Format for the Selection of Case Study

Examples of Health in All Policies (HiAP)

Health in All Policies (HIAP) is a horizontal and complementary policy that has a high potential to contribute to the population´s health. What is key of HIAP is that it examines the determinants of the health, which can be influenced in order to improve the health, but are controlled mainly by other sectors beyond health. [1]

HIAP is different from other intersectoral approaches in that:[2]

- It is coordinated by the formal mechanisms of government
- It is explicitly tied to the supra-governmental agendas and
- It has a common budget

Health in all Policies is an innovating political strategy that describes the need of a new social contract between sectors move human development, sustainability and equity forward, and that improves the health of the population. HIAP works better when:

- *There is a clear mandate that makes the whole-of-government a priority;*
- *The systematic processes take into consideration the interactions between diverse sectors;*
- *The mediation happens through diverse interests;*
- *The processes of accountability, transparency and participation are present;*
- *The interested parties are and work together outside the government;*
- *The intersectoral initiatives create alliances and confidence.*

Declaration of Adelaide on Health in all Policies. WHO, the Government of South Australia, Adelaide 2010.

SECTION 1: Title/Author Information	
Name of Case of **HIAP**	HiAP Quick Assessment of Health Inequities
Location of Case of **HIAP**	Republic of Suriname
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At what level is the HIAP case applied? (National, Provincial, Local)	National

[1] Sihto M, and Ollila, Koivusalo M. (2006). Principles and challenges of the health in all Policies. In: Stahl T, M Wismar, and Ollila, Lahtinen and, K Leppo (eds), Health in all Policies: perspective and possibilities. Ministry of Social Subjects and Health and the European Observatory of Systems and Health Policies, Helsinki, pp. 3-20.

[2] Shankardass, K. ET to. (2011). Introduction to the Health in all Policies. Report for the Ministry of Health and Length Term (Ontario).

When did the **HIAP case start**? (Minimum 2 years)	May 2015
Describe: the population in which HIAP Case is based in.	All of Suriname

SECTION 2: Considerations of HIAP	
Explain the origins of the **HIAP Case**?	After organizing the first sub-regional training in HiAP for the Caribbean in Suriname, the Surinamese government requested PAHO's TC to implement HiAP in Suriname. In order to implement, the Govt needed to know what the health inequities were, tio this end, a Health in All Policies Quick Assessment of Health Inequities was conducted
Describe the actors who have been involved in this **HIAP Case**.	This assessment was a participatory exercise with several consultation rounds that started with health data experts, but then progressively widened its circle of participants to include people in all different line ministries as well as in civil society and academia. Key actors are: the permanent secretaries ("directors" of the line ministries, ministers, technical officers in the ministries.
Describe the role of the political will and how greater levels of Government have participated in this **HIAP Case**.	Government requested the QA and thus plays a key role; it was key to identify policy champions and involve them from the start. For us these are the Vice president, H.E. Ashwin Adhin; The Minister and Director of Health, H.E. Patrick PENGEL and director Maureen van Wijngaarde-van Dijk and the chair of parliament, Dr. Jennifer Geerlings-Simons
Has the **HIAP Case** incorporated a *"whole of government approach*[3]*"* to reduce inequalities?	Yes
Why was the interpectoral action selected? How was it developed?	Efficiency, transparency and coordination at national and district levels all the way down to the community 1) The assessment had several steps: I) **Equity Profiles:** The quick assessment was based on a rapid scan of the available data on the 15th largest burdens of disease, so **the 15 diseases that account for the largest**

[3] Whole of Government Approach: "Whole of government denotes public service agencies working across portfolio boundaries to achieve to shared goal and an integrated government response to particular issues. Approaches dog sees formal and informal. They can focus on policy development, program management and service delivery." (Australian Public Service Commission, 2012: http://www.apsc.gov.au/mac/connectinggovernment1.htm)

	number of *productive life years lost* (*technical term*: "Disability-Adjusted Life Years" DALYs lost). Where we had data (about 50% of the time), we displayed the disease against a number of **key social determinants** such as **location (district), sex, ethnicity, income, and a key risk factor**. Where there was no quantitative data, we backed it up with qualitative studies. II) Then we flipped those graphs, looking at what the **key social determinants** were that cause these diseases. Though several participatory rounds that asked for feedback from our participants, this helped us come up with 8 areas for policy action. III) **[25th August 2015]** These **8 promising areas for intersectoral policy action** were then refined and **adopted** during a **National Consensus Workshop** in August. IV) [October 21st 22nd] A high-level international conference was held to present all results and get political buy-in from key stakeholders.
Describe the roles of the main sectors involved and how they contributed to the development of the **HIAP Case**. Does an interpectoral team exist?	Yes exists in the participants in the delphi rounds and national consensus workshop, and now in the intersectoral policy groups that are being formed. It is truly whole of government, so all ministires are involved
Also describe the role of the health sector and who led the process.	MoH is a key ally, a convener together with ministry of foreign affairs and the secretariat for HiAP activities
Is there an inter-ministerial or interdepartmental Committee? If so, describe and include an organizational chart with the different actors and sectors.	Yes. One meeting of Permament secretaries, resulting in 8 intersecotral policy working groups (formulated by national consensus workshop) and 1 "Hiap Monitoring strategy" steering group: 1 Education and jobs - Poor education and transition into adulthood are strong determinants for health inequity for one self and for one's children, and for responsible participation in society. Proposed policy options include: compulsory education (4 to 16 years); second chance education; aligning education to labour market needs; improve teaching on health, nutrition, water and sanitation, good traditional practices, environment, physical education, entrepreneurship and innovation; and strengthen labour planning, adherence to labour law and health at work place. Sectors: Education, regional development, district councils, labour, trade and industry, agriculture,

	environment, private businesses, civil society organizations, and health 2 Spatial planning and management - People who are already disadvantaged, e.g., poor or marginalized are more affected by weak spatial planning and management than those better off. Proposed policy options include: coordinate physical planning; strengthen district level structures and capacities; neighbourhood planning and community centres; recognize communal land rights; reduce illegal mining; inventory of harmful facilities and activities; decrease destruction of the environment; etc. Sectors: Planning office, regional development, district councils, public works, environment, physical planning, trade and industries, natural resources, agriculture, education, civil society, and health 3 Built environments - Roads, transportation system, settlements, housing, and infrastructures provide the physical frame for how people live and move. Proposed policy options include: formulate and implement infrastructural norms that consider health and well-being, including for safe walking and physical activities; coordinated policy on low cost housing; adequate and affordable housing as part of district plan; etc. Sectors: Public works, regional development, district councils, housing authority, home affairs, transport, planning, police, home affairs, environment, civil society, social affairs, and health 4 Integrated approach at community and household levels - Disadvantages tend to cluster in certain communities and households where they are mutually reinforcing. Proposed policy options include: increase political and administrative responsibility and accountability at local and community level; multidisciplinary action on gender and domestic violence and child abuse; early child development; link integrated planning at community level to regional and national planning; conditional cash transfer; etc. Sectors: Regional development, district councils, public works, education, justice and police, social affairs, planning, spatial planning, sports and youth, gender bureau, civil society, and health 5 Consumables - There are close links between food, smoking and alcohol consumption patterns and the level of disease and health inequity. Proposed policy options include: taxation according to nutrition and health value; regulation of advertising and marketing

	(including targeting of children), content of processed food (salt, sugar, trans-fats, and additives), labelling, alcohol and fast food outlets; and promotion of local healthy food production and distribution Sectors: Trade and industry, finance, agriculture, regional development, spatial planning, education, vocational training institutions serving the food sector, private food and beverage sector, civil society, and health 6 Training and employment of staff – often staff of public and private organizations do not know how their 'business' influences health and how they can work with each other to reduce inequity. Proposed policy options include: Assessment and revision of curricula of training institutions (health and others); include HiAP in generic and specific post descriptions; incentives and rewards for "desired" behaviour; integration of inequity and social determinant knowledge and skills into in- service training and career paths; integrated training for community workers; etc. Sectors: Education, professional and higher learning institutions, regional development, district councils, spatial planning, public works, trade and industry, agriculture, justice and police, social affairs, professional associations, civil society, and health 7 Health system's governance - influences how it operates, its ability to work with other sectors, how priorities are set, who benefits; and participation, transparency and accountability mechanisms. Proposed policy options include: make inequity reduction part of the system's ethics code, budget allocation and success criteria; make contributions of all relevant sectors visible in policy, budget and reporting; structure for participatory, multi-sectoral and culturally appropriate planning and implementation; safe systems for protecting patients' rights and handling malpractice. Sectors: Regional development, district councils, social affairs, insurance, NGO and private health care providers, justice, civil society, and health 8 Health system's organization and management - may cause the system to perform belo its potential for reducing health inequities due to e.g.: fragmentation, weak administrative and managerial capacity. Proposed policy options include: Enhanced and coherent coordination of the different subsystems of the national health system; enhanced evidence-based

	managerial effectiveness towards health inequity reduction goals; enforcing Primary Health Care (PHC), including intersectoral action, referral system, telemedicine and the integration of preventive services Sectors: Regional development, district councils, social affairs, insurance, NGO and private health care providers, professional associations, civil society, and health
Describe the **HIAP** case´s financial mechanisms; does it have its own budget?	Yes. Helped by PAHO CO and also raised with UNCT, IDB, etc through resource mobilization
Describe the economic arguments that exist for the continuous financing of this **HIAP** case.	1) Poor health and health inequities cause personal suffering and missed opportunities for social and economic development. Each year, Suriname loses 170 000 productive life-years due to ill-health and premature death. "Communicable diseases, maternal, neonatal, and nutritional disorders", "Non-communicable diseases" and "Injuries" account for 27%, 58%, and 15% respectively. Individual health care only explains 20% of the level and inequity in population health. The remaining 80% is shaped by a range of social determinants (50%) and individual health behaviours (30%)2. Health behaviours, in turn are also shaped by social determinants. Social determinants are the conditions, in which people are born, grow, work, live, and age. Key forces at play are: social, economic and political systems; development agendas; and social norms. Social determinants cause health inequities and influence health and development via several pathways. They can be addressed through public policy and intersectoral action. The three main dimensions of inequity in Suriname are: geographic location, socio-economic status, and population group and gender. 2) Intersectoral collaboration SAVES money because of increased efficiency and reduced duplication
Describe the role of public participation; what participation mechanisms are used?	Participatory monitoring, drafting of policies and national consensus workshop; delphi rounds

Describe how the **HIAP** case has used the following tools: evaluation of the impact of the health[4] and Urban Heart[5].	See monitoring strategy.

SECTION 3: health promotion Considerations	
Has the **HIAP** case contributed to policy changes in other sectors? If yes, please describe.	Yes (X) No ( ) Policy optinms are now being developed and prepared for implemntation by the working groups. The council of ministers is implementing anumber of HiAP intersecotral policies now
Does this **HIAP** fit under supranational / global mandate? If yes, please describe.	Yes (X) No ( ) Great scalable exaple of real implementation
Has the **HIAP** case contributed to the collaboration between public and private sectors? If yes, please describe.	Yes (X) No ( ) Yes- provate secoor is a key partner and sits on each of the working groups
Has the **HIAP** case contributed to the collaboration with the social sector? If yes, please describe.	Yes (X) No ( ) Yes same as above
Has it developed capacity in its target population for the continuous application of **HIAP**? If yes, please describe.	Yes (X) No ( ) Yes, it is a sustained and ongoing effort facilitated by PAHO and UNCT, but now natinally and sustainably owned
Describe how this **HIAP** case demonstrates creativity and the innovation.	Yes see analysis and products of research
Has this **HIAP** case contributed to interinstitutional work? If yes, please describe.	Yes (X) No ( ) Yes see previous
Has the **HIAP** case contributed to the gender perspective women empowerment? If yes, please describe.	Yes (X) No ( ) Yes see WG4: community and household level integration
Has the **HIAP** case contributed to ethnic diversity? If yes, please describe.	Yes (X) No ( )
Has the **HIAP** case contributed to the improvement of human rights? If yes, please describe.	Yes (X) No ( ) Participatory rights based monitoring approacj (see monitoring strategy
Has this **HIAP** case had a multiplying effect? If yes, please describe.	yes

SECTION 4: Impact and lessons learned

[4] http://www.who.int/hia/en/
[5] http://www.who.int/kobe_centre/measuring/urbanheart/en/

Describe to what extent the objectives were fulfilled in this case of **HIAP**?	Ongoing but very successful national proces. HiAP is nationally implemented
Which was the impact of the **HIAP** case; How did it contribute to intersectoral action?	See above
How has this **HIAP** case contributed to social change?	Creation of safe, transparent and open spaces and forums for discussion and policy developmennt
Describe how the **HIAP** case has helped to decrease health inequities.	To be determinaed by implementation of our monitoring strategy
Describe the sustainability of the interventions.	Fully sustainable and ongoing
Describe the facilitation factors and barriers found in the application of the **HIAP** case.	Participatory approach and buy in were essential, it took 6 months to get process going but once on course, is also hard to stop

SECTION 5: Evaluation and roll-out	
Describe the results of the formal evaluations on this **HIAP** case.	Ongoing; no formal evaluation yet
Was there an information system of intersectorial nature and of evaluation used?	Yes see monitoring strategy, in formation and implementation
It there published Literature on this **HIAP** case? If yes, please describe.	Yes ( ) No (X)
Please enclose photos, materials or proofs of the efficacy of this experience	enclosed
Does this **HIAP** Case have a Website, and if so, can it be found in online social networks?	Nmot yet

SECTION 6: search Criteria of the experience in the Web	
In which of the 6 strategic lines of action on HIAP can this case be located?	**1- To establish the needs and priorities to achieve HIAP:** 2- **To establish the framework for the planned action** **3- To define the complementary structures and processes:** **4- To facilitate the evaluation of the participation** **5- To guarantee the follow-up, evaluation and presentation of information.** **6- To develop and strengthen capacities:** All 6

see: (link to lines of action)	
Indicate the amount of people who benefit from the case.	500,000+
Select the age of the people who benefit from the case (she can be marked more than an option)	0 to 5 years: 5 to 15 years: 15 to 30 years: 30 to 60 years: 60 years and over: All the population: Vulnerable populations: ALL pop[ulations benefit
Select the scope in which the case is developed (more than an option can be chosen):	Urban: Rural: Insular: Subnational: National: ALL pop[ulations benefit
Indicate the sector that has the lead in the case (more than an option can be chosen):	Education: Health: Urbanism: Development: Infrastructure: Housing: Labor: Companies (private sector): Civil society: Security/Safety other? ALL pop[ulations benefit
Name of the organizations that have led or lead the experience.	ALL pop[ulations benefit
Do you authorize the publication of an email	Yes: No: Authorized electronic mail: yes

in the HIAP Web page?	
Do you authorize the publication of this case´s Webpage in the HiAP web page?	Yes: No: official Web Page of the experience: Other pages Web (maximum 2): yes
Do you authorize the publication of videos of this experience in the HIAP Webpage ?	Yes No The video must have a minimum quality of 640 px of wide, variable height, in MPEG format. The videos can come annexed or please send the youtube or vimeo links where they can be seen. YES
Do you authorize the publication of photographs of the experience in the HIAP Webpage?	Yes No Attach minimum one and maximum 5 photos. The minimum resolution of each photo would have to be of 960 pixels of wide, variable height, to 72 ppp pixel per inch. The format of the photos must be jpg. Number the photos by order of importance. YES
Do you authorize the publication of this document about your case in pdf, on the HIAP webpage?	Yes No YES
AUTHORIZATION	The sending of information, attached archives, photos, videos, contact information etc. that this format and its annexes has, is understood as an authorization to be used on the HIAP webpage and as well as in other PAHO materials on the same topic.