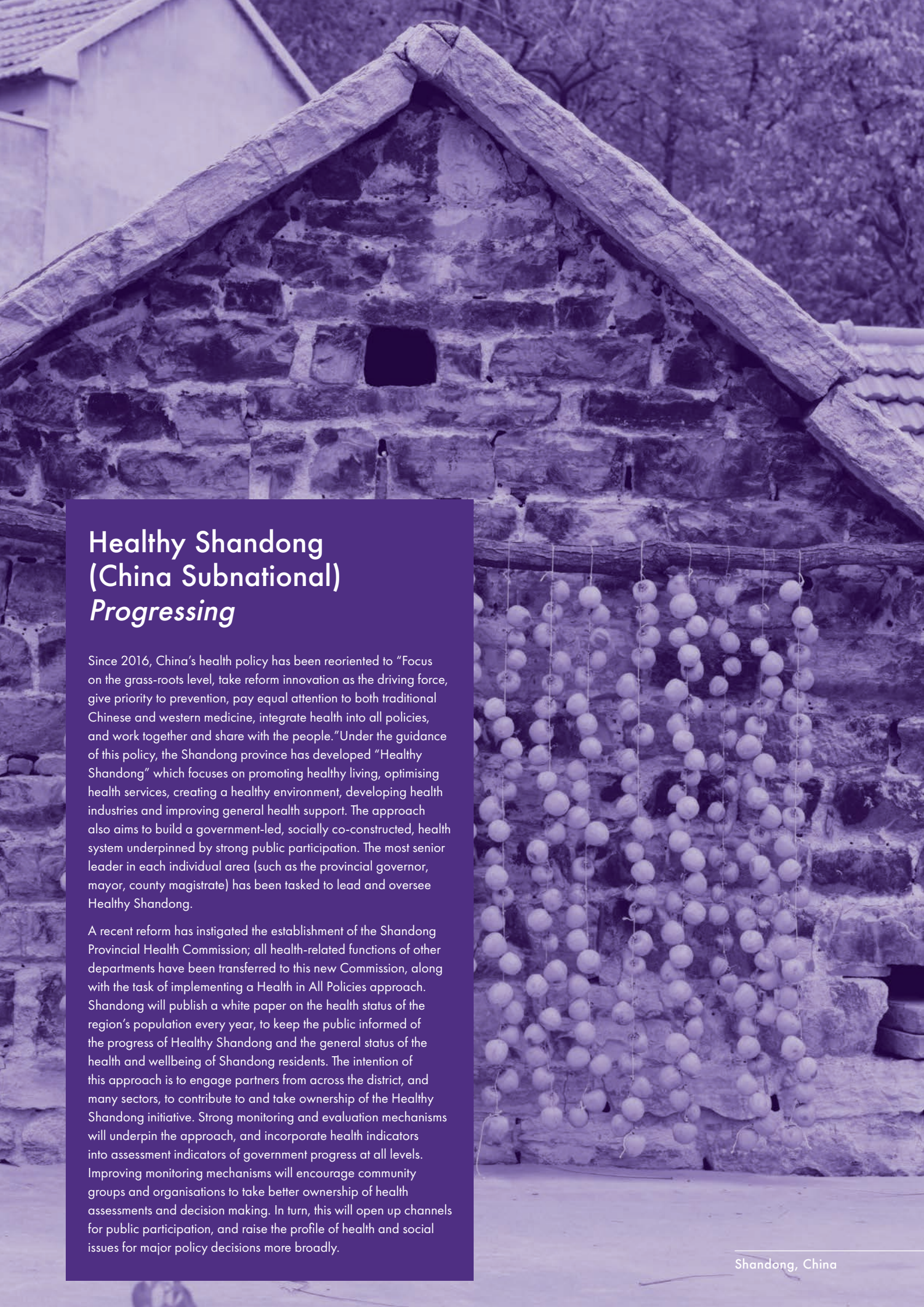
FIGURE 3-16

Importance of evidence in identifying linkages between health and other government priorities by level of government (percentage)



The use of evidence in HiAP implementation was also examined. Over 70 percent of respondents in all phases of practice maturity (Figure 3-15) and at all levels of government (Figure 3-16) indicate that evidence is "*very important*". Figure 3-15 also shows that over 90 percent of respondents in the Established phase believe evidence is "*very important*" suggesting that over time and with more experience of implementation, the role that evidence plays in engaging other sectors in common priorities becomes even more apparent.

These responses offer a good starting point for considering methods for comprehensive HiAP practice.



Healthy Shandong (China Subnational) *Progressing*

Since 2016, China's health policy has been reoriented to "Focus on the grass-roots level, take reform innovation as the driving force, give priority to prevention, pay equal attention to both traditional Chinese and western medicine, integrate health into all policies, and work together and share with the people."Under the guidance of this policy, the Shandong province has developed "Healthy Shandong" which focuses on promoting healthy living, optimising health services, creating a healthy environment, developing health industries and improving general health support. The approach also aims to build a government-led, socially co-constructed, health system underpinned by strong public participation. The most senior leader in each individual area (such as the provincial governor, mayor, county magistrate) has been tasked to lead and oversee Healthy Shandong.

A recent reform has instigated the establishment of the Shandong Provincial Health Commission; all health-related functions of other departments have been transferred to this new Commission, along with the task of implementing a Health in All Policies approach. Shandong will publish a white paper on the health status of the region's population every year, to keep the public informed of the progress of Healthy Shandong and the general status of the health and wellbeing of Shandong residents. The intention of this approach is to engage partners from across the district, and many sectors, to contribute to and take ownership of the Healthy Shandong initiative. Strong monitoring and evaluation mechanisms will underpin the approach, and incorporate health indicators into assessment indicators of government progress at all levels. Improving monitoring mechanisms will encourage community groups and organisations to take better ownership of health assessments and decision making. In turn, this will open up channels for public participation, and raise the profile of health and social issues for major policy decisions more broadly.

Shandong, China

3.5 Capabilities (Individual and Organisational)

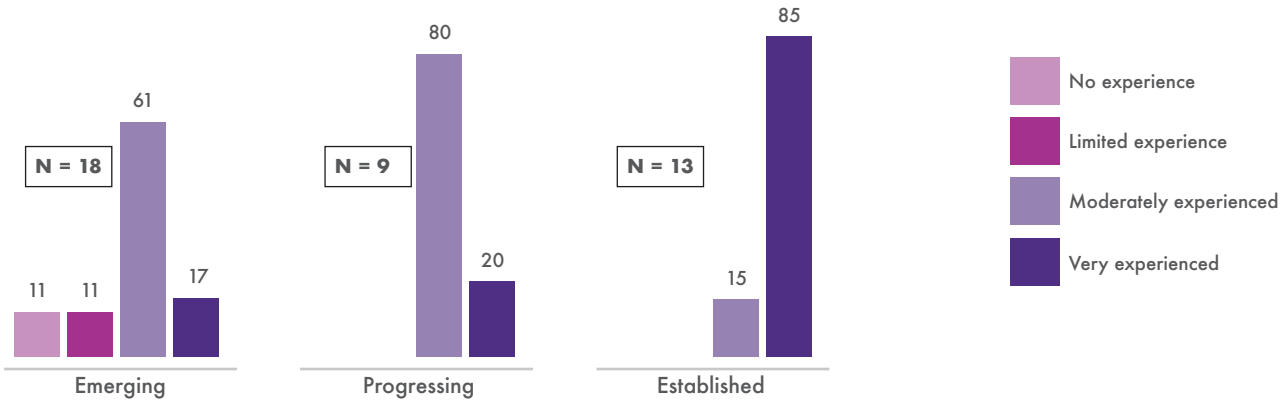
The survey sought to investigate whether individual and organisational capabilities such as strong relationship building expertise and high-level negotiation and diplomacy skills were in place to understand and be respectful of the needs and demands that drive sectors outside of health.

The response "*moderately experienced*" was most commonly selected by respondents (51 percent), when rating the level of their organisation's experience in working with other sectors on health issues or health determinants. More than a third of respondents (39 percent) reported that their organisation is *"very experienced"*.

As expected, when rating this experience at the organisational level,[i] there is a relationship to the maturity of HiAP practice (Figure 3-17). A small number of Emerging respondents report that their organisation has "*no experience*" or "*limited experience*", whereas no respondents in the Progressing or Established phases selected those options. Of the Progressing respondents, 80 percent report having "*moderate experience,*" as do the majority of Emerging respondents. Over 80 percent of Established respondents report that their organisation is "*very experienced*" in working with other sectors on health issues and health determinants.

FIGURE 3-17

Organisational level of experience in working with other sectors on health issues and health determinants by maturity of practice (percentage)



[i] The data reported in section 3.5 are from survey questions that relate to the Capabilities category, reported at an organisational (Q9 and Q14), individual (Q39-40) and jurisdictional level (Q41-42) (see Appendix 2 for a full copy of the Survey Questions).

39%

of respondents reported that their organisation is "very experienced".

Adelaide, South Australia

FIGURE | 3-18

Organisational level of engagement in HiAP by maturity of practice (percentage)

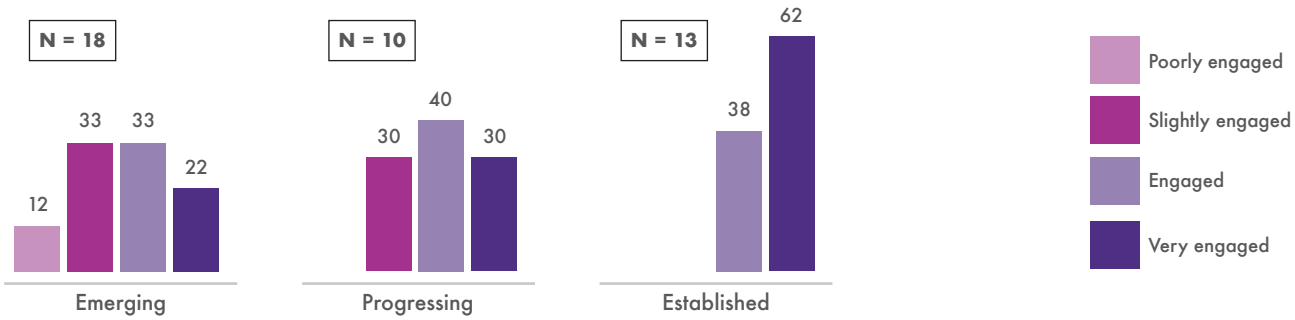


FIGURE 3-19

Individual level of knowledge, skills and capacity to implement HiAP by maturity of practice (percentage)

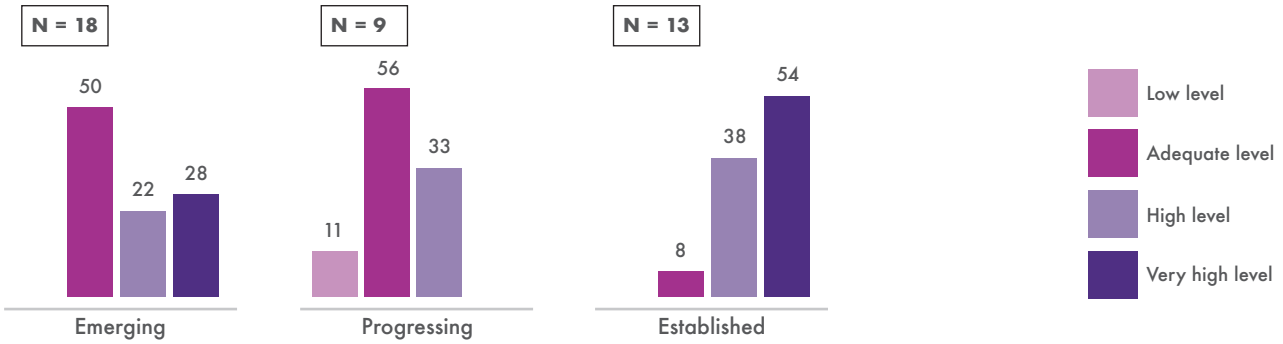
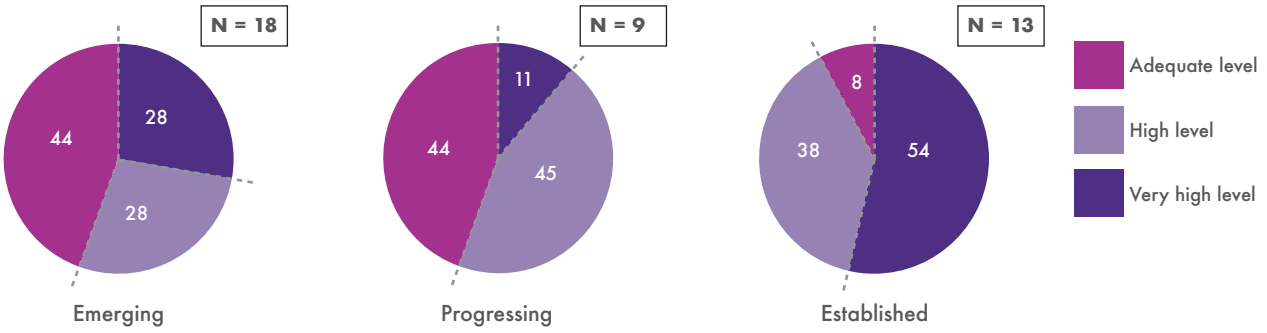


FIGURE 3-20

Individual level of negotiation and diplomacy skills by maturity of practice (percentage)



Similarly, a link between level of organisational engagement with HiAP and maturity of practice is apparent, as shown in Figure 3-18. Of all respondents, 37 percent report that they feel their organisation is "*very engaged*" and a further 37 percent report that their organisation is "*engaged*". A small number of Emerging respondents report poor organisational engagement and close to 30 percent of Emerging and Progressing respondents report that their organisation is "*slightly engaged*". All Established respondents report that their organisation is either *"engaged"* or "*very engaged*".

As shown in Figure 3-19, individuals generally report an adequate skill level for implementing HiAP throughout all phases of practice. Of the 40 respondents who report on this, 37% report "*adequate level*", 30 percent reported "*high level*" and 30 percent reported "*very high level*" overall knowledge, skills and capacity. Similar rates were reported for negotiation and diplomacy skills, where 37 percent report "*adequate level*", 37 percent report "high level" and 25 percent report "*very high level*".

As expected, the majority of Established respondents report having high or very high levels of both knowledge, skills and capacity to implement HiAP as well as negotiation and diplomacy skills (Figure 3-20). Interestingly, the only respondents who report low level skills for either of these categories are in the Progressing phase. "*Adequate level*" knowledge, skills and capacity to implement HiAP are most common for the Progressing respondents; a higher percentage of Emerging respondents report having "*very high level*" HiAP capacity and skills as compared to the Progressing phase. Generally, organisational and individual levels of knowledge, skills and capacity to implement HiAP are fairly positively self-assessed.

Of the 40 respondents who reported on the same skill set at the jurisdictional level, the most common response (42 percent) was "*adequate level*" with 25 percent reporting "*low level*", 22 percent reporting "*high level*" and 10 percent reporting "*very high level*". Responses are consistent at each phase of practice, with "adequate level" the most common response across the board. It should be noted that some responses may have been made on behalf of the respondent organisation and others on behalf of all partner organisations. The fact that "*adequate level*" is the most common response indicates that respondents may not feel confident reporting on this, and therefore consistently select a mid-range response.

3.6 Monitoring, Reporting and Evaluation

Monitoring, reporting on and evaluating HiAP progress is important as this enables evidence gathering about what has worked and why, and facilitates identification and reporting on challenges and best practices.[k] Of the 40 survey respondents answered survey questions relating to monitoring, reporting and evaluation, 40 percent report on their HiAP activities and outcomes and 47 percent evaluate their HiAP practice and action.

As expected, there is a link between practice maturity and whether monitoring, reporting and/or evaluation occur. Figure 3-21 and Figure 3-22 show that the majority of Established respondents report on and evaluate their HiAP practice, whereas a large majority of the Emerging respondents do not. Results from Progressing respondents are more varied, however over 50 percent do undertake some form of evaluation.

There also appears to be a link between formal governance structures and monitoring, reporting and evaluation. Of the 18 respondents who have formal governance arrangements to oversee HiAP, 14 also report on their HiAP progress, and 15 evaluate their HiAP approach.

It is important to note, that definitions of monitoring, reporting and evaluation are vast. Of the respondents that do report, either monthly or annual reporting is common, and in some cases both. Annual reports are typically more comprehensive and presented to senior decision makers. Formal reporting processes are more common at the subnational and national levels of government.

The descriptive responses in relation to evaluation and reporting approaches indicate that in some jurisdictions reporting and evaluation appear to be conflated terms. For example, one respondent describes a "*mid-term evaluation report and final evaluation report*" as reporting.

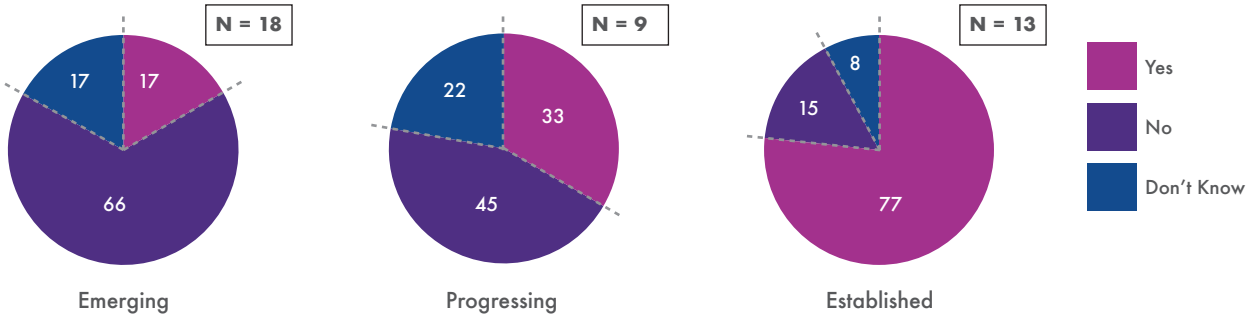
Evaluation methods also appear to vary. One Emerging respondent is in the process of developing an evaluation framework - "*The HiAP Evaluation is in the early planning stage at present. It has a focus on a qualitative process evaluation of the engagement phase of HiAP approach. It is based upon six identified HiAP success strategies noted previously which form the basis of our jurisdiction's HiAP work programme*".

One Progressing respondent reported plans to develop a program logic and evaluation framework in partnership with a University. Another Progressing respondent described their evaluation approach as follows: "*The evaluation of the HiAP approach is carried out through a meeting of the HiAP Technical Committee, where the Departments of Agriculture, Fisheries and Food Policy, Social Policy, Housing, Education, Economy and Budgets, Culture, Youth and Sport, Environment, Transport, Regional and Urban Planning, and Health are represented*".

One Established respondent reported – "*In the early days each HLA (Health Lens Analysis) was evaluated, more recently a five year research program was completed to evaluate the whole HiAP initiative, which included a number of case studies. An evaluation plan is under development to evaluate the new PHPA (Formal Partnership) methodology*".

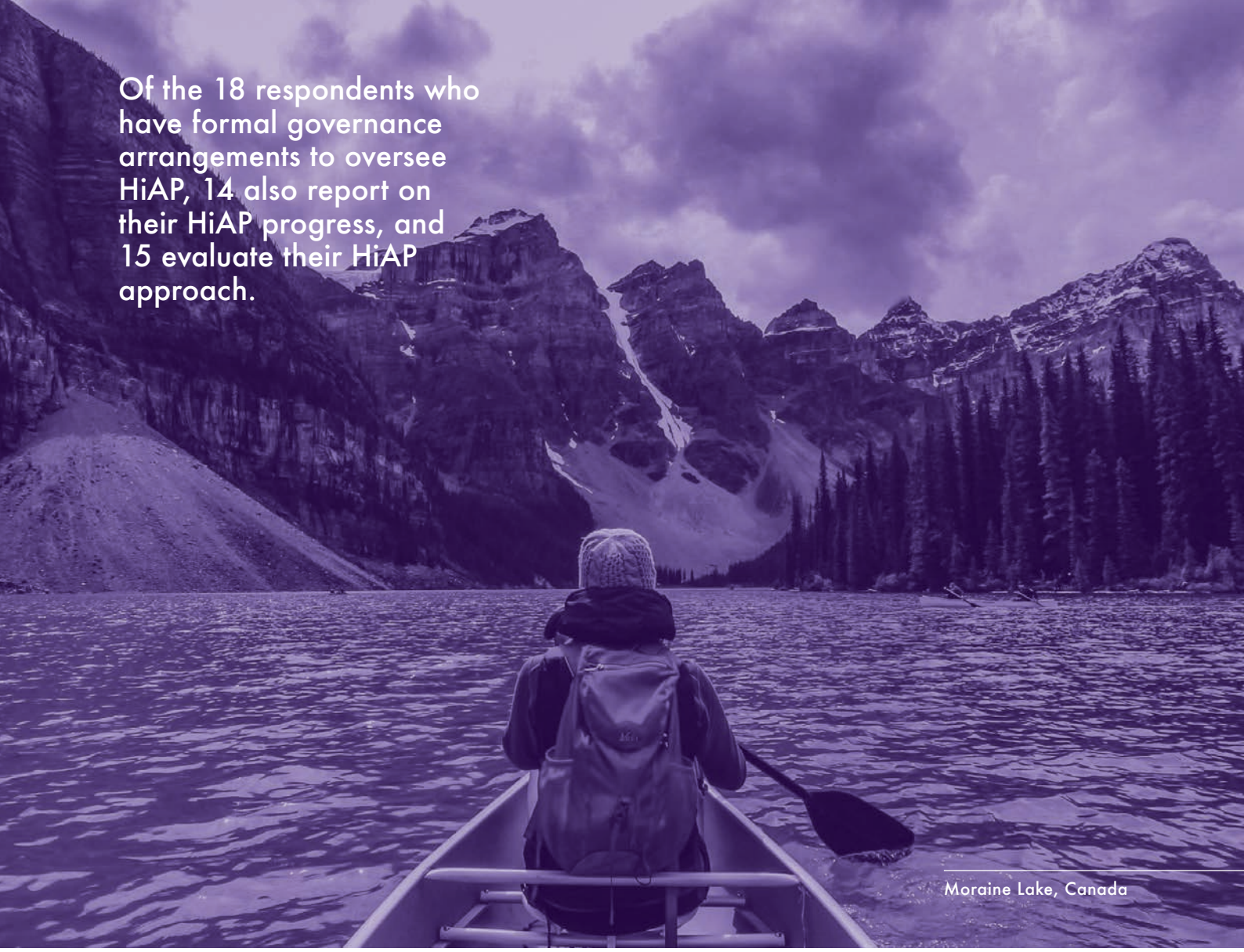
FIGURE 3-21

Percentage of respondents that report on HiAP activities and outcomes by maturity of practice



[k] The data reported in section 3.7 are from survey questions that relate to the Monitoring and Evaluation category, these include: Questions 43 to 46 (see Appendix 2 for a full copy of the Survey Questions).

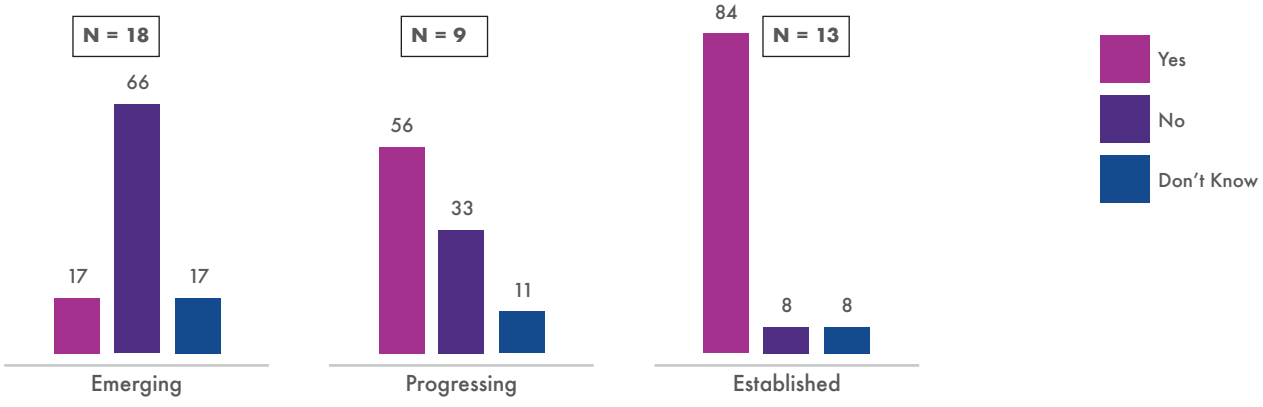
Of the 18 respondents who have formal governance arrangements to oversee HiAP, 14 also report on their HiAP progress, and 15 evaluate their HiAP approach.



Moraine Lake, Canada

FIGURE | 3-22

Percentage of respondents that evaluate HiAP practice or actions across sectors by maturity of practice



3.7 HiAP Priorities and Outcomes

As expected, the priorities for HiAP (considering priorities for the next 2-5 years), at different levels of government and phases of maturation appear to be reflective of contextual issues.

While reducing inequalities regionally was mentioned once at the local level of government, equity was mentioned more frequently at the national and subnational level.

Increasing equity should always be an underpinning goal of HiAP implementation at all phases of practice maturity and in all levels of government; however this takes long term progress and commitment.[4] The results of this survey show there is no clear link between equity as an explicit target of a HiAP approach and the maturity of the practice.

Specific health issues are commonly listed as upcoming priorities for HiAP practice, as well as determinants related issues and/or sectors to target moving forward. As expected, formalising HiAP approaches is a common priority for those in the Emerging phase. Other examples of priorities listed in this phase include: gaining more political support, developing a strategy and more tools for greater cross sector collaboration.

Some respondents in the Established phase at the local level indicate goals to better engage community in decision-making, and one respondent at a subnational level reported plans to focus on expanding HiAP practice to be implemented at the local government level. Finally, one jurisdiction at the national level also described expanding HiAP to be implemented at a state level, across all states.

As with priorities, the reported number of policy outcomes addressed through HiAP increase for respondents with more mature HiAP practice.[I] The maturity of HiAP practice appears to be important when considering the structures and processes in place to enable a focus on a particular priority issue, but is less important in determining the types of issues to prioritise. Rather, these are influenced more by the level of government and/or context specific issues that present in specific jurisdictions.

The policy outcomes reported, can be broadly summarised under the following categories:

- increased political commitment to HiAP (generating momentum from the bottom up)
- introduction of formal legislation or policy (including inter-departmental)
- stronger focus on HiAP issues at the municipal/local government level (top down)
- increased multisectoral action on improving population health and wellbeing
- increased multisectoral action on addressing the social determinants of health and equity
- increased multisectoral action on addressing specific health issues - examples of issues reported include:
  - obesity/nutrition/physical activity
  - labour and workforce
  - planning/environment/energy issues
  - substance abuse
  - gender equity
  - equity for Indigenous populations

Improving health equality and equity and addressing inequities are most commonly reported at the national level of government. The social determinants of health are reported at subnational level jurisdictions but also appear to be a strong focus at the national level. These tiers of government offer the processes and mechanisms to enable settings in which broader societal issues of health equity and primary/primordial prevention can be addressed.

Policy focused outcomes are more common for those operating at a national level. Building capacity is reported at both the subnational and national level; one national level jurisdiction, in a developing nation, also reported building accountability as a key outcome. Addressing specific health problems/protection issues (e.g. non-communicable diseases, anti-vectorial fight or anti-microbial resistance) are more common as policy outcomes (or intended outcomes) at the subnational level.

There appears to be variation, particularly at the subnational level, in how policy priorities and/or outcomes are defined. Some respondents reported very specific issues, such as "anti-vectorial fight" or "food and nutrition joined up policy" and others more strategic issues such as "*built capacity across the public sector to be able to consider and influence the DoH [determinants of health]*". Ultimately responses and experiences are very context specific. Some responses indicate community driven outcomes and priority setting; it is important to acknowledge the varied mechanisms for priority setting adopted in certain jurisdictions.

[I] The data reported in section 3.7 are from survey questions that relate to the HiAP Priorities and Outcomes category, these include: Questions 33 and 34 (see Appendix 2 for a full copy of the Survey Questions).

Scotland (National) *Established*

In Scotland several organisations support action on the determinants of health. While not set up as a HiAP approach, over the years Scotland has developed a strong culture and practice of intersectoral collaboration which aligns well with the principles of HiAP.

The Scottish Health and Inequalities Impact Assessment Network (SHIIAN) have supported Health Impact Assessment (HIA) since 2001, delivering training and producing evidence reviews to support HIA in specific policy areas. Its current work plan includes capacity building for a broader HiAP approach. The Glasgow Centre for Population Health has also helped increase understanding of the breadth of health determinants in Scotland.

NHS Health Scotland's strategy- *A Fairer Healthier Scotland* (developed in 2012 and updated for 2017-22) led to an approach to health inequalities centred on cross-agency collaboration, supporting action on the determinants. It created a culture and practice where public health staff engage directly across levels of government, departments and sectors to influence policy and practice with a view to improving health and redressing health inequality. NHS Health Scotland is accountable to its board for progress in achieving improved health outcomes through influencing the determinants of health.

A new organisation, Public Health Scotland, will incorporate NHS Health Scotland and other national public health organisations and HiAP is recognised as a key approach to 'Improving the Health of Scotland's People'. In 2017 the Scottish Faculty of Public Health identified HiAP as one of its 8 priorities, and is advocating for the Government to commit to HiAP for all public policies in Scotland.

Public health departments in local health boards have worked with local authorities and other organisations for many years. Until recently most partnerships focused on implementing health improvement initiatives but many are now developing a HiAP approach to influencing broader policy.

Glasgow, Scotland

4.0
FINDINGS AND IMPLICATIONS

Tunis, Tunisia

This chapter outlines the key themes and findings of this report, informed by the data collected through the Global Network for Health in All Policies Survey. The results provide insight into HiAP practice in a broad range of global settings as the momentum and uptake of HiAP practice continues to grow. Whilst the data presented here is not definitive, for the first time the report provides a framework of HiAP processes and conditions, with some consideration of context specific nuances. Good HiAP practice requires long-term commitment and dedication. In theory, all HiAP practitioners, whether emerging or more established in their approach, would aim to evolve practice maturity, to embed and systematise HiAP for the long term.

4.1 Advancing the HiAP Model

We know that HiAP works best when a combination of factors and conditions are in place:

- good governance
- development of strong and sound partnerships based on co-design, co-delivery and co-benefits
- dedicated capacity and resources and
- the use of evidence and evaluation.

Together, these factors can and do deliver positive change.[22]

The conceptual framework underpinning the survey and this report, present the key elements of a model for initiating a sustainable HiAP approach. Published by WHO, Figure 1-1 in Section 1.5 is one of the few frameworks to adequately document a model for HiAP,[18] albeit with a focus on initiating, rather than embedding and systematising HiAP. This report attempts to adapt this model and recognise how, through the lens of the known conditions for sustained and good HiAP practice, such a model could be broadly applied to track transitions through HiAP maturity phases; from Emerging, to Progressing and Established HiAP practice. The results of this survey help to further conceptualise how the conditions integral to HiAP can enhance this framework. Storm and colleagues developed a similar maturity model for HiAP in 2014.[26] The findings in this report are validated by the model developed by Storm et al. and extend it beyond the local level of government to the international arena.

4.2 Key findings

Figure 4-1 shows the integration of these factors and conditions (as shown by the symbols in this report) within the WHO framework.[18] The findings of the survey reinforce the notion that Governance and Leadership are overarching requirements; sustained HiAP action that can evolve, mature and be embedded into policy and practice, requires good governance. Resources are also important throughout many stages, and depending on context, they feed in at different points to support HiAP action. Resources are particularly important for building capacity, and creating tangible actions to produce measurable outcomes. It's important to acknowledge that much of the success of HiAP, particularly in the Emerging and Progressing phases, appears to involve drawing on resources that are not explicitly dedicated to HiAP.

Several other elements of the model fit neatly with the conditions found to be important in the survey. For example, Establish the needs and priorities for HiAP clearly aligns with the HiAP Priorities and Entry Points conditions; Identify supportive structures and processes also aligns with Entry Points as well as Ways of Working; Frame planned actions and Facilitate assessment and engagement align with Ways of Working.

Whilst the survey response numbers are small, the data presented in this report provide many unprecedented insights into the status of global HiAP practice. These findings build on and reinforce much of the existing HiAP evidence base. In particular they provide grounded evidence of three distinct "phases" of maturity to inform a broad-based model that can be sensitive to context.

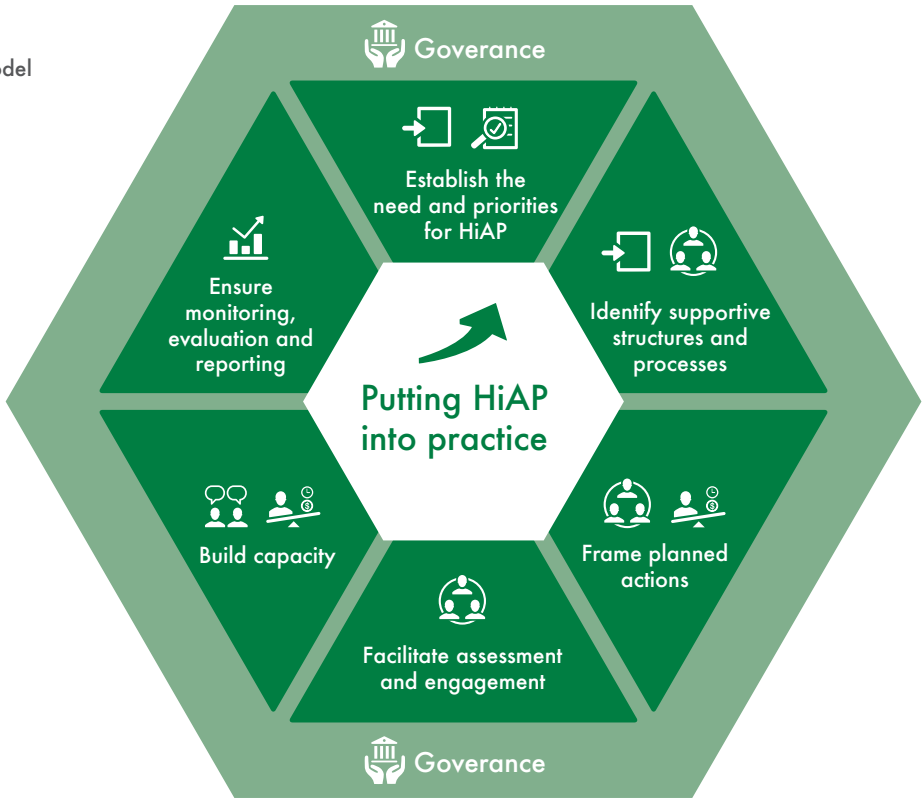
The following subsections explore what this survey has revealed about the nuances of the conditions for HiAP through the phases of maturity, and where appropriate, any additional implications of the level of government where HiAP practice operates.

4.2.1 Governance and Leadership

Good practice in governance for HiAP includes a strong authorising environment, with political support and high-level leadership. As evidence shows it is ideal to have two types of formal governance structures in place for HiAP: oversight structures to support the mandate for HiAP, and structures to support the implementation of HiAP practice.[12]

Furthermore, political support and governance arrangements are recognised as strategically important in supporting the ongoing implementation of HiAP. In different contexts, high-level formal governance mechanisms can enable HiAP practice to evolve and mature, as the authorising environment helps in leveraging the status of the approach. In other cases however, particularly where HiAP may have evolved from the "ground up", justification for establishing more formalised governance arrangements may grow as the HiAP practice matures.

FIGURE 4-1
Advancing the HiAP model



The survey data show that the more established the HiAP practice, the more likely a jurisdiction is to have a strong authorising environment with political support, as well as governance mechanisms or formal structures in place to oversee HiAP. Some other governance related findings of note are:

- Where jurisdictions have governance mechanisms or formal structures in place to oversee HiAP it is often very senior officials who provide the mandate and authorising environment, with the day-to-day HiAP work managed by lower level officials such as middle managers.
- Whilst some jurisdictions may not have political support or oversight governance arrangements to support HIAP, the majority of respondents report some form of governance arrangements or formal structures to support the implementation of HiAP.

4.2.2 Resources

Resources are required to support and sustain good HiAP practice. As HiAP is dependent on strong collaborative relationships, dedicated personnel are key. Budgets to support HiAP activity are also ideal, but the results of the survey show that HiAP implementation is possible with minimum budgets regardless of the level of practice maturity. The data show that dedicated budgets are less common than dedicated staff, reinforcing that relationships and partnerships are integral to sustainable and effective HiAP practice.[5,10] These results may also indicate that staffing resources are easier to fund than other resources and activities. Dedicated resources, are most common at the subnational level, and in the Established phase. This could be indicative of a number of factors:

- That commitment of resources in the Emerging and Progressing phases is a key enabler for maturation to the Established phase.
- That in order to reach the Established phase it's important that HiAP practice is shown to be resilient, flexible and demonstrate tangible impact; it is possible that it is at this point that formal resource commitment is justified.
- That lower numbers of dedicated staff in the Progressing and Emerging phases may indicate that less staff are required during this time. The Progressing phase can be a period for navigating the policy landscape before finding where to fit long-term, hence the emphasis on informal support networks during these phases, rather than dedicated budgets.
- That both dedicated and informal support staff are required to sustain HiAP action once the Established phase has been reached.
- That obtaining budget and general resource commitment is a markedly complex process at the national level and there is typically more flexibility at the subnational level. Furthermore, resources are generally fewer at the local level.

Interestingly, six respondents indicate that they have neither a dedicated team, nor any informal support staff for HiAP. However with the exception of one outlier, all of these responses are from those in the Emerging phase; it could be that it is difficult in this phase, to identify the point at which HiAP practice is formalised, and therefore whether staff engaging in HiAP are, by definition, formally contributing to the approach.

Another interesting question raised in response to queries on resourcing and ways of working, is whether HiAP practice is seen as most effective if other agencies, beyond where the approach was initiated, are taking on responsibility for implementation and resourcing. In some jurisdictions, agencies external to the health department or central government agency, where HiAP was initiated, have committed resources and staff to HiAP work, suggesting broader support for HiAP.

4.2.3 Entry Points

The results of this survey confirm how context specific HiAP entry points can be. There is no single way to get HiAP on the agenda, but rather action needs to reflect and leverage current cross-cutting issues, potentially drawing on both the local and international context. Respondents were asked to report on entry points at the time of initiation of their practice. These data have been -for the most part - compared by the level of government at which the practice occurs rather than the phase of practice maturation. Some insights and findings from the data, relating to HiAP entry points, include:

- Health system and health protection related factors are common imperatives for action, particularly at the local and subnational level of government.
- Social equity, the social determinants of health and political drivers appear to be more common driving factors for HiAP at the national level. This implies a greater impetus to address these issues at this level and is reflective of the different roles and degree of influence of government at different levels.
- Reducing health inequities was a top response at all levels, and particularly the national level. Whilst addressing health inequities might be an ambition at the point of initiation, it does not align as strongly with reported current or intended ways of working (see section 4.2.5). This reinforces what we know,[36] that whilst addressing equity is recognised as an important issue, the complexity in defining the problem plus identifying straightforward solutions means that policy opportunities for addressing health inequities rarely manifest, other than in relation to particular high need groups.
- Legislation was not listed as a potential driver but appeared in one of the *"other"* responses. Legislation could be considered either a driver or a reinforcer in different cases.

- Entry points appear to vary by maturity of practice with Emerging or more recent starters acting on "top down" drivers than more established jurisdictions. Potentially this is a result of the growing evidence base, but it's also important to consider the role of the SDGs which were adopted in 2015.
- The most common actions taken to initiate HiAP are a "*High-level strategy*", an "*Action plan*" and "*Running an event*". The combination of developing a strategy/action plan/resource, and a networking meeting or event appears to be a common approach for initiation at both the local and subnational level of government. These confirm the actions outlined in the model/framework for country action (Figure 4-1).
- The fact that a common key strategy for implementing HiAP is information sharing through meetings and events reinforces how important relationship building and high-level negotiation and diplomacy aptitude are to effective and sustainable HiAP practice.

4.2.4 Capabilities (Individual and Organisational)

Experience suggests collaborative and joined-up approaches require a combination of what are viewed as soft and hard skills – that is (soft) skills to develop and manage relationships such as negotiation and diplomacy, and more technical (or hard) skills, such as public health planning expertise, research skills, data and policy analysis skills, evaluation skills and general knowledge of, for example, public health and social determinants issues. Survey respondents generally reported high personal and organisational skills in HiAP. The results reinforce the literature which shows that HiAP practice requires complex and comprehensive negotiation and diplomacy skills and the ability to navigate and be responsive to political, administrative, cultural and environmental contexts.[18,37] Furthermore, the data reinforces that consideration of context is crucial in HiAP; there is no one size fits all formula or model for how many personnel are needed and which skills are required, nor a roadmap for understanding when they may become most crucial.

Other key findings in relation to HiAP capabilities and capacity include:

- Skills and competency are more poorly reported in the Progressing rather than in the Emerging phase. It seems likely that a process of reflection and realisation may occur during the Progressing phase about the true breadth and complexity of skills required for HiAP and a need for growth and skill development may be recognised. These complexities may not be fully realised in the Emerging phase, where respondents appear to over-estimate their skills and capabilities.
- In the Emerging phase there appears to be a strong sense of aspiration and ambition generally, however the Progressing phase is a time to take stock; to recognise what the true challenges of effective HiAP practice are and how to strategically position HiAP in the political, cultural and administrative context for support and long-term impact. This may result in a recognised need for growth in capacity and capability at that point.
- The results also suggest that skills and experience in working with other sectors are developed and strengthened as HiAP practice evolves. In some cases however, those committed to implementing HiAP may possess these skills, potentially leading to a more rapid maturation of HiAP practice.

4.2.5 Ways of Working

The Ways of Working related survey questions help to unpack the complexity of the HiAP model; the application of tools, relationships/partnerships and processes are applied uniquely in differing settings. The Ways of Working in HiAP encompass a combination of principles, strategies and processes. The survey questions were designed to capture these elements including a focus on equity and/or applying co-design principles. The results, as expected, show that Established phase respondents report a more comprehensive range of current, or intended approaches to implementing HiAP in their jurisdiction.

"Delivery of strategic policy for health is integral to HiAP practice; this is the level of policy" delivery at which government priorities are set and where resource distribution is managed.[11] The results of this survey show that "*Delivery of strategic or "big P" policy...*" is the most common policy-related focus for HiAP practice. This result is encouraging, as policy impact is widely considered the ultimate goal of a comprehensive and sustained HiAP approach, supporting the greatest long-term impact for the health of the population.[11] Furthermore, as expected, based on the results of the resources section, having a dedicated team is more common in supporting "*big P*" policy approaches than having a dedicated budget – it takes people skills and time, more so than specific budgets.

The focus on strategic and "*big P*" issues becomes greater as practice maturity increases, however there is only a marginal (80% to 85%) increase between the Progressing and Established respondents. It is also more common at the national level of government, which makes sense given this is where the greatest opportunity to influence strategic policy lies. Theoretically, those working on *"little p"* policy are taking a bottom-up approach, with ambitions to work towards influencing *"big P"* policy in the future. This is however influenced by government and therefore the level of influence available in that jurisdiction.

The presence of informal structures and groups to support HiAP implementation are another critical element of the HiAP Ways of Working. The majority of respondents report having informal structures and groups in place to support the implementation of HiAP, and the presence of these increase with practice maturity, demonstrating their importance. There is also a relationship between the level of government, and the presence of informal structures and groups to support HiAP implementation. All jurisdictions operating at the local level report having support from informal structures and groups, while these are less likely at the national level (63 percent).

The large number of respondents that utilise informal structures and groups, and the nature and variety of the structures and groups that these repondents describe is indicative of how important these truly are to the HiAP effectiveness.

Some other notable survey findings relating to the Ways of Working in HiAP practice include:

- *"Health Lens Analysis"*, "*Health Impact Assessment,*" and "*Research*" are common key strategies for implementing HiAP; in particular for identifying the links between health and the work of other sectors. More than two thirds of all respondents, in all phases of maturity and at all levels of government, indicate that evidence is very important in informing and documenting the links between health and other government policy priorities. This may reflect the use of evidence in the health sector, where most strategies are typically evidence-based.
- Meetings and events are critical for sharing information and create important opportunities for engaging key HiAP influencers. Over 90 percent of all respondents in the Established phase share information through meetings and 85 percent utilise events (considerably higher than other phases). Once again these results reinforce the importance of in-person information sharing, networking and relationship building for sustained HiAP practice.
- "*Addresses environmental determinants and climate change*" appears to be one of the least common focus areas of current HiAP practice for Established respondents. The reasons for this can only be hypothesised. It is possible that there is a lack of integration between environmental and other social determinants. Anecdotal evidence suggests there is a common failure to see environmental justice as a health and social issue, where traditionally the concepts linking environmental sustainability to health equity have been relatively foreign to public health practitioners. Another inference that could be drawn from this result is that addressing the environmental determinants and climate change is quite specific in comparison to many of the other statements included.
- "*Addresses health inequities*" is another less prominent focus area for Established respondents. This highlights the challenges and sensitivities in (directly) addressing health inequities. This response may indicate that addressing equity as part of a broader social equity agenda is favoured, rather than as a specific health or HiAP target. Evidence suggests that addressing health inequities is challenging, and that challenge increases at a systematic level. "*Promotes health and equity*" was one of the top statements aligning with current or intended HiAP practice (40 of 41 respondents selected *"yes"*), selected by respondents. These results highlight the distinction between promoting health equity, which appears to be a priority in most jurisdictions, and the capacity for HiAP practitioners to effectively influence or address health inequities which is complex and challenging in all jurisdictions, at all phases of practice maturity.
- These two Ways of Working (addressing environmental determinants and equity) did score notably lower in all phases of maturation however were least common for those in the Progressing phase, when compared to the Emerging phase. This reinforces the notion that Emerging phase respondents may be highly aspirational in what they set out to achieve.

4.2.6 Monitoring, Reporting and Evaluation

Monitoring, reporting and evaluation mechanisms enable HiAP practitioners to validate the importance of their work by tracking and reporting on outcomes and impact. These can be used to track short-term deliverables and in turn influence future priority setting and the achievement of long-term outcomes.

The data presented in this report show clear linkages between the maturity of HiAP practice and any reporting and evaluation mechanisms in place; they are more common for Established HiAP approaches. The data also show a positive relationship between formal governance structures and monitoring, reporting and evaluation. Further, the results indicate that monitoring, reporting and evaluation are defined differently across global jurisdictions. Some common monitoring and reporting mechanisms include monthly or annual reports, and evaluation descriptions vary from health lens analysis to university partnerships for longer-term tracking.


Bangladesh

4.2.7 HiAP Priorities and Outcomes

For HiAP to be seen as relevant, priorities need to be set so that they are attentive to the cultural, administrative and political climate.

The survey results show that priority setting is important in all phases of maturity; the nature of these priorities is however dynamic and influenced by the level of government. Whilst some jurisdictions report on priorities related to evolving their practice and processes, others reported on specific health issues they intend to tackle in the next two to five years.

Furthermore, to gain long-term support for HiAP, the approach needs to demonstrate tangible impact and outcomes. Whilst long-term outcomes are in many cases a 20 year process (to demonstrate population level shifts in health outcomes) short term outcomes are simpler to demonstrate.

Outcomes reported tended to fit into categories, from an increase in political commitment, multisectoral action on health and social determinants of health issues, to the introduction of legislation and policy to support the systematisation of HiAP.

4.2.8 Emerging cross-cutting themes

Several cross-cutting themes have emerged from the data presented in this report. Due to small survey response numbers, it is not possible to draw definitive conclusions about these however they do reinforce much of the existing HiAP evidence. They also raise important questions for future surveys of this kind:

- **Formal versus informal**: The survey data reveal that understanding of the terms and descriptions of formal and informal are varied. It is possible that levels of formality have varied implications in different cultural contexts and global jurisdictions. In some instances formality in governance, legislation, roles, partnerships etc. is important, but for HiAP the informal steps to build to formality are just as critical at different points in time. Furthermore the data show divergent views, in different global jurisdictions, about the technical definition of formality in relation to many of the elements of HiAP and also HiAP practice as a whole.
- **Equity - explicit or implicit**: Equity appears to be influenced by level of government and political context more than by the maturity of practice. Subnational levels of government have a lesser focus on equity as a target than local or national. In all six local level cases, equity was a focus. HiAP processes and practice elucidate a distinction between improving health equity and the more challenging agenda of addressing health inequities.
- **Relationship building and partnerships:** We know that relationships are a cornerstone of good HiAP practice.[38] Strong partnerships and relationships have been recurring themes in the data, underpinning many of the conditions of HiAP; resources, capabilities and ways of working. Fostering these relationships is crucial; it's important to establish long-term commitment to HiAP with partner organisations, which in turn produces effective policy integration and sustained commitment.
- **Significance of level of government**: The level of government appears not to be as relevant to the results of this study as was initially anticipated by the Technical Group. In relation to entry points and governance structures the level of government is critical. Beyond this the level of government was a less useful way of analysing the data. Stronger themes in the data became more apparent when dividing the data by the phase of practice maturity. It is also important to recognise the challenges of interpretation related to the "level of government" due to differences in responsibilities and government structures within each country.

4.3 Recommendations for the next survey instrument and sampling method

The results of this survey provide a starting point for tracking HiAP practice across the globe. The findings have, in many cases, raised new questions about HiAP practice. To build on the learnings of this first survey and report - on the global status of HiAP and current understandings of HiAP practice - it is recommended that the following themes be explored in future global HiAP surveys or complementary research:

- The role of HiAP in addressing inequity versus improving health equity. Future research (using more qualitative methods) could explore cases where equity has been an explicit HiAP target, to more comprehensively understand how and why it has been addressed and the associated challenges.
- The difference between having a dedicated HiAP team, a dedicated staff member or informal scoping and networking approaches. The commitment of personnel to support HiAP appears to be equally as important as any existing or potential governance and leadership arrangements, in enabling HiAP practice to mature.
- Incorporating more nuanced questions in relation to resources and capabilities throughout the phases of HiAP practice. Responses to a number of survey questions indicate a lower level of reported commitment/dedication/skill during the Progressing phase. One hypothesis for this is that strong investment in training and resources occurs when a HiAP approach is initiated, and that the Progressing Phase is a time to settle and navigate the landscape before reaching the Established phase when greater commitment is reinforced. The Progressing phase is a time to fully demonstrate the value of a long-term and sustained approach to HiAP. Thus, it would be valuable to better understand this phase.
- Using qualitative research methods to draw out the finer details of relationship building, and how partnerships operate in HiAP. These have been consistently validated as underpinning success and good HiAP practice. In the early stages of designing this survey a decision was made to limit the questions relating to relationships and partnerships based on their complexity. Qualitative methods would allow greater exploration of this detail and the cultural context and unique challenges of partnering and relationship building in different global jurisdictions.
- Determine where legislation fits as a driver or enabler for HiAP. Legislation was not listed as a potential driver but appeared in one *"other"* response.

The results presented in this report have confirmed many of the issues explored in Section 2.6. Some more technical recommendations in relation to the design and dissemination of future surveys include:

- Reaching out to broader communities and networks to capture a more comprehensive representation of Global HiAP practice.
- Consolidating clarity on key HiAP terms and concepts to improve comparability of data, such as:
  - formal versus informal
  - definitions of HiAP
  - what is included in budget allocations e.g. staffing
  - monitoring/reporting/accountability/evaluation.

4.4 Summary

This first Global Status Report on Health in All Policies adds to the collective understanding of how HiAP is being progressed in 41 jurisdictions around the world. It provides a wealth of information on critical aspects of implementation including governance, leadership, funding, resourcing, partnerships, methodologies, capability requirements, evaluation and much more. The results provide a useful base against which further developments in HiAP can be measured. Further, they contribute to the framing of a maturity model for the stages of HiAP practice. Importantly, it helps advance our understanding of HiAP and enhance the conceptual model for HiAP based on real world experience.

Appendix 1

The Global Network for Health in All Policies

Table A-1 Current Steering Committee Members by sector

Government Sector
Sudan, Federal Minister of Public Health
Australia (South Australia), SA Department for Health and Wellbeing, the State of South Australia
Botswana, Ministry of Health and Wellness
Canada (Quebec), Ministry of Health and Social Service, the Province of Quebec
Ecuador, Municipality of Quito
Finland, Ministry of Social Affairs and Health, National Institute for Health and Welfare
Namibia, Ministry of Health and Social Services
Thailand, National Health Commission Office
Tunisia, Ministry of Health
United Kingdom (Wales), Public Health Wales
Academic Institutions
Peter L. Reichertz Institute for Medical Informatics, University of Braunschweig - Institute of Technology and Hannover Medical School, Germany
Global Health Centre, the Graduate Institute of International and Development Studies, a WHO Collaborating Centre on Governance for Health and Global Health Diplomacy, Switzerland
School of Health Systems and Public Health, University of Pretoria, WHO collaborating Centre for Health in All Policies and Social Determinant of Health, South Africa
United Nations Agencies
United Nations Environmental Programme (UNEP)
United Nations Educational, Scientific and Cultural Organisation (UNESCO)
World Health Organization (WHO)

Table A-2 Executive Committee members, by sector

Government Sector
SA Department for Health and Wellbeing, the State of South Australia, Australia
National Institute for Health and Welfare, Ministry of Social Affairs and Health, Finland
Federal Ministry of Public Health, Sudan
National Health Commission Office (NHCO), Thailand
Academia Institution
Global Health Centre, the Graduate Institute, Switzerland
United Nations Agencies
World Health Organization (WHO)

Appendix 2

Global HiAP Survey 2018 to inform the Global Status Report on HiAP

17 October 2018 (Final version)

Welcome to the Global Network for Health in All Policies Survey

Thank you for participating in our survey. Your input is very important in providing an overview of the current status of Health in All Policies (HiAP) in your jurisdiction and collectively across the world. The information you provide will be used to inform the Global Status Report on HiAP and provide baseline data to track HiAP progress. This is the first time a global survey on HiAP practice has been undertaken. Participation is voluntary and responses are confidential. The published results will be aggregated and will not be identifiable. Individual answers will not be shared.

This work is an initiative of the Global Network for Health in All Policies (GNHiAP).

Completion Instructions

- Please complete this survey by reading each question and selecting the most appropriate response option.
- You can change your answers on any survey page until you complete the survey and click the Done button.
- Responses are saved page by page as you progress through the survey.
- Please complete the survey in one go. If you exit the survey and go back to it, your existing responses will not be saved.
- The survey will take about 20 minutes to complete.
- If you have any questions, please contact HealthHiAP@sa.gov.au and we will respond during business hours (Monday to Friday, Australian Central Daylight Time).
- Survey closes on Friday 21 December at 5:00pm (Australian Central Daylight Time).

Rationale

Who should complete this survey?

Population health and health inequities are shaped by a broad range of societal, environmental, economic, cultural and political factors that often sit outside the remit of the health sector. Taking action across sectors (in government and society) to protect and promote health is therefore required to address the determinants of health and health inequities. Intersectoral work varies from one-time or occasional collaborations to more systematic approaches that are embedded in organisational structures and processes.

Health in All Policies (HiAP) is one example of intersectoral action for health. HiAP includes a wide spectrum of activities and can be implemented in many different ways. It provides a systematic approach to public policy making and delivery. A key feature of HiAP models is the emphasis on governance mechanisms and other supportive structures to facilitate collaborative action. HiAP is described as a policy-related strategy that contributes to population level interventions through providing a supportive policy environment rather than concentrating on specific programmatic action or service delivery.

The World Health Organization (WHO) defines HiAP as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity".

This survey aims to gather information on how HiAP operates in different jurisdictions. Please complete this survey if the work you do is considered HiAP practice (i.e. governance and policy level work that occurs in a sustained way rather than one-time pieces of work).

If you are in the early stages of planning your HiAP approach and have not yet commenced implementation, you are still eligible to complete this survey.

1. Contact Information

All textboxes are required fields.

*Full Name
*Organisation
*Address
*City/Town
*State/Province
*ZIP/Postal code
*Country
*Email address
*Position Title

Perspectives on your HiAP approach

The term jurisdiction for the purposes of this survey is defined as a specific level of government, such as national, subnational, region, municipality, local or city. As you complete this survey, please answer the questions referencing only one level of government. If you work across multiple levels of government, please complete a separate survey for each level.

2. Please select the category that best describes the level of government at which HiAP is being implemented in your jurisdiction.

Please select only one answer.

a. National government
b. Subnational government (state/province/regional)
c. Individual local government or city/municipality
d. Multiple local governments or cities/municipalities
e. Other, please specify

As you complete the rest of the survey, please answer the questions in reference to your selected level of government.

3. What sector are you currently working in? Select up to three responses that best describes the sector or sectors you work in.

a. Agriculture and farming
b. Central government/Cabinet office/Central planning office
c. Defence
d. Early childhood
e. Economic development
f. Education
g. Energy
h. Environment and sustainability
i. Finance/Treasury and investment
j. Foreign affairs
k. Health and wellbeing
l. Immigration
m. Industry and mining
n. Infrastructure
o. Local government
p. Social welfare
q. Sports and recreation
r. Tourism
s. Transport
t. Trade
u. Urban planning
v. Other, please specify

4. Health in All Policies can include a range of activities. How would you describe your HiAP work and engagement with other sectors? Please select one answer only.

a. Occasional collaborations to address one issue or a determinant of health with a single partner (e.g. tobacco, food labelling) (proceed to Q5)
b. Occasional collaborations to address a range of issues or determinants of health with various partners (proceed to Q5)
c. On-going regular collaborations with one or two partners to address one issue or a determinant of health (e.g. children's nutrition) (proceed to Q6)
d. On-going regular collaborations with more than two partners to address multiple issues or determinants of health (proceed to Q6)

5. Does your organisation have plans to expand its engagement with other sectors so that it includes a more systematic approach to collaborative work?

a. Yes
b. No
c. Don't know

6. For each of the following statements, please select if it aligns with your current or intended approach to applying HiAP?

	Yes	No	Don't know
Integrates health considerations into policy-making across sectors			
Systematic (joined-up) work across sectors on public policy			
Supports cross sector collaboration			
Works at the population level rather than at the individual level			
Creates "co-benefits" or "win-wins" for multiple partners (i.e the work simultaneously addresses the goals of the health sector and other agencies to benefit more than one end)			
Addresses the social determinants of health			
Addresses environmental determinants and climate change			
Addresses health inequities			
Creates structural or process change			
Promotes health and equity			

7. Select the response that best describes the level of governance mechanisms or formal structures in place to support the implementation of HiAP in your jurisdiction? Please select one answer only.

a. Strong governance mechanisms are in place to support HiAP implementation
b. Some governance mechanisms are in place but there is room for improvement
c. Discussion and planning about governance mechanisms to support HiAP implementation is underway, however, none are operating as yet
d. There are no governance mechanisms in place to support HiAP implementation

8. What aspect of policy delivery is your HiAP approach aimed at in your jurisdiction? Please select all that apply. "Policy delivery" in this question refers to implementation and delivery.

a. Delivery of strategic or "big P" policy (includes national or state/provincial/regional law, city ordinances and comprehensive plans, typically needing elected officials' approval. The implications for change can be far reaching – affecting a much larger population rather than just one organisation, department or sub-group)
b. Delivery of organisational or operational or "little p" policy (typically at an institution, department or agency level and generally influence organisational practices. These types of policy changes can create quick wins and can sometimes lead to larger changes that typically are not as labour-intensive as "big P" policy changes)
c. Policies supporting programme delivery
d. Policies supporting service delivery
e. None of the above
f. Other, please specify

9. How would you rate the level of experience your organisation has in working with other sectors on health issues or health determinants?

a. Very experienced
b. Moderately experienced
c. Limited experience
d. No experience
e. N/A

Initiation of HiAP in your jurisdiction

The following questions are about how HiAP was initiated or is being initiated in your jurisdiction. These questions explore how HiAP got on the political agenda in your jurisdiction and the key features which were necessary to support the establishment of a HiAP approach.

10. How long have you been developing and/or implementing the systematic work across sectors (HiAP approach) in your jurisdiction? Select only one answer.

a. We have not yet formally started to develop our HiAP approach
b. We are in the early stages of planning our HiAP approach
c. 1-2 years
d. 3-5 years
e. 6-9 years
f. 10 or more years

11. 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.

a. We are interested but have not yet sought formal commitment/approval to develop and implement HiAP in our jurisdiction
b. We are working with other sectors but are yet to seek formal commitment/approval to develop and implement HiAP in our jurisdiction
c. We are not working with other sectors as yet but we are actively trying to obtain formal commitment/approval to develop and implement HiAP in our jurisdiction
d. 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
e. We have developed a formal governance structure and are in the early stages of implementation
f. We have well developed formal mechanisms for governance and implementation and are making good progress
g. HiAP approach is embedded as a mandatory or recognised way of working in our jurisdiction
h. Other, please specify

12. For each of the following statements, please select if it was a key driver in initiating and adopting HiAP in your jurisdiction?

	Yes	No	Don't know
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 multi-sectoral action			
A major structural/political reform (e.g. country joining the European Union)			
Addressing the social determinants of health – structural and intermediary			
Addressing only the intermediary social determinants of health – lifestyle or working and housing conditions			
Achievement of universal health coverage			
Action on non-communicable diseases			
Reducing health inequities			
Increase financial investment in health or increase the status of health across government			
Addressing gender inequality			
Strengthening work on human rights			
International influences			
Political gain for the political leaders in power			
Address communicable disease prevention or eradication			
Prepare for health emergencies			
Access to health services			
Progressing the Sustainable Development Agenda			
Policy change window			
Addressing climate change and environmental sustainability			
Action on anti-microbial resistance (AMR)			
Research or study findings on benefits of HiAP practice			
Other, please specify			

13. Once the initiation of HiAP was agreed or supported, what actions were taken to commence or progress HiAP in your jurisdiction? Please select all that apply.

a. Regional consultation meeting
b. An executive order
c. A funded pilot
d. Action plan
e. High-level strategy (e.g. national public health policy)
f. Declaration
g. Charter or Statement on HiAP
h. Development or use of legislation
i. Support from a human catalyst to progress the HiAP agenda (i.e. politician, mayor or local leader, academic, 'thinker in residence')
j. Running of an event (e.g. Conference, Training Course)
k. Development and dissemination of manuals or tools on HiAP implementation
l. Development of a report or formal recommendations to assist in progressing HiAP
m. N/A – a formal action for HiAP initiation or progress has not been identified or developed
n. Other, please specify

14. How well do you feel your organisation is engaged with HiAP?

Very engaged, engaged, slightly engaged, poorly engaged, N/A

15. Is equity an explicit targeted outcome of your HiAP approach?

a. Yes
b. No
c. Don't know

16. Do you have political support for HiAP in your jurisdiction? Select only one answer.

a. Yes (proceed to Q18)
b. No (proceed to Q17)
c. Don't know (proceed to Q17)

17. Do you intend to seek political support for the HiAP agenda in your jurisdiction?

a. Yes
b. No
c. Don't know

Operation of HiAP in your jurisdiction

Please answer the following questions to explain how HiAP operates in your jurisdiction.

Governance mechanisms and oversight of HiAP

18. Does your jurisdiction have formal governance arrangements to oversee HiAP?

a. Yes (proceed to Q20)
b. No (proceed to Q19)
c. Don't know (proceed to Q19)

19. Do you intend to set-up a formal governance arrangement for HiAP in the next 12-24 months?

a. Yes (proceed to Q24)
b. No (proceed to Q24)
c. Don't know (proceed to Q24)

20. Select the governance arrangement that best describes the oversight structure of HiAP in your jurisdiction? Select only one answer.

a. Cabinet committee
b. Inter-departmental committee
c. Inter-departmental unit
d. Parliamentary committee
e. Governing board
f. Presidential/Ministerial/Governor oversight
g. Municipal committee
h. Local health board
i. Other, please specify

21. Which organisation/agency/department takes the lead role for the development and delivery of HiAP in your jurisdiction? In answering this please include the name and primary function of the lead department or agency/organisation. (E.g. Ministry of Health, oversight of hospitals and prevention action; Office of the Prime Minister, government administration and coordination)

Name_____

Function_____

22. List the position title of the person who provides the mandate and authorizing environment for HiAP and their relevant department/agency/organisation? (e.g. Prime Minister, Chief Executive, Director). This is different to the person who oversees and manages the day-to-day HiAP activities.

Position title of person who provides the mandate for HiAP:

_____

Department/agency/organisation of the person specified above:

_____

23. List the position title of the person who oversees and manages the day-to-day HiAP activities and their relevant department/agency/organisation? (E.g. HiAP Manager, HiAP Program Co-ordinator, Cross-sector Liaison Manager).

Position title of person who oversees the day-to-day HiAP activities:

_____

Department/agency/organisation of the person specified above:

_____

24. Do you have any informal structures or groups that support the implementation of HiAP in your jurisdiction?

a. Yes (proceed to Q25)
b. No (proceed to Q26)
c. Don't know (proceed to Q26)

25. Please briefly describe the informal structures or groups that support the implementation of HiAP in your jurisdiction.

Free text response

Human Resources for HiAP

Dedicated HiAP teams/staff

26. Does your jurisdiction have a dedicated HiAP team that supports HiAP action?

a. Yes (proceed to Q27)
b. No (proceed to Q28)
c. Don't know (proceed to Q28)

27. How many staff (Full-time equivalent, FTE) are dedicated to the development and delivery of HiAP in your jurisdiction? This relates to the number of staff who are core members of a HiAP specific team.

Please provide your best estimate or type N/A if don't know.

Number of FTE _____

HiAP participatory staff

28. Does your jurisdiction have staff that participate in and support HiAP activities but are not part of the core HiAP team?

a. Yes (proceed to Q29)
b. No (proceed to Q30)
c. Don't know (proceed to Q30)

29. What percentage of the workforce in your jurisdiction is estimated to support HiAP practice? This includes all staff involved in any aspect of HiAP work. Please provide your best estimate or type N/A if don't know.

% _____

Financial resources for HiAP

30. Does your jurisdiction have a dedicated budget for HiAP activities?

a. Yes (proceed to Q31)
b. No (proceed to Q33)
c. Don't know (proceed to Q33)

31. What is your budget for HiAP activities in the next 12 months? Please answer in the currency relevant to your jurisdiction (e.g. US$).

_____

32. Which agency/organisation has responsibility for the allocation and spending of the HiAP budget? Please select one answer only.

a. Central government/Cabinet office
b. Health agency/department or Ministry of Health
c. It is a shared responsibility. There is an integrated budget that is overseen by more than one agency
d. Don't know
e. Other, please specify

HiAP priorities and achievements in your jurisdiction

33. What are the three most significant policy outcomes that your HiAP approach has addressed? If N/A please specify in the text box.

1.
2.
3.

34. What are the three HiAP priorities you hope to achieve over the next 2-5 years?

If N/A please specify in the text box.

1.
2.
3.

Stakeholders involved in HiAP practice in your jurisdiction

35. Who contributes to the development and implementation of the HiAP approach in your jurisdiction? Select all that apply.

a. Government
b. Non-government organisations
c. Universities/academia
d. Community/civil society
e. Private sector/businesses
f. Donor agencies
g. International agencies (e.g. United Nations)
h. Professional bodies (e.g. Public Health Association)
i. Other, please specify

Ways of working to support HiAP implementation

Methods

36. How does your organisation identify the links between health and other policy outcomes when undertaking HiAP practice? Select all that apply.

a. Health Impact Assessment
b. Health Lens Analysis (aims to identify the key linkages between policies and strategies of other sectors and population health and wellbeing and health equity)
c. Economic Analysis
d. Joint problem definition
e. Literature reviews
f. Research (qualitative and quantitative)
g. Other, please specify

37. How is this information shared with key decision-makers to shape and influence policy outcomes? Select all that apply.

a. Parliamentary briefs
b. Memos
c. Project Reports
d. Policy briefs
e. Events
f. Meetings
g. Public health reports
h. Newsletters or network briefings
i. Other, please specify

38. How important is using evidence to document the links between health and other government policy priorities for the successful implementation of HiAP in your jurisdiction?

a. Very important
b. Slightly Important
c. Neither important or unimportant
d. Slightly unimportant
e. Not at all important

Current knowledge, skills and capacity in the HiAP approach

When answering the following questions, refer to your own personal skills and knowledge.

39. Please rate your overall level of knowledge, skills and capacity to implement the HiAP approach.

a. Very high level
b. High level
c. Adequate level
d. Low level
e. Very low level

40. Please rate your level of negotiation and diplomacy skills.

a. Very high level
b. High level
c. Adequate level
d. Low level
e. Very low level

When answering the following questions, refer to your jurisdiction's skills and knowledge.

41. Please rate your jurisdiction's overall level of knowledge, skills and capacity to implement the HiAP approach.

In answering this question consider the combined capacity of your immediate colleagues and the workforce employed across the other sectors, government departments and organisations in your jurisdiction.

a. Very high level
b. High level
c. Adequate level
d. Low level
e. Very low level

42. Please rate your jurisdiction's level of negotiation and diplomacy skills.

In answering this question consider the combined capacity of your immediate colleagues and the workforce employed across the other sectors, government departments and organisations in your jurisdiction.

a. Very high level
b. High level
c. Adequate level
d. Low level
e. Very low level

Monitoring and tracking success

43. Does your jurisdiction regularly report on HiAP activities and outcomes?

a. Yes (proceed to Q44)
b. No (proceed to Q45)
c. Don't know (proceed to Q45)

44. Briefly describe the reporting process (e.g. how often does it occur; what is included in the reporting; who endorses the report).

Free text response

45. Does your jurisdiction evaluate HiAP practice or actions across sectors?

a. Yes (proceed to Q46)
b. No (proceed to Q47)
c. Don't know (proceed to Q47)

46. Briefly describe the evaluation approach that is undertaken.

Free text response

GNHiAP Support

The Global Network for Health in All Policies (GNHiAP) is a recently established network to promote the implementation of HiAP across regions and support capability development for HiAP practice.

47. How/when did you first learn of the GNHiAP? Select only one answer.

a. World Health Assembly 2017
b. World Health Assembly 2018
c. Through word of mouth from colleagues
d. Through GNHiAP promotional material forwarded from a jurisdictional colleague
e. Through an invitation to attend the GNHiAP meeting in Bangkok,Thailand, 2017
f. I have just learned of GNHiAP through receipt of this survey
g. Other, please specify

Other comments

48. Are there any other comments you would like to make about HiAP implementation in your jurisdiction?

Thank you for participating in this survey.

Appendix 3

Survey Question 11 – Determining the phases of maturation

Respondents who selected (a), (b) or (c) have been grouped in the Emerging (n=18) phase, respondents who selected (d), or (e) have been grouped in the Progressing (n=10) phase and respondents who selected (f) or (g) have been grouped in the Established (n=13) phase. The following Table lists the possible survey responses, grouped within these categories of practice maturity.

Question 11	What stage is your jurisdiction at in the development and delivery of the HiAP approach?
Emerging	a) We are interested but have not yet sought formal commitment/approval to develop and implement HiAP in our jurisdiction
	b) We are working with other sectors but are yet to seek formal commitment/approval to develop and implement HiAP in our jurisdiction
	c) We are not working with other sectors as yet but we are actively trying to obtain formal commitment/approval to develop and implement HiAP in our jurisdiction
Progressing	d) 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
	e) We have developed a formal governance structure and are in the early stages of implementation
Established	f) 6.We have well developed formal mechanisms for governance and implementation and are making good progress
	g) HiAP approach is embedded as a mandatory or recognised way of working in our jurisdiction

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Further information

Global Network for Health in All Policies
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