Appendix 2: Overview of case studies

	USA California	Canada Quebec	China	Ecuador City of Quito	Finland	Namibia
Stage of maturity	Mature	Emerging	Emerging	Emerging	Mature	New
Starting point	HiAP task force, created by Executive order (2010) – consistent high-level government leadership support since then	Government policy on prevention in health (2016) – building on years of broadening policy mandates Development of interministerial action plan (by October 2017)	Healthy China 2030 (2016) - first long-term national strategy for health taking a "one health" approach. Means for participation in global health governance and achievement of SDGs	Enabling legal and policy environment Metropolitan Ordinance 0494 (2014)	Long track record on HiAP (since 1972) Government's ten year objectives and key projects (2015)	National consultation workshop to draft HiAP implementation plan – identified 6 entry points for first wave policy action (WHO mission in October 2016)
Pathway to HiAP	Establishing mandate and structure (2009-2010) Engaging stakeholders (2010-2011) Securing commitments (2011-2012) Implementation (2012-2015) Systematisation/ formalisation (2016 onwards) Spread of HiAP in California and the US (2009 to now)	Policy on health and well-being (1992) Public health act (2001) Government action plan to promote healthy lifestyles (2006-2012)	Strong history of Government commitment to health (at highest level) 18th CPC Central Committee decision to promote development of a healthy China (2015), with drafting group established 2016	Joining Healthy Cities movement (2016) Focus on NCDs initially, then broadened to health inequities	Finland's EU position (since 1995) EU presidency (2006) with focus on HiAP 8th Global Conference on Health Promotion (2013)	Aligned with national development plan (NDP5)
Level (National, state, local)	State	Province	National	District/ Municipality	National	National
Partnerships	Task force with broad intersectoral representation from 22 agencies – support by backbone HiAP team key Inputs by external stakeholders (e.g. local and regional governments, advocacy organisations, think tanks)	Firm political anchor in MSSS, with support from other sectors (contributions by 15 ministries and government agencies, modelled against SDGs)	Over 20 ministries participated in working group to draft policy, supported by experts and research	District level Departments (health and others), public corporations, Ministry of Public Health (Ecuador), PAHO, communities	Multiple structures and mechanisms for intersectoral collaboration – natural continuation of existing work	Initially led by Ministry of Health and Social Services with support from WHO Proposed to be led by Office of the Prime Minister with MoH in secretariat role National planning commission to support policy screening

New Zealand Christchurch	Australia South Australia	Sudan	Suriname	Thailand	United Kingdom Wales	Zambia
Mature	Mature	New	Emerging	Mature	Emerging	New
Long history of collaboration Healthy Christchurch charter (2002), signed by high-level city decision makers and modelled after Healthy Cities	Adelaide Thinker in Residence (2007) – HiAP initiated, supported by a high level mandate from central government, an overarching framework which is supportive of a diverse program of work, a commitment to work collaboratively and in partnership across agencies, and a strong evaluation process	National health policy (2007) – 2013 assessment draws attention to intersectoral collaboration HiAP Roadmap (2015) – framed in relation to UHC	Initiated through WHO subregional training workshop (2015), followed by participatory assessment and national consensus workshop High-level commitment through engagement of Chair of parliament, Vice president and ministers Parliament briefing by Michael Marmot (2015)	National Health Act (2007) Broad vision of health facilitates participation by non-health sector including civil society	Wellbeing of future generations act (2015) – provides an enabling framework for thinking and working differently	Government's vision for health in revised national development plan Recognises that broader determinants of health lie outside the health sector – HiAP framed as an approach to tackle these for better health and health equity New division on health promotion, social and environmental determinants (2017) with multisectoral approach as a key principle
Series of health impact assessments (2005 onwards) Canterbury earthquakes (2011) Canterbury HiAP Partnership (2011 onwards)	5 distinct phases have evolved in response to a variety of challenges and opportunities, which in turn informed the HiAP model and practice Proof of concept and practice (2007 – 2008) Establish and apply method (2008-2009) Consolidate and grow (2009-2013) Adapt and renew (2014) Strengthen and systematise (2015-2017)	HiAP preliminary stakeholder assessment (2015) Policy dialogue on HiAP (2015) Development of Roadmap (2015) Series of stakeholder meetings and workshops (2016) – leading to commitments and operational plan (2017)	Establishment of policy working groups and a monitoring steering and strategy (MSS) group, chaired by Vice president's office, with Director of Health as secretariat (2016)	Long history of reform towards whole of society approach	Long-standing commitment to sustainable development at the heart of devolution (since 1998)	Existing experiences and structures to respond to crosscutting concerns e.g. HIV/gender HiAP not yet institutionalised: a strategy has been drafted and approval is in process
District/ Council	State	National	National	National	National	National
Municipal government, District Health Board, a national government department and an Indigenous organisation	HiAP unit (initially 1 Program manager, now unit of up to 6) within the Health department	Ten ministries signed commitments with MoH – another 12 are in development	Buy in through several conferences with VP's office and through VP's office and MoH with cabinet and chief executives	National health commission as an advisory body to the Cabinet, chaired by Prime Minister and covering government, knowledge and people sectors	All public bodies work towards legally binding common purpose (7 statutory wellbeing goals)	Central role of the policy analysis and coordination division in the cabinet office in the Office of the President

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Engagement process	Task force guided by shared principles/vision, updated over time – clarity of values and principles important Key partnership strategies include: shared vision, shared leadership, benefits to participating agencies, individual relationships, navigating differences	Responds to long-term criticism of lack of coherence between central and local levels of government Long process of policy development (starting with consultations in 2010)	Policy has strong administrative power (reviewed and passed by the Political Bureau of the CPC, and issued by the CPC Central Committee and State Council) Local governments, ministries and agencies expected to put Healthy China on top of the policy agenda – implementation mechanisms currently being set up, including regular and standardised supervision and assessment mechanisms, as well as monitoring and evaluation mechanisms	Setting up mechanisms for social participation/ community leadership Supported by cross-sectoral collaboration around community priorities	7 key projects as pilots, divided into 2 thematic groups – with separate orientation meetings and briefing papers Focus on testing new methods of collaboration and looking for co-benefits	Intersectoral action not new (a range of policies and mechanisms exist) but HiAP an opportunity to strengthen and broaden partnerships
Community engagement/ equity	Commitment to equity in government practices (action plan under development)	Pressure from citizens, organised groups, experts and media important to create political impetus for action	Equity and fairness central to the policy (including emphasis on primary and rural health and UHC)	Citizen & community participation central (e.g. priority setting, developing plans, work teams, certification of spaces)	Often easier to talk about equity with other ministries that health	Involvement of communities seen as critical
Funding sources (including in-kind resources)	Funding through government, private foundations and in kind-support through other state agencies	Financial incentives (new money) important to get other sectors involved	Multiple-sourced financing mechanisms	Municipal government	Not indicated (central government?)	Not indicated (central government?)
Lessons	Change in culture over time Important to be nimble to respond to emerging opportunities Increasingly calls for specialised technical expertise – may exceed existing capacity of team Monitoring and evaluation especially challenging Challenge of ensuring continuity of HiAP in future – given funding constraints and political changes	Process as important as results – including creating appropriate linkages between political, bureaucratic and civil society spheres Presence of a team dedicated to coordinating the project is an asset Other sectors' capacity and commitment to HiAP varies and follows diverse paths	Taking a "one health" approach calls for coordinating efforts, including those of various government ministries and departments, sectors, society and individual actors. Policy is a major milestone – strategically places health on the development agenda. Now needs to be followed by developing key mechanisms, especially national health impact assessment mechanism.	Culture of social participation important but may vary (marginalised groups) Collaboration across sectors takes time and happens step by step	Collaboration is time-consuming and continuous High-level mandate essential, backed by concrete plans Be prepared to defend gains on HiAP Evidence e.g. on co-benefits can help	Policy coherence remains a challenge Many existing mechanisms and policies – but not all functional Weak implementation, budget lines and human resources Opportunities around child welfare, women's health/gender and GBV, informal settlements, remote populations

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	Started with ad hoc meetings, increasingly strengthened relationships and trust, supported through joint training, capacity building, working together, electronic portal, joint publications & presentations	Partnerships and collaboration are core to the approach. Practices and processes have strong focus on building and sustaining relationships. Co-design and co-benefit direct effort towards establishing trust, a shared understanding and common purpose amongst partners. 5 key stages: Engage, gather evidence, generate, navigate and evaluate. 4 methods: desktop analysis, 90 day projects, Public Health Partner Authorities, Health Lens Analysis	General consensus that lack of coordination and collaboration was a challenge Series of workshops to improve understanding of SDH and generate buy in	8 intersectoral policy working groups were established and each developed 3 proposals 6 promising proposals selected in first round; another six in second round (previous 6 were peer reviewed) PWGs to be disbanded and replaced by policy implementation teams A national health forum and annual population health report expected at the end of 2017	National Health Assembly meets annually: there have been 9 NHAs with 73 resolutions Process involves agenda setting; policy formation; policy adoption; policy implementation; monitoring and evaluation and revision	Accountability mechanisms built into the legislation including roles for an independent future generations commissioner and the auditor general	Consultation integral to policy development: mechanisms for consultation are in place Interministerial committee of officials
	From early on focused engagement of Ngai Tahu (the local tribe), later focus on equity more broadly	Equity part of the vision – but not always at the centre of the approach Equity issues regularly raised and there is growing understanding of equity issues and the need for equity to become a greater focus in future	Equity is one of the core values	Health inequities as well as the SDGs more broadly a key focus of HiAP	Whole of society approach (people one of three sectors involved)	Public engagement contributed to development of act Act established public service boards as mechanism for collaboration at local level – requires partners to work together to develop local well-being assessment and plan	Health equity is a central concern Coalition of willing partners – including communities/civil society
	Government (and government funded unit) Participating organisations	Small portion of health budget - relies on HiAP project partners providing in-kind support and contributing limited additional resources where possible	Not indicated	Not indicated (central government?)	Central government	Not indicated	Not indicated
	Need for continuous institutionalisation of HiAP; and systematic and coordinated engagement of partners while being able to adapt to changing environments/ partnerships and opportunistic interactions	Two foundational pillars: strong governance and flexible partnership practices and processes including Health Lens Analysis Learning by doing to devise a suitable HiAP model for the given context & innovate and adapt over time Relationships are crucial for success and ensuring that HiAP remains relevant, useful and sustained Continuity of staff and connections invaluable HiAP is not linear - requires balancing the science and technical skills with political Intuition, emotional intelligence and creative insights	High-level commitment has been key – challenges include weak capacity (PHI, MoH and others), lack of coordination and structural barriers Bilateral engagement between MoH and others to develop operational plan Better monitoring and reporting would be beneficial	HiAP institutionalisation constrained by economic downturn HiAP needs not to be framed as a burden – but a vehicle to achieving sustainable development HiAP needs time, commitment and goes through multiple cycles	A broad definition of health has facilitated engagement of partners Important to seize opportunities that arise (may not be named HiAP) Success requires a mindset change NHC as the driving force for HiAP	Ministerial support an important enabler for the development of the Act, framed as a model for how SDGs can be translated to the subnational level Organisational and cultural change is an iterative process – emphasis to be placed more on "difference required"	Political will for HiAP: President as a champion Growing economy provides opportunities Need for more staff exposure/training on HiAP