

The globally recognised need for multisectoral action to tackle noncommunicable diseases

– *ways and means to make it happen*

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Master thesis

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“The world has reached a decisive point in the history of noncommunicable diseases (NCDs) and has an unprecedented opportunity to alter its course.... NCDs are driven by the effects of globalization on marketing and trade, rapid urbanization and population ageing – factors over which the individual has little control and over which the conventional health sector also has little sway. While individual behaviour change is important, tackling NCDs definitively requires leadership at the highest levels of government, policy development that involve all government departments, and progress towards universal health coverage.”

Dr Margaret Chan, Director-General World Health Organization (WHO 2014)

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Abstract

Background

Multisectoral action in health have been discussed over the last decades and the conceptual thinking has developed in several different waves: From the Alma Ata Declaration on Primary Health Care in 1978 and the Health for all movements, through the Report by the Commission on Social Determinants of Health in 2008 with the consequent development of Health in all Policies as a governmental strategy, via the Political Declaration on Prevention and Control of Noncommunicable Diseases in 2011 with the commitment to develop and implement national multisectoral policies and plans to the post 2015 discussion about the new Sustainable Development goals. The post 2015 discussion has again underlined the need for multisectoral action and the call for multistakeholder engagement. It is increasingly recognized that health issues cannot be tackled within the health sector. The comprehension have increased the focus on multisectoral action both within governments, across sectors and involving the full picture of multi-stakeholders. This thesis addresses two different sets of research questions. First, to explore whether the general focus on multisectoral action is reflected in the documents of the governing bodies of WHO during the last 15 years. Second, if the new framework proposed by WHO on actions across sectors is in line with the existing knowledge base and to what extent national plans are utilizing perspectives aligned with this framework.

Method

The documents discussed at the World Health Assembly (WHA) in the period from 1999-2014 was analysed by a content analysis using a word count programme and statistically processed by the open source software "R statistics" to explore if there was any change in expressed awareness of the need for multisectoral action in the period, if there was any differences between different programme categories, if there was any changes in the terms used to express multisectoral action and also the development in private sector mentioned in the documents.

The Second Draft of the Framework for Country Action Across Sectors for Health and Health Equity (WHO 2014) proposed to the World Health Assembly in 2015 was analysed and compared with other frameworks for actions across sectors. The framework was applied to national multisectoral plans developed as part of the implementation of the WHO Global Action Plan for the Prevention and Control of Noncommunicable diseases 2013-2020.

Results

The word analysis gives reason to believe that there has been a dramatic increase in the use of the words expressing multisectoral action in the documents discussed in the World Health Assembly from 1999 - 2014. There are differences between the different program categories both trend wise and in total share of words. Noncommunicable diseases being the category of health programmes with the largest share of multisectoral action mentioned and the programme category preparedness (natural and humanitarian crises) being the category of health programmes with the lowest share. There is a change of terms used to express multisectoral actions over the period which to some extent is related to conceptual frameworks developed at the same time. There is a co-existing increase in “private sector” and “multisectoral action” in the period from 1999-2014. This study do not allow any further conclusions about correlation between the expression “private sector” and multisectoral action.

The frameworks for multisectoral action addressed in the study describes mainly key elements of a stepwise approach to “what to do” to establish multisectoral plans. There is very little elaboration of “how to” and, in general, difficult to see a link to a theoretical conceptual framework on which these frameworks are built. The Global Capacity Survey on NCD contains most of the key components of the new framework and the survey seems well placed to monitor the existence of the steps described. The Intersectoral Action for Health Equity Case Studies database (ISAC database) provides elements to map context assessments, policy solutions and engagement models and provide more obvious links to “how to” theories on what works in setting up intersectoral actions.

The Second Draft of the Framework for Country Action Across Sectors for Health and Health Equity (WHO 2014) proposed to the World Health Assembly in 2015, proved to be a good tool to identify steps in the development of national multisectoral plans. The key components from this framework were in place, to some extent, in all 4 countries analysed

(Bangladesh, Mozambique, Malta, Trinidad and Tobago). In general the plans contained less information about multisectoral implementation mechanisms or strategies. Management of conflict of interest was not mentioned in any of these plans but is suggested to be included in the newly proposed framework for actions across sectors from WHO.

Discussion

The word analysis gives reason to believe that there has been a dramatic increase in the use of the words expressing multisectoral action in the documents discussed in the World Health Assembly from 1999 – 2014 and that there is an increased utilization of the concept of multisectoral action in WHO reflecting the need for action to be able to tackle NCDs. All the frameworks for multisectoral action addressed in the thesis shows mainly a stepwise approach to “what to do” to establish multisectoral plans and to some extent descriptions of some topical domains of content of the plan. There is no obvious link to a conceptual, knowledge based framework and “how to do” elements are less developed.

There may be necessary to differentiate future frameworks to different mechanisms for multisectoral actions, according to; targeted level, breadth or in depth approaches (the integrated NCD plan as such or only on tobacco), upstream, mid - or downstream interventions. Target setting and accountability beyond health sector might also be another issue to achieve multisectoral action and should be part of the discussion. It can be claimed that multisectoral action is a new area that are under development and that more deep understanding of most aspects is needed. The framework examined in this thesis is aligned with the current knowledgebase but there is obvious existing knowledge gaps that have to be filled.

Acknowledgments

This thesis is addressing key questions in the implementation of the World Health Organisation (WHO) Global Action Plan on Prevention and Control of Noncommunicable Diseases (NCD) 2013-2020, namely the need of working across sectors to tackle NCDs. The thesis has only used public sources. Relevant literature was identified and discussion enriched by the contributions from colleagues in WHO and the following individuals are duly acknowledged for their contributions in different phases of the work and as inspirators: K C Tang, Shanthi Mendis, Ruitai Shao, Leanne Riley, Nick Banatvala, Yasuyuki Sahara, Onyema Ajuebor, Meindert Onno Van Hilten, Ashley Bloomfield, Nicole Valentine, Cherian Varghese, Jonathan Santos as well as Marcello Tonelli volunteering with WHO from The University of Calgary and Abigail Johnston interning from Cambridge University.

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As always my family is a great support and I love them very much.

Disclaimer

The authors alone are responsible for the views expressed in this article and they do not necessarily represent the views, decisions or policies of the institutions with which they are affiliated. The author do not report any competing interest and in particular no relationship with industry.

Abbreviations

EB WHO Executive Board

ECOSOC Economic and Social Council

FfD Financing for Development on health

GCCS Global Country Capacity Survey

GFF Global Financing Facility for maternal and child health

HiAP Health in all policies (WHO framework)

MDG Millennium Development Goals

NCD noncommunicable diseases

NCD GAP Global action plan for the prevention and control of NCDs 2013-2020

NGO nongovernmental organization

NSA non-state actors

ODA Official Donor Agreements

OOP Out of pocket payment

PAHO Pan American Health Organization

PEN (WHO) package of essential noncommunicable disease interventions

PB WHO Programme Budget

SDG Sustainable Development Goals

UHC Universal Health Coverage

UN United Nations

UNCT UN Country Team

UNDP UN Development Programmes

UNDAF UN Development Assistance Framework

UNGA UN General Assembly

UNIATF United Nations Inter Agency Taskforce on NCD

USA United States of America

WHA World Health Assembly

WHO World Health Organization

WHO FCTC WHO Framework Convention on Tobacco Control

WHO GCM WHO Global Coordination Mechanism on NCD

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Annex;

Annex 1 Document selection and categorisation

1 Introduction

It is increasingly recognized that health issues cannot be tackled within the health sector alone. This has led to an increased focus on multisectoral action both within governments (health-in-all policies and whole-of-government approaches, across sectors) and across the full picture of multi-stakeholders (non-state actors as civil society, Non-Governmental Organizations (NGOs), private sector, philanthropies and international partners).

One recent example comes from the World Health Organization (WHO) Global Action Plan for the Prevention and Control of Noncommunicable diseases (NCDs) 2013-2020 (NCD GAP or NCD Global Action Plan) which stated that (WHO 2013);

«It should be recognized that effective noncommunicable disease prevention and control require leadership, coordinated multi –stakeholder engagement for health both at government level and at the level of a wide range of actors, with such engagement and action including, as appropriate, health-in-all policies and whole-of-government approaches across sectors such as health, agriculture, communication, education, employment, energy, environment, finance, food, foreign affairs, housing, justice and security, legislature, social welfare, social and economic development, sports, tax and revenue, trade and industry, transport, urban planning and youth affairs and partnership with relevant civil society and private sector entities.»

There is reason to believe that there has been an increased awareness and subsequently increase in decisions and recommendations in the WHO's governing bodies that are made dependent on multisectoral actions and that there is an increased need for technical assistance to achieve such multisectoral actions both in health planning and in implementation both in developing and in developed countries.

My focus is to address the awareness of the need for multisectoral actions and to discuss if the current development of a framework for action across sectors respond to the need to establish and implement multisectoral actions for the implementation of the NCD Global Action Plan and also to discuss the ways and means that the global level can facilitate and have an impact on multisectoral country level action.

This thesis aim to document the development of expressed awareness for multisectoral action in documents from different programme areas to the World Health Assembly (WHA) in the period 1999-2014. The proposed Second Draft of the Framework for Country Action Across Sectors for Health and Health Equity (WHO 2014) presented to the WHA 68/2015 (WHA 68/11 2015) is reviewed, analyzed and compared with other frameworks for actions across sectors. The framework was applied to national multisectoral plans developed as part of the implementation of the WHO Global Action Plan for the Prevention and Control of Noncommunicable diseases to discuss ways and means to move from awareness to implementation in multisectoral action and the potential role of WHO.

The work will raise further awareness of the need for multisectoral action in all health areas, with a specific focus on NCD, and hopefully give some insights of mechanisms to achieve multisectoral action and highlight some knowledge gaps. I will use multisectoral, across sectors and intersectoral as synonyms throughout the text of the thesis.

2 Research questions

In this thesis I have addressed two different sets of research questions. First, I have explored whether there is an increased utilization of the concept of multisectoral action in the documents of the governing bodies of WHO during the last 15 years. Second, I have examined whether the new framework proposed by WHO is in line with the existing knowledge base and to what extent national plans are utilizing perspectives aligned with this framework. These questions are detailed below.

2.1.1 The expressed awareness for multisectoral action

- Is it possible to demonstrate a change in expressed awareness of the need for multisectoral action in the documents discussed at the World Health Assembly (WHA) in the period from 1999-2014?
 - Is there an overall trend change in awareness?
 - Is there any differences between different program categories?
 - Is there any change in the use of words to express multisectoral actions?
 - Is there any correlation between expressed focus on private sector and expresses awareness of multisectoral action?

2.1.2 Towards a framework for multisectoral action at a country level applied in country cases for NCD multisectoral action plans and implementation

- How does the framework for across sector action at county level which is proposed to the 68th WHA in 2015 reflect current theoretical or practice based knowledge on how to develop and implement multisectoral action?
- How do existing national multisectoral action plans on NCDs align with the proposed framework?

3 Thesis structure

The background chapter will contain information on definitions and development of multisectoral actions in health in general. The main focus is on noncommunicable diseases (NCDs). The chapter will present the background of why NCDs matter so much for development, poverty and sustainability and to justify the urgency for multisectoral action at country level to tackle the epidemic of NCDs.

The next chapter will explain the methodology of the thesis.

The results of the two main research questions will be presented in the following chapter.

The last part of the thesis will use the results to discuss how WHO can facilitate multisectoral actions at the country level and the knowledge gaps yet to be filled in implementation of multisectoral action.

4 Background

4.1 Multisectoral action needed in tackling Health issues

It is an impression that there is a growing awareness at the global level of the need to overcome fragmentation and silos in the overall UN system as well as fragmentation at country level. Expressions of this is easy to trace in the requests for reforms like one-UN (UN 2005) in WHO reform (WHO 2015) and as part of the post 2015 sustainable development goal (SDG) discussions to be finalized this year. The same awareness is growing at country level. Health action across sectors is necessary, because many factors that are key to health outcomes lie beyond the reach and control of the health sector. Such factors include the causes of, distribution of and risk factors for many diseases (both communicable and noncommunicable); inequitable access to care; and the social, economic and environmental determinants of health. Action across sectors is particularly important in low-income countries; for example, because of weak physical infrastructures in such countries, overemphasis on economic development, and limited capacity of and access to health systems. Action across sectors is a key part of sustainable health intervention in the context of the post-2015 development agenda.

The link between nutrition, health and environment cannot be dealt with by the Ministry of Health alone, there has to be set up mechanisms between health, education, trade, food production, access and supply chain management and other sectors to be able to provide universal access to healthy food. In many cases multisectoral action at country level is also dependent or at least helped by multisectoral mechanisms also at a global level. The call for multisectoral and multistakeholder coordination and collaboration to deal with health issues was also partly the background for the Commission of Global Governance for Health (Ottesen 2014), initiatives like EAT¹ (EAT 2014) and is reflected in the discussions around the SDGs (Sustainable Development 2015) and the search for overarching goals and indicators across programs. The most recent arena where this discussion is pronounced is in

¹ EAT – an international consortium of government, world leading universities and research institutions, philanthropic foundations, non-government actors and organisations, and companies, which all share the common understanding that it is essential to collectively address the issues of food, health and sustainability across the fields of academia, business, politics and civil society to ultimately be able to feed 9 billion healthy people within safe planetary boundaries.

the UN process on Financing for Development (FfD). The global landscape on financing is changing with more countries graduating from low to middle income countries and there is an growing awareness that financing through existing donor agreements alone will not either be sufficient, nor sustainable to tackle the challenges. This has led to suggestions like the Global Financing Facility (GFF) on maternal and child health built on a mixture of aid, loans and return of investment with the aim to strengthen the domestic financing for maternal and child health in countries.

This thesis tries to examine these trends by looking at global health and the UN agency responsible for health– namely; WHO, and how expressed awareness for multisectoral action changes during a period of nearly 15 years (1999-2014).

It will also briefly look at the different understanding and approaches to achieve multisectoral action reflected by the variety of expressions used in the documents to the WHA. Discussing the most recently proposed framework for action across sectors and how it relates to other existing approaches and framework gives an opportunity to discuss existing knowledge gaps and the need for further development. The last entry point of this thesis will be through applying the proposed framework to some country cases of existing and reported operationalized multisectoral national plans. This will help the discussion of what is required to move from planning to implementation, and to discuss if there is a role for the global community to play to achieve multisectoral action at country level.

4.1.1 Historical development and understanding of multisectoral action

Skankardass (Skankardass.K 2012) states the following in his scoping review of intersectoral action for health equity involving governments;

“Over the past 30 years, the concept of intersectoral action for health equity, and more recently health in all policies, is increasingly promoted by international institutions such as the World Health Organization and the European Union (Public Health Agency of Canada, World Health Organization 2008), and there is growing interest in the effectiveness, feasibility, and cost effectiveness associated with such approaches (Public Health Agency of Canada 2007). However, much of the key material is not based on academic analysis or scholarly research. For example, the World Health Organization has provided a compilation of case studies where intersectoral action was used to address health equity (Public Health Agency of Canada and World Health Organization 2008), but the scholarly literature was not systematically consulted”

According to Wikipedia; The term Health in All Policies (HiAP) was first used in Europe during the Finnish Presidency of the European Union (EU), in 2006, with the aim of collaboration across sectors to achieve common goals. HiAP is a strategy which further aims to include health considerations in policymaking across different sectors that influence health, such as transportation, agriculture, land use, housing, public safety, and education. HiAP reaffirms public health's essential role in addressing policy and structural factors affecting health and has been promoted as an opportunity for the public health sector to engage a broader array of partners. There is still a strong engagement in WHO and beyond for this approach and the 9th Health in all Policy meeting is planned in Shanghai in 2017. The 8th meeting was in Helsinki in 2013 and resulted in a statement from the meeting. This statement linked the current approach with the Alma Ata Declaration on Primary Health Care (1978) and the Ottawa Charter for Health Promotion (1986), all of which identified intersectoral action and healthy public policy as central elements for the promotion of health, the achievement of health equity, and the realization of health as a human right at country level with a specific emphasize on primary health and community (WHO 2013). These principles have been reinforced in the 2011 Rio Political Declaration on Social Determinants of Health, the 2011 Political Declaration of the UN High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, and the 2012 Rio+20 outcome document (the Future We Want). This is also reflected in many other WHO frameworks, strategies and resolutions, and contribute to the formulation of the post-2015 development goals. An alternative approach to the ambitious goal of formally including health in all national policies is a more proven issue-centred and narrower strategy. Here the goal is to integrate a specific health concern into other relevant sectors' policies, programmes and activities. Widespread adoption of the WHO Framework Convention of Tobacco Control has made tobacco control an excellent example of this strategy (WHO 2011).

A 'whole-of-government' approach is defined as: Public service agencies working across portfolio boundaries to achieve a shared goal and an integrated response to particular issues by the Australian Government (Australia 2004). It is less focused on health and is a more general approach to intersectoral action. A quick net search reveals that this approach is very widespread between countries such as Austria, EU, USA and Canada, as a broad basis for collaboration and coordination. In the area of NCD, multisectoral planning was introduced as a key part of the Political Declaration on NCDs (UNGA 2011) and the NCD Global Action Plan 2013–2020 (WHO 2013). The focus was reaffirmed and the importance underlined in the

outcome of the July 2014 United Nations General Assembly Review meeting that evaluated the progress on NCDs (UNGA 2014). The heads of states and governments committed to develop multisectoral policies and plans by 2015 and to set national targets for prevention and control of NCDs by 2016. According to the WHO Global Country Capacity Survey (GCCS), as of December 2013, only 43 countries had an operational, integrated, multisectoral national plan consistent with the NCD Global Action Plan 2013–2020 (WHO GCCS 2013).

4.2 Why does Noncommunicable Diseases matter? – Global burden of disease

Noncommunicable diseases (NCDs) are medical conditions or diseases that can be defined as non-infectious and non-transmissible among people. NCDs can refer to chronic diseases which last for long periods of time and progress slowly. NCDs can also result in rapid deaths such as seen in certain types of diseases such as autoimmune diseases, heart diseases, stroke, most cancers, asthma, diabetes, and many more. NCDs are distinguished only by their non-infectious cause, not necessarily by their duration. WHO have chosen to define NCDs as 4 diseases; cardiovascular diseases, cancer, diabetes and lung diseases on the basis of their global burden of disease, their premature mortality under age 70 and due to their 4 shared risk factors; tobacco use, harmful use of alcohol, unhealthy food and physical inactivity.

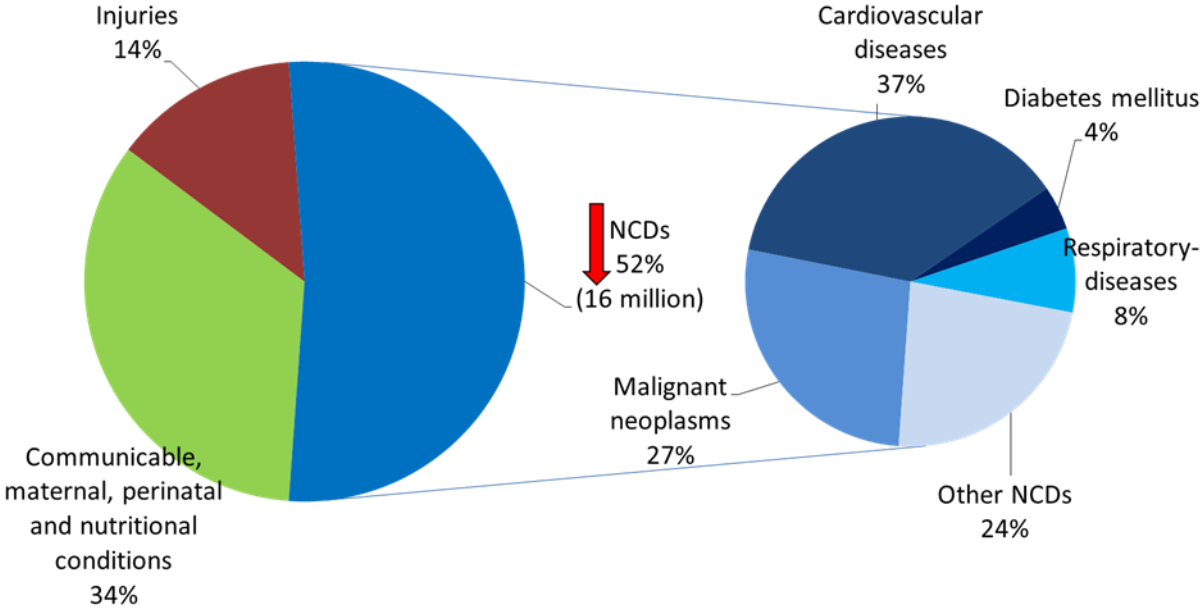
		Causative risk factors			
		Tobacco use	Unhealthy diets	Physical inactivity	Harmful use of alcohol
Noncommunicable diseases	Heart disease and stroke	✓	✓	✓	✓
	Diabetes	✓	✓	✓	✓
	Cancer	✓	✓	✓	✓
	Chronic lung disease	✓			

Figure 1 What are NCDs?

NCDs were responsible for 38 million (68%) of the world's 56 million deaths in 2012. More than 40% of them (16 million) were premature deaths under age 70 years. Almost three quarters of all NCD deaths (28 million), and the majority of premature deaths (82%), occur in low- and middle-income countries (WHO 2014). Many other diseases could medically be defined as NCDs like muscular skeleton diseases, neurological diseases, hearing and seeing disorders and some will argue even a huge group of diseases as mental health and substance abuse disorders. The choice of the "4 by 4" was made because of their dependence on a shared group of risk factors, their contribution to the global burden of disease and the potential to define effective and affordable measures at a public health level. In short, it was a choice made from strategic, political and technical knowledge. Another way of putting it would be to say that if these 4 diseases and their risk factors are prevented and controlled, huge improvements will be made in the perspective of development, sustainability, economic development, curbing human suffering and some will say that this is one of the best ways to achieve universal health coverage. Many of the other diseases have their own WHA approved global action plans like mental health, hearing disorders, some skin diseases.

Across different disease programs and categories of programs instituted by the WHO there are common denominators like the need for translation into health system strengthening at all levels, establishment of patient centered, integrated primary health care systems, the need for sufficient health work forces, capacity building both at local community level at the point of service delivery and also in the government like for regulatory capacity, legal capacity, relations to trade etc. The call for multisectoral action is a call for provisions from all sectors but also a call for integration between programs in health and for Health System strengthening.

Figure 2 NCD and premature mortality under age 70 (WHO 2014)



The number of NCD deaths has increased worldwide and in every region since 2000, when there were 31 million NCD deaths. NCD deaths have increased the most in the WHO South-East Asia Region, from 6.7 million in 2000 to 8.5 million in 2012, and in the Western Pacific Region, from 8.6 million to 10.9 million. While the annual number of deaths due to infectious disease is projected to decline, the total annual number of NCD deaths is projected to increase to 52 million by 2030. The economic burden of life lost because of NCDs will double from 2010 to 2030 and NCDs are expected to account for three quarters of total DALYs in middle-income countries by 2030, up from two-thirds in 2008 and near the level of high-income countries (WHO 2014).

The epidemic of NCDs is still hidden, misunderstood and underreported (UNGA 2014). As the NCD alliance summarizes the myths of NCD; NCD is still believed to be diseases of the affluent, there is still an opinion that it is all about personal choices and solutions, there is a lack of knowledge of the existence of cost effective solutions and some argue that focusing on NCD will distract the attainment of the current millennium developmental goals. In addition, these myths exist in an unfavorable landscape of NCDs not being part of the current development goals and the world experiencing financial constraints.

There is a change in the global financial landscape from Official Donor Agreements (ODA) and aid based support to more domestic finance focus and aid being based on return of investments. This is the context on which the Member States needs to consider how to finance

NCDs to close the funding gap and to raise resources to implement the NCD Global Action Plan..

4.2.1 Global milestones in the prevention and control of noncommunicable diseases

The Member States of WHO have focused on NCDs from 2000. Figure 3 shows many of the decisions made by the WHA and by UNGA in these years, with main watershed events like the adoption of the WHO Framework Convention on Tobacco Control (WHO FCTC) in 2003, the Political Declaration in 2011 and the adoption of the NCD Global Action Plan in 2013. The vision of the NCD GAP is; A world free of the avoidable burden of NCDs and the goal is to reduce preventable and avoidable burden of illness, death and disability due to NCDs by multisectoral collaboration and cooperation at national, regional and global levels and populations to reach highest possible standards of health and productivity, wellbeing or socioeconomic development at every age.

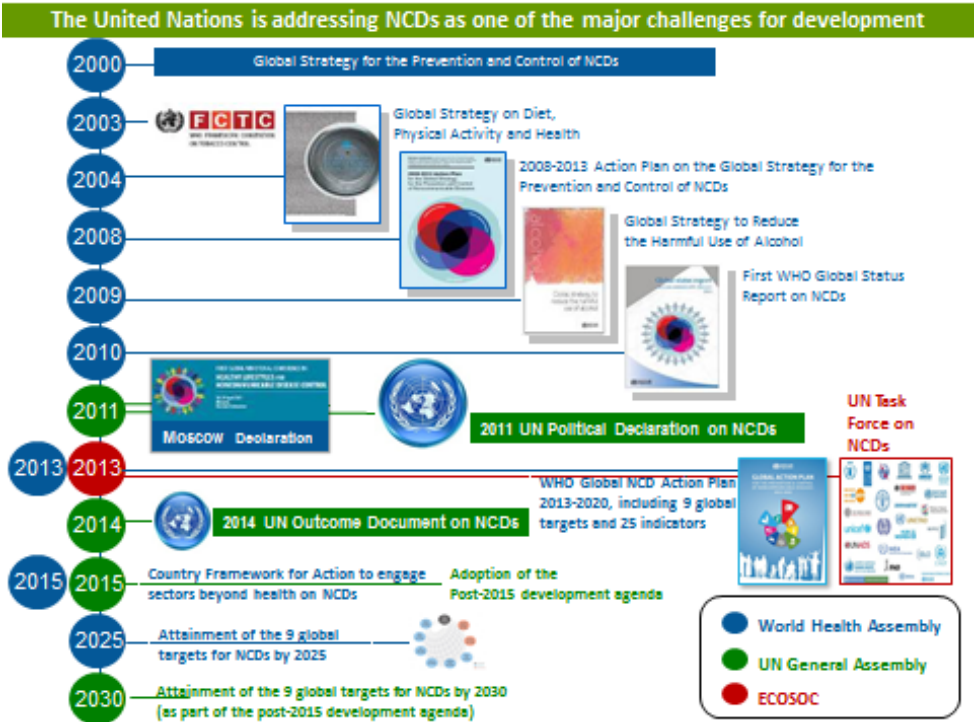


Figure 3 Global milestones in the prevention and control of noncommunicable diseases (WHO)

The NCD GAP created a major momentum due to the fact that there was an adoption of a global monitoring framework based on 6 objectives, 9 voluntary targets (see figure 4) and 26 indicators.

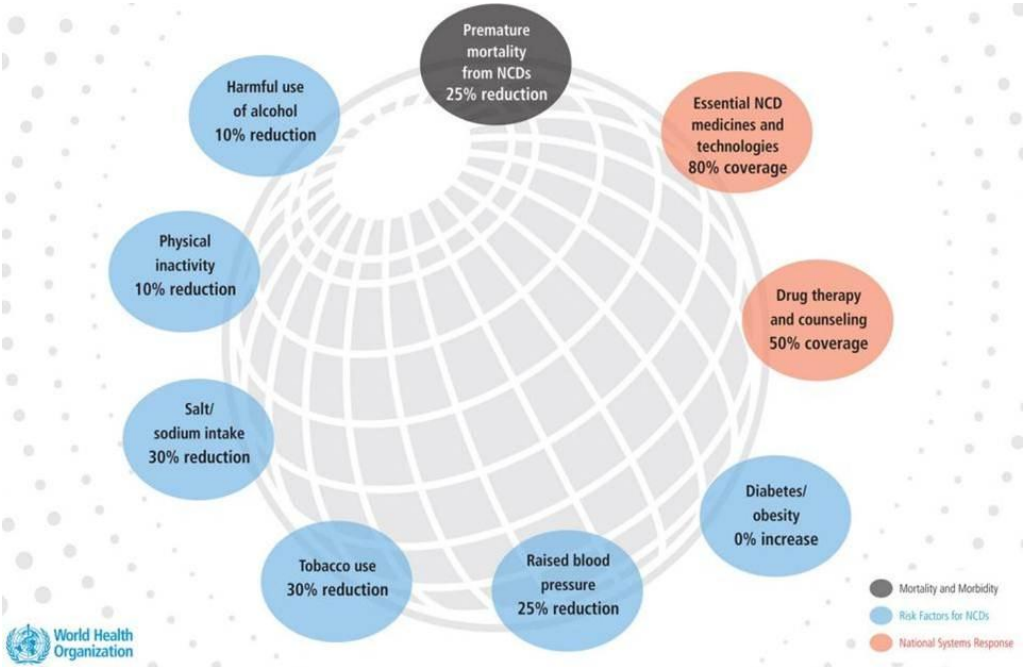


Figure 4 9 Global NCD Targets 2013-2020 (WHO 2013)

This will make it possible to track global accountability both at the WHA in 2015, 2020 and 2025. There will also be measures of progress indicators at country level reported to the UNGA in 2015, 2016 and 2017.

4.2.2 Prioritized actions and political commitments

Political leadership and commitment was established in September 2011 (UNGA 2011) by World leaders adopting the Political Declaration on NCDs at the United Nations in New York. WHO has been leading efforts to complete a number of global assignments to accelerate national progress and provide technical support to countries since the endorsement of the NCD GAP (WHO 2013). A menu of policy options and affordable and highly effective measures (called the best buys, Appendix 3) was defined in the action plan that will help

countries to attain the global target of a 25% reduction in premature mortality from NCDs by 2025 (WHO 2013).

The last two elements of the global architecture to tackle NCDs were put in place in 2013 and 2014. The UN Interagency Task Force on NCDs (UNIATF), was established by the UN Secretary-General by a resolution in the Economic and Social Council (ECOSOC) and placed under the leadership of WHO (WHO 2013). This was only the second time in history that a health matter was brought to ECOSOC. The UNIATF is providing support to developing countries by a unified multisectoral action by relevant UN agencies through joint missions to countries to define joint programming of actions and more specific, global programs on cancer, technology or capacity building. The UNIATF is very much aligned with the one-UN thinking as well as it seems to be a good measure in achieving multisectoral actions. The second element of the global architecture is the WHO Global Coordination Mechanism on NCDs (WHO GCM) which was adopted by the WHA in 2014 with the purpose of;

“enhance the coordination of activities, multi-stakeholder engagement and action across sectors in order to contribute to the implementation of the WHO Global NCD Action Plan 2013–2020” (WHO 2014)

WHO GCM was set up to provide a strategic platform to facilitate engagement among Member States, UN agencies and non-State actors. It is assigned to provide knowledge sharing through webinars, communities of practice, organize strategic dialogs on NCD, poverty and development and also to establish Working Groups to help governments to realize commitments done through the Political Declaration in 2011. The WHO GCM is an important measure to create multistakeholder engagements and activities.

The United Nations General Assembly, in July 2014, conducted a review to assess progress in implementing the 2011 Political Declaration. Progress achieved at national level since September 2011 was recognized but also that progress in implementing the commitments included in the 2011 Political Declaration “was insufficient and highly uneven, and that continued and increased efforts are essential” (UNGA 2014). The members of the UN made new commitments to a set of measures within four priority areas – governance by setting national targets and developing multisectoral policies and plans, prevention by implementing the very effective and affordable interventions (the best buys), health care strengthening by

implementing the very effective and affordable interventions (the best buys), and strengthening of surveillance and monitoring. The political commitment was also reaffirmed at the UNGA in 2014.

Dr Oleg Chestnov, Assistant Director-General Noncommunicable Disease and Mental Health World Health Organization says in the preface of the Second Global Status Report , published in 2014 (WHO 2014);

«Noncommunicable diseases (NCDs) are one of the major health and development challenges of the 21st century, in terms of both the human suffering they cause and the harm they inflict on the socioeconomic fabric of countries, particularly low- and middle-income countries. No government can afford to ignore the rising burden of NCDs. In the absence of evidence-based actions, the human, social and economic costs of NCDs will continue to grow and overwhelm the capacity of countries to address them.» says

Most premature deaths from NCDs can be prevented by governments taking a leading role and responsibility along the agreed commitments and priorities.

4.2.3 NCD, poverty and development

Data from the second WHO Global Status Report in 2014, estimate that in 2012 the vast majority of the premature deaths of individuals from NCDs (82 per cent or 11.8 million) before the age of 70 occurred in developing countries. The probability of dying from any of the major NCDs between the ages of 30 and 70 ranges from 10 per cent in developed countries to 40 per cent in developing countries (WHO 2014). See also figure 5 that illustrates geographical distribution of the probability of dying from NCDs. Without targeted and sustained interventions, this inequality is likely to widen within and between countries and populations, causing even greater individual, social and economic consequences. These diseases undermine social and economic development throughout the world and threaten the achievement of internationally agreed development goals. Through a policy brief on domestic financing, produced by Professor Diane McIntyre for the working group under the WHO GCM on how to finance NCD, it was demonstrated that there is limited government funding (WHO 2014). She states that in the absence of adequate public funding for health services, out-of-pocket (OOP) payments are the single largest component of domestic funding in many developing countries, accounting for 48% and 36% of total health expenditure in

low- and middle-income countries respectively in 2012, which in itself demonstrate the vulnerable situation for the poor population (WHO 2014).

World leaders have noted the vicious cycle whereby NCDs and their risk factors worsen poverty, while poverty contributes to rising rates of NCDs, posing a threat to public health and economic and social development. NCDs and their risk factors lead to increased burdens on individuals, families and communities, including impoverishment from long-term treatment and care costs, and to a loss of productivity that threatens household income and leads to productivity loss for individuals and their families, and to the economies of countries,. This make NCDs a contributing factor to poverty and hunger, which may have a direct impact on the achievement of the current Millennium Development Goals (WHO 2015). The underlying determinants of these diseases and their shared risk factors mean that multisectoral, whole-of-government and whole-of-society responses are required to prevent and control NCDs (UNDP/WHO 2015)

The political process to establish the new Sustainable Development Goals (SDGs), post 2015, has been ongoing the last two years and will be finalized in the UN General Assembly meeting in September 2015. As we can see in the synthesis report from the Secretary General of the UN on the post-2015 development agenda “The Road to Dignity by 2030” NCDs are included in the developmental goals (see paragraph 70) for the first time as part of the indicators (UN 2015). The new developmental goals will be the roadmap for the world for the next 15 years and are expected to shape and influence the agendas, priorities and even financing of global initiatives and domestic programs in this period. To visualize the importance of NCD to development and to get prepared to the implementation of the new SDGs the WHO Global Coordination Mechanism on NCD (WHO GCM) was mandated to create a web site on NCD poverty and development (WHO 2014) and also to organize a multi - stakeholder dialog on how to encourage the continued inclusion of noncommunicable diseases (NCDs) in development cooperation agendas and initiatives, internationally agreed development goals, economic development policies, sustainable development frameworks and poverty reduction strategies (WHO 2015). The information note produced before the dialog reviews current knowledge, discuss knowledge gaps and showcase examples on how to include NCD into development agendas, goals and poverty reduction strategies (WHO 2015).

Premature mortality from NCDs: probability of dying from the 4 main NCDs between ages 30 and 70, 2012

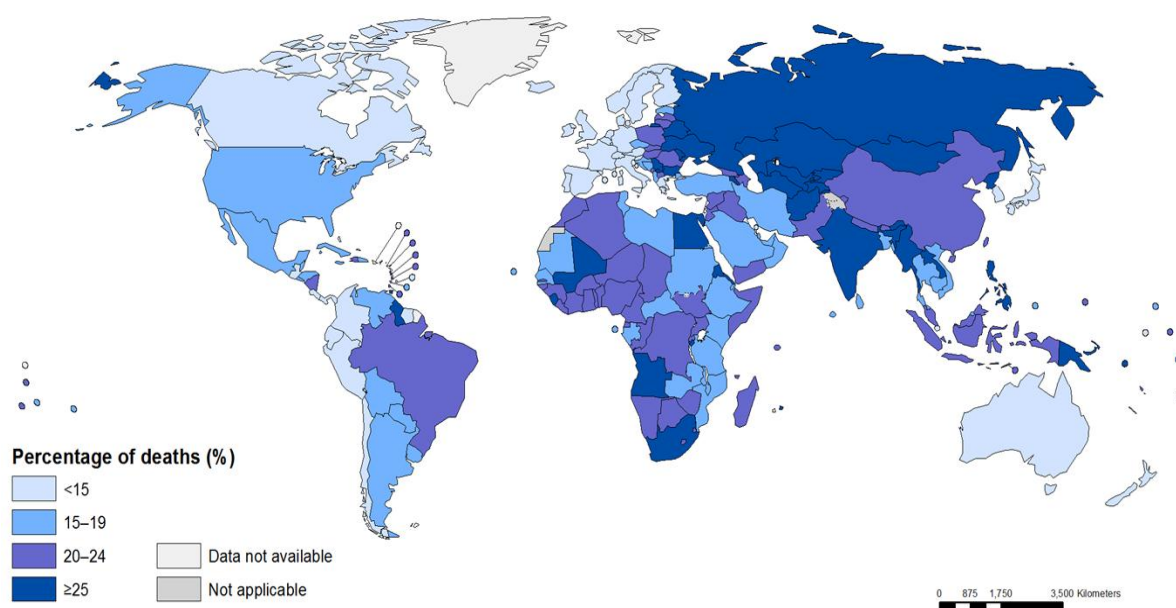


Figure 5 Geographic distribution of premature mortality from NCDs (WHO 2014)

The information note to the dialog on NCD and development talks about how NCD's have significant macroeconomic and poverty impact. It refers to literature that gives good evidence that reducing adult NCD mortality promotes poverty reduction (WHO 2015). *“Higher rates of NCDs impede poverty reduction initiatives in low-income countries, particularly by increasing household costs associated with health care and loss of productivity. Also, tobacco expenditure can constitute a significant portion of household expenditure leaving less money for food, education, housing, and clothing particularly for the poor households who have competing needs. Vulnerable and socially disadvantaged people get sicker and die sooner than people of higher social positions, especially because they are at greater risk of being exposed to harmful products, such as alcohol, tobacco or unhealthy food, and have lower health literacy and limited access to health services. The poorest 20% of people get sicker and die sooner than people in higher income quintiles of higher social positions, especially because poor people are afforded much lower levels of protection from the risks and consequences of NCDs than people in high income quintiles. Additionally, most NCDs are chronic diseases which require repeated interactions with the health system. These continuous medical expenditures can be catastrophic for household budgets. For instance, studies have shown that in low and middle-income settings more than 70% of stroke survivors*

could experience catastrophic out-of-pocket expenditure and more than 35% of patients and families were pushed below the poverty line. A study conducted in India showed that 40% of CVD patients lost their income secondary to their illness and 13% could not continue the medication due to factors related to cost. As a consequence, NCDs make it difficult for the “bottom billion” to break free from the cycle of poverty.”

The information note also gives facts about management on NCD and poverty (WHO 2015); *“The economic burden of NCD care is consistently higher for the poor than the higher income groups. Catastrophic spending for cardiovascular diseases occurred among more than 90 percent of patients in Tanzania and India, more than 70 percent of patients in China, and for more than 60 percent of cancer patients in Iran. “*

A multisectoral approach is important, since sectors such as trade, finance, education, agriculture and food, and urban development all impact risk factors for NCDs at the population level. Different exposures to risk and barriers access to care and treatment are responsible for major inequalities in the occurrence and outcome of NCDs.

4.2.4 Multisectoral action and NCD – Global Survey

To assess the capacity of countries to respond to NCDs, WHO carries out a global country capacity surveys (GCCS). The first of these was conducted in 2000. The next two was done in 2005 and in 2010. The fourth, and most recent, survey was conducted in early 2013. The survey asks countries to provide information about their capacity to address NCDs including national multisectoral plans, budgets and to what extent the plan covers all 4 diseases and 4 risk factors. In 2013 the response rate was 92% covering 178 countries. The surveys makes it possible to track self-reported progress on many of the enabling factors to implement the NCD GAP (GCCS 2013).

Countries with	2010	2013
NCD unit, branch or department in a Ministry of Health	89%	95%
Integrated national policies or plans on NCDs	65%	78%
Integrated operational NCD policies/plan and NCD budget	32%	50%
Cancer registries	80%	81%
Recently-conducted risk factor surveys	30%	63%
Programmes providing primary prevention and health promotion	85%	95%
Programmes providing risk factor detection	77%	88%
Programmes providing risk factors and disease management	82%	85%

Figure 6 Global Country capacity survey on NCD 2010-2013 (WHO 2013)

In 2013 the survey also mapped out the existence and operationalization of multisectoral mechanisms. The definition used for multisectoral collaboration was;

“Multisectoral collaboration: A recognized relationship between parts of, or different sectors of, society (such as ministries [e.g. health, education], agencies, non-government agencies, private for-profit sector and community representation) which has been formed to take action to achieve health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone” (WHO 2013)

61% of the countries reported the existence of a multisectoral mechanism but only 33% reported that the plan was operational. Countries in the South East Asia had the highest and African countries the lowest percentage. Most operational multisectoral mechanisms was in high income countries, using the World Bank Income grouping. All in all 72 countries had multisectoral policies and plans witch covered all 4 diseases out of which 43 was operational (WHO 2014).

The current report concludes as follows (WHO 2013);

“The 2013 NCD CCS revealed that challenges in addressing NCDs at the national level included: gaps in infrastructure; disparities between the existence of policies and operational plans to address NCDs and their implementation; weak population-based surveillance and inadequate funding for surveillance; gaps in health systems related to NCD service provisions; and weaker capacity among low- and lower-middle-income countries, with low-income countries having very weak capacity. Opportunities revealed by the survey included widespread recognition of the importance of addressing NCDs; existence of policies, plans and strategies to address NCDs; availability of funding and diversified funding sources; improvements in country capacity across the board; increased surveillance; and new and diverse platforms for communicating as part of efforts to influence and encourage sound health behaviors.”

4.2.5 Financing of NCDs

During 2011–2025, cumulative economic losses due to the four major NCDs under a “business as usual” scenario in low- and middle-income countries have been estimated at US\$ 7trillion according to a 2011 study conducted by the Harvard School of Public Health and the World Economic Forum (WHO 2011). The same study estimates an annual cost of US\$ 11.4 billion of implementing a set of high-impact interventions (‘best buys’, NCD interventions) to reduce the NCD burden. The estimated resource requirements for population-based health promotion interventions would according to this study have a median cost of less than US\$0.20 per person per year for low-income and lower middle-income countries and US\$0.50 in upper middle-income countries. Individual-based, mainly preventive, interventions provided at a primary care level would cost less than US\$1, US\$1.50 and US\$2.50 per person per year in low-, lower middle- and upper middle-income countries respectively. The total cost for these ‘best buy’ population- and individual-based interventions in all developing countries would represent about 4%, 2% and less than 1% of current health expenditure in low-, lower middle- and upper middle-income countries respectively (WHO 2011).

In India, the current GDP loss from NCDs is estimated to be 4-10 percent per year. Losses from NCDs (including mental health) are estimated to be \$6.2 trillion between 2012 and 2030 (World Bank 2010) . These economic costs are even higher in China. The total losses associated with the four major non-communicable diseases and mental health in China are US\$ 18.4 trillion and US\$ 9.4 trillion, respectively, over the period 2012-2030 (National Bureau of Economic Research. 2013). These estimates equate to more than eight times India’s total health expenditure over the previous 19-year period, and more than twelve times China’s total health expenditure in the 19 years prior to 2012 (WHO 2015).

Three policy briefs were produced to support the working group under the WHO GCM on how to finance NCDs relating to the commitment by Heads of State and Government at the High Level Meeting of the UN General Assembly on the Prevention and Control of Noncommunicable Diseases in September 2011 to explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms. From the

policy brief on domestic financing it is shown that the out of pocket payment is high (48% in low income and 36% in low and middle income countries) (WHO 2014), from the policy brief on bilateral financing it is shown that NCDs only gets 1,23% of the current donor assistance for health (DAH) although representing a vast majority of the global burden of disease (Figure 7), that few donors are in place to support NCD and that few innovative mechanisms currently supports NCDs (WHO 2014).

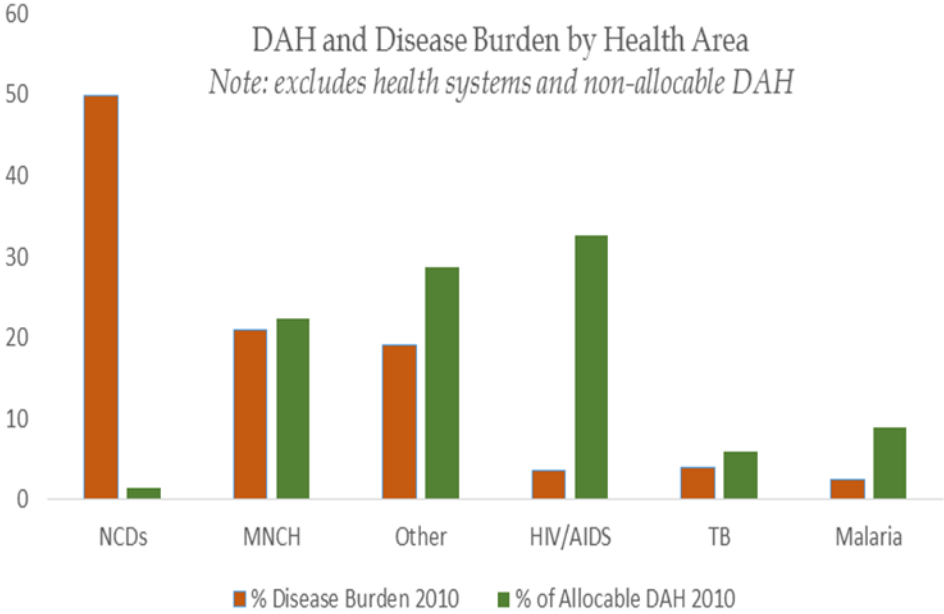


Figure 7 DAH and Global Burden of Disease (Rachel Nugent 2014)

Resources to support necessary NCD interventions should be ensured by fully utilizing domestic financing, bilateral and multilateral financing, and innovative financing in an appropriate manner of combination.

NCDs are lifelong diseases with high requirements for domestic population based preventive measures, frequently high costs associated with diagnosing and treating NCDs and a need for strengthened health systems and the vast majority of health financing needs to come from domestic government budgets linked to policies and plans on NCDs. Some developing countries, such as the Philippines and Thailand, have succeeded in having some tobacco tax revenue (and less frequently alcohol tax revenue) earmarked for health services. These revenues are sometimes used for health services or for NCD-specific interventions. According the GCCS 85% of countries reported taxations on tobacco, 11% on high sugar content food

and non- alcoholic beverages and only 3 % reported taxation on high-fat foods. There is a potential in looking into the taxation mechanisms and the fiscal space.

From the policy brief on innovative financing by Craig Courtney, it was referred to the “Monterrey Consensus” from 2002, “the value of exploring innovative sources of finance”. Since then innovative financing has been gaining momentum. Today, innovative sources to fund development include a wide range of different structures. They are not limited to taxes and levies, but include voluntary contributions and market-based financial mechanisms. While not expected to serve as a replacement for traditional domestic and bilateral financing, such structures are supplementing existing funding, increasing its effectiveness, and incentivizing innovation in targeted areas. Collectively, since 2000, innovative finance mechanisms generated US\$ 94 billion, US\$ 7 billion of which has been mobilized in support of global health issues (WHO 2014).

5 Methodology

5.1 The expressed awareness for multisectoral action - methodology

5.1.1 Document selection and categorization

One aim of this thesis is to explore and document changes in expressed awareness for multisectoral action in the documents discussed at the World Health Assembly (WHA) in the period from 1999-2014. I would like to look at the overall trend, differences between different health programs, look for changes in the terms used to express multisectoral action and also explore if there is any changes in the expressed focus on the private sector.

Formal documents to the World Health Assembly (WHA), available on the governing body web site of World Health Organization (WHO) (WHO. <http://apps.who.int/gb/>) are used in the analysis. The World Health Assembly (WHA) is the main governing body of WHO. Documents to the WHO Executive Board (EB) was not used in the analysis since documents discussed in the EB are in general also discussed in the WHA. To avoid duplication, and due to supremacy, a choice was made to only analyze documents from WHA. The web archive of WHO for WHA documents covers the full sets of documents to the WHA from 1998-2015. Several of the documents in the archive for year 1998 were scanned documents and not converted from word to pdf. Since the statistical software used is based on analysis of .pdf documents, the period from 1998-1999 could not be accessed. 2015 is also excluded since WHA is scheduled to happen after the end of the planned study period, 15 May 2015.

First, the WHA documents from 1999 - 2014 was downloaded as .pdf from the WHO website, <http://apps.who.int/gb/archive/>. Second, the documents for the full research period was organized in 6 programme categories according to the categories suggested as part of the WHO Programme Budget 2014-2015 (PB 14-15) and used for the first time at WHA67/ 2014 (WHO 2014). This categorization took over from earlier categorizations and was part of the WHO reform to make the PBs being the primary tool for technical programming, and also anticipated to act as the main instrument for accountability and transparency, as well as for financing and resource mobilization. Only the technical categories 1-5 have been subject to analysis (see figure 8). The 6th category is a category that contains corporate services and

enabling functions of the secretariat and is considered to a very much lesser extent to serve the purpose of tracking awareness of the need and request for actions at country level or beyond the secretariat.

Category 1 COMMUNICABLE DISEASES

Category 2 NONCOMMUNICABLE DISEASES

Category 3 PROMOTING HEALTH THROUGH THE LIFECOURSE

Category 4 HEALTH SYSTEMS

Category 5 PREPAREDNESS, SURVEILLANCE AND RESPONSE

Category 6 CORPORATE SERVICES/ENABLING FUNCTIONS

Figure 8 Categories of programmes in WHO according to structure from 2014

The categorization is done by the thesis author without validation from WHO. The documents were generally easy to categorize. When in doubt a search was done on the WHO official web sites to see which organizational unit the document was produced from, since the categories and WHO main organizational units (clusters) at headquarters are aligned. The documents are only organized into one category based on relevance. The full list of documents can be viewed in appendix 1.

5.1.2 Definitions of multisectoral actions

I have based this thesis on the different terms for multisectoral actions that occurs in the documents produced to the WHA and the literature addressed in the period from 1999-2014. Some of the words are neutral synonyms while others are linked to a set of recognized approaches, resolutions or trails of public discussions. Words that seems to be rather neutral are; across sector, multisectoral and beyond health.. Terms like whole-of governments, Health in all policies and intersectoral are linked to defined approaches.

Following on from the High-level Meeting of the UN General Assembly on the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of NCDs (resolution A/RES/68/300) WHO was requested to prepare a framework for

country action as set out in Resolution WHA67.12. As this is the latest WHO document on multisectoral action I have used the Second Draft of the Framework for Country Action Across Sectors for Health and Health Equity (WHO 2014) as my primary source for terms to address multisectoral action and also as the framework to discuss and analyse. This documents gives different terms for multisectoral action:

Action across sectors refers to policies, programmes and projects undertaken by two or more government ministries or agencies. It includes both purely horizontal action, between ministries and agencies, and action across different levels of government.

Health in all policies (HiAP) is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergy and avoids harmful health impacts. It aims to improve population health and health equity. It also improves accountability of policy-makers for health impacts at all levels of policy-making, and emphasizes the consequences of public policies on health systems, and on determinants of health and well-being .

The whole-of-government approach is one in which public service agencies work across portfolio boundaries, formally and informally, to achieve a shared goal and an integrated government response to particular issues. It aims to achieve policy coherence in order to improve effectiveness and efficiency. This approach is a response to departmentalism that focuses not just on policies but also on programme and project management. (Australia 2004)

Multisectoral action is action between two or more sectors within the public sector. This term is generally interchangeable with “intersectoral action”. In the Global country capacity survey (GCCS) the definition is; Multisectoral collaboration: A recognized relationship between parts of, or different sectors of, society (such as ministries [e.g. health, education], agencies, non-government agencies, private for-profit sector and community representation) which has been formed to take action to achieve health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone. (WHO 2013)

Multistakeholder action refers to action by actors outside the public sector, such as nongovernmental organizations (NGOs) and the private sector. See Paragraph 37 of the

“Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases” (A/RES/66/2).

Based on this I selected the following words and phrases for the systematic word analysis:

"multisectoral", "action across sectors", "beyond health", "intersectoral",
"health in all policies", "whole of government", "multistakeholder", "multidisciplinary",
"cross sectoral".

Due to time and to avoid complexity there have only been done single phrase search and not combined phrase searches.

While looking through relevant literature on multisectoral action and intersectoral dimensions, there is additional terms in use more linked to social determinants of health and health equity (Shankardass.K 2012). The main feature is that these terms is they consists of combination of two phrases for example; intersectoral and policy or collaboration. The only expression I might have considered to include is “Health for all”, but it seems on the margin of the scope of this work.

5.1.3 Statistical method

The methodology used is a quantitate content analysis as described by Krippendorf (Krippendorf 2013). The documents were converted from .pdf to .txt using the software "PDFMate" (<http://www.pdfmate.com/>). Using the open source software "R statistics", the texts have been cleaned for irrelevant characters, such as punctuations, numbers and stop words (full list of stop wordsat <http://jmlr.csail.mit.edu/papers/volume5/lewis04a/a11-smart-stop-list/english.stop>). This process of cleaning the text does not make much of a difference, but signs like " ", - and superscripts might distort the word count. After this cleaning process, the frequency of selected words and phrases have been counted. The sum of these frequencies for each year, within each of the 5 categories, have been divided by the total number of words in all documents that same year and category. The total number of documents in each category per year is also registered to serve as part of the discussion.

5.2 Towards a framework for multisectoral action at a country level applied in country cases for NCD multisectoral action plans and implementation

5.2.1 Methodology - framework

The research question was; -How does the proposed framework for across sector action at county level which is proposed to the 68th WHA in 2015 reflect current theoretical or practice based knowledge on how to develop and implement multisectoral action? The question was also an entry point to address the current status of knowledge on how to achieve multisectoral action at country level and also to discuss knowledge gaps.

In May 2014, the Sixty-seventh session of the World Health Assembly accepted Secretariat Report EB 134.54 on *“Contributing to social and economic development: sustainable action across sectors to improve health and health equity (follow-up of the 8th Global Conference on Health Promotion)”*, and approved the associated Resolution EB 134.R8. Resolution WHA 67.12, Operative Paragraph 3 (1) charges the WHO Secretariat *“... to prepare, for the consideration of the Sixty-eighth World Health Assembly, in consultation with Member States, UN organizations and other relevant stakeholders as appropriate, and within existing resources, a framework for country action, for adaptation to different contexts, taking into account the “Helsinki statement on health in all policies”, aimed at supporting national efforts to improve health, ensure health protection, health equity and health systems functioning, including through action across sectors on determinants of health and risk factors of noncommunicable diseases, based on best available knowledge and evidence.”* Key approaches include the *“health in all policies”* approach and the *“whole-of-government”* approach. *Working across sectors will be central to implementation of the post-2015 development goals currently being negotiated by Member States. Non-state actors and private sector engagement”* (WHA. 67/2014, Resolution EB 134.R8)

I have chosen to use the Second draft of the Framework for Country Action Across Sectors for Health and Health Equity published on WHO web site since this is the latest WHO produced document based on literature reviews of existing frameworks in WHO and related organizations. In addition I have also compared this framework with the guidance note on how to include NCD into UN Development Assistance Framework (UNDAF) (WHO/UNDP

2014), *Intersectoral Action on Health: A path for policy-makers to implement effective and sustainable action on health from 2011* (WHO 2011), *Discussion paper on Intersectoral action on health; a path for policy-makers to implement effective and sustainable intersectoral action on health* (WHO 2011), chapter 10 in the *Global Status Report on NCD* ; *Development and implementation of national multisectoral action plans to attain national targets* (WHO 2014), and two monitoring measures; the GCCS (WHO 2013) (WHO 2015) , and *The Intersectoral Action for Health Equity Case Studies database (ISACS)* which is developed on the basis of a conceptual framework for intersectoral action as part of the work from the *Commission on Social Determinants for Health* (WHO 2011, WHO 2013, UNDP 2011) and the *Health in all Policies framework* (WHO 2011).

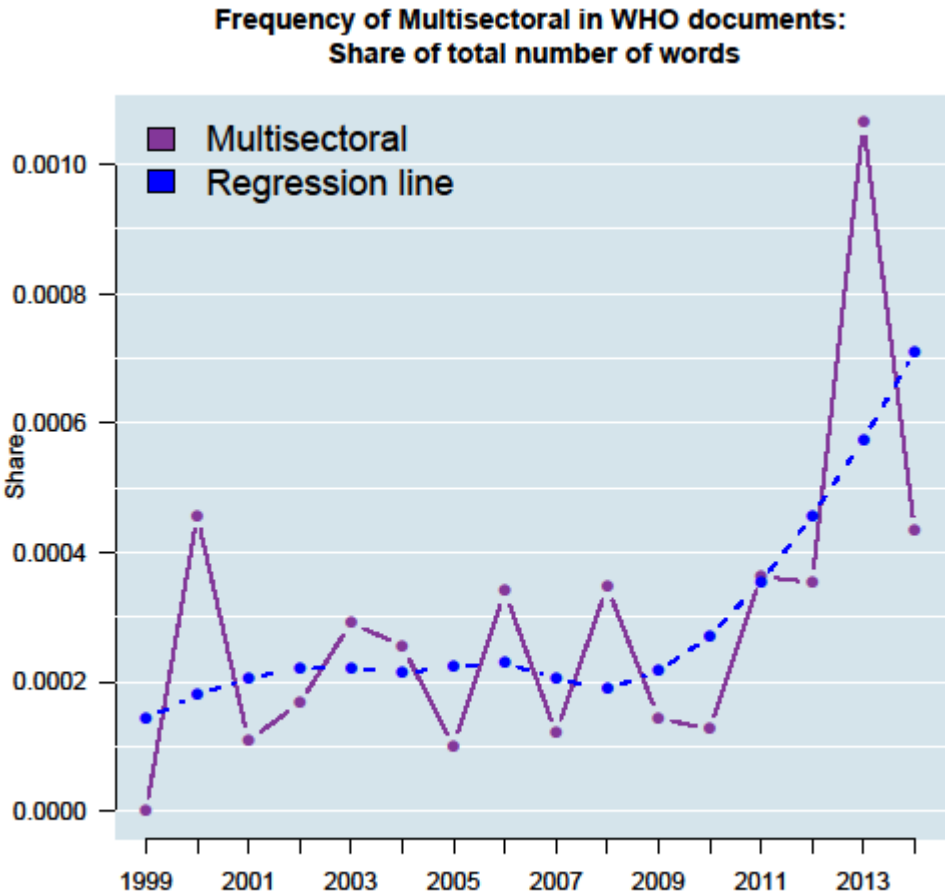
5.2.2 Methodology for country cases

I have applied the core elements from the Second draft of the *Framework for Country Action Across Sectors for Health and Health Equity* to 4 national multisectoral plans; two from developed and two from developing countries. The countries were selected among the 43 countries reported in the GCCS, to have operational multisectoral plans in place (GCCS 2013). One selection criteria was that the plan had to be publicly available on the internet in a language that was possible to do a google translate on. The result will of course only be indicative but hopefully it will give a picture and a possibility to discuss the current provision of guidance and the potential space for development to accommodate the countries need for guidance. The result from this exercise will be discussed in the result chapter.

6 Results

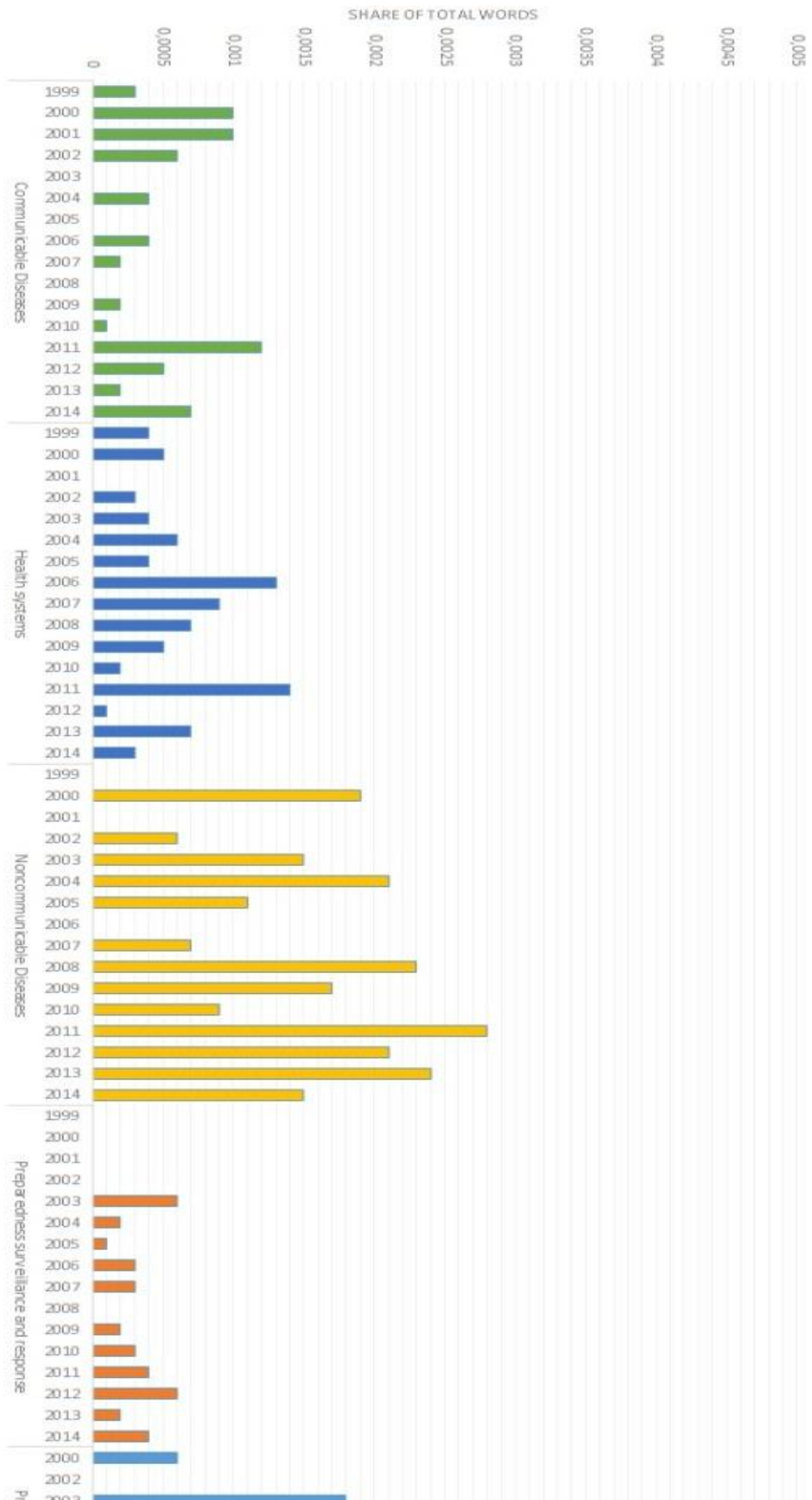
6.1 The expressed awareness for multisectoral action

The first figure shows an overall increase in the number of words expressing multisectoral action as a share of the total number of words in the period from 1999-2014. It is used a regression curve to show the trend.



Figur 9 Regression line; multisectoral and year – share of total number of words²

² The regression line is a local polynomial regression line, or a "loess" curve. This means that fitting is done locally using least squares. That is, for the fit at point x, the fit is made using points in a neighbourhood of x, weighted by their distance from x. Each point along the curve represents a sort of weighted mean. It should be noted that the line does not represent a statistical significance.



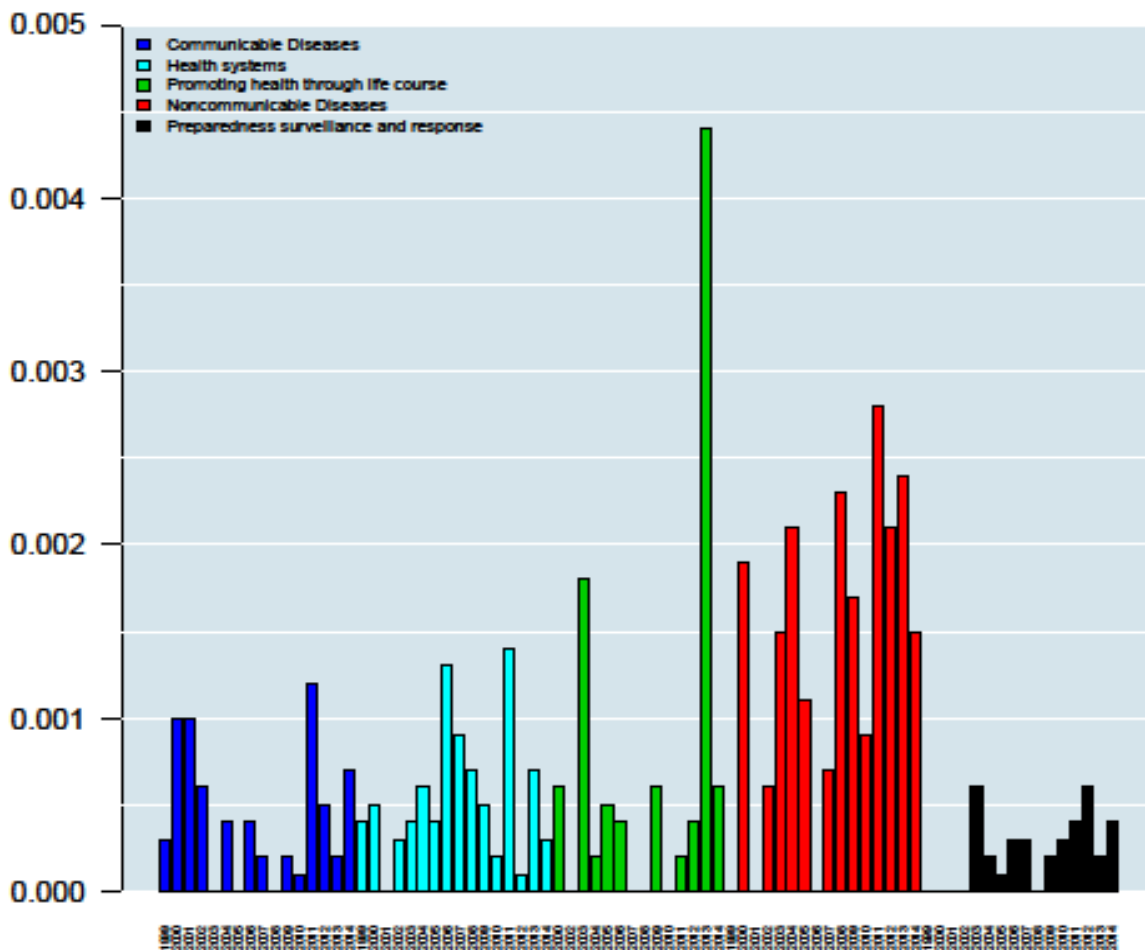


Figure 10 A og B Multisectoral action, Category and year – share of total number of words

The next two figurer shows that multisectoral action as a share of the total number of words per year differs in various programme categories.

The x-axis indicates the year, the y-axis indicates the share, and the colors indicate the categories of programs. The figures is the same, only with two different graphic expressions. As we can clearly see it is differences between programmes.

One should note that the frequency of these words have increased, but so has the total number of words. The mean number of words within a category in 1999 was about 2255 words. In 2014, that number has increased to 18905 words.

Thus, dividing the frequency of the words in a category by the total number of words per year in the same category is expected to be a conservative approach, and even a stable share over the years should confirm my point:

We have reason to believe that there has been a dramatic increase in the use of the words expressing multisectoral action.

However, the method of dividing the selected phrases by the total number of words is suboptimal. There is not necessarily a linear relationship between the increase in the number of selected words in the list above and the total number of words.

For example, in the document WHA53/5 "Stop Tuberculosis Initiative" in the communicable diseases category in 2000, we may read on page 3:

"to promote expanded national partnerships to stop tuberculosis, and multiyear, multisectoral plans of action so that the foundations for accelerated action may be built up and maintained."

In 2014, we may read on page 1 in document WHA67/11 "Draft global strategy and targets for tuberculosis prevention, care and control after 2015" in the communicable diseases category:

"In May 2012, Member States at the Sixty-fifth World Health Assembly requested the Director-General to submit a comprehensive review of the global tuberculosis situation to date, and to present new multisectoral strategic approaches and new international targets for the post-2015 period to the Sixty-seventh World Health Assembly in May 2014, through the Executive Board. The work to prepare this has involved a wide range of partners providing substantive input into the development of the new strategy, including high-level representatives of Member States, national tuberculosis programmes, technical and scientific institutions, financial partners and development agencies, civil society, nongovernmental organizations, and the private sector."

These two paragraphs try to communicate the same thing: The development of a multisectoral approach, using several partners. That took 27 words to say in 2000, and 102 words in 2014, but both only had to use "multisectoral" once to give the paragraph this meaning. A more thorough investigation of this would require extensive research in communication and the process of text-generating, which is beyond the scope of this thesis.

As we can see from the figure 10A and B there are differences between the different categories of programs;

The category preparedness has the lowest number of multisectoral and equivalents and category noncommunicable diseases has the highest frequency and increasing numbers.

The category preparedness is very much about natural and humanitarian crises (earthquakes, refugees, pandemics, Ebola etc.). Regarding the type of work that fall under this category, it is a bit strange that the number of words for multisectoral action is the lowest during the whole period. If we look at the documents produced in this category it is even more strange since 112 documents (26% of the total documents produced within the 5 categories from 1999-2014) was concerning preparedness, being the second largest amount of documents.

The category of communicable diseases specifically covers HIV/AIDS, hepatitis, tuberculosis, malaria, neglected tropical diseases and vaccine-preventable diseases. There are some changes from year to year with three peaks in 2000, 2001 and in 2011. In 2000 and 2001 HIV and AIDS was recognized as a major treat with UN ECOSOC having its first ever health topic on its agenda, HIV/AIDS. HIV/AIDS might explain the peak in these years. In 2011 the new draft strategy for HIV/AIDS was discussed and there was probably even more focus on intersectoral action since the disease changed to a lifelong disease due to effective and accessible treatment. The HIV population developed comorbidities and a need for more intersectoral work was probably recognized. 72 documents (17% of the total documents produced within the 5 categories from 1999-2014) was produced in this category.

The frequency of multisectoral words in Health Systems Category is almost at the same level as for communicable diseases with some peaks in 2006, 2007 and 2011. This category is especially engaged in health systems, national policies and plans, financing, universal health coverage, access to medicines, people – centered health care, palliative care, information and research. This category is the most producing category of documents to the WHA with in total 126 documents, almost 30% of the total in the whole period. One should believe that financing, national policies and plans and to some extent research should be dependent on multisectoral action. In the years with the peaks documents was discussed about; Health Millennium Goals (MDG), international health and trade, intellectual property (2006), Universal Health Coverage (UHC), Health Promotion in a Global Perspective, health care workers research (2007). in 2011 MDGs and in addition spurious medication was the topics

discussed . All these cases in the peak periods can be attributed of having a multisectoral focus.

Promoting health through life-course programme category is about reproductive health, aging, adolescence health, gender, human rights maternal and child health. In general this category had fewer documents in total to the WHA over the years (38 documents in the period, 9% in total). There is one peak in 2003 explained by the strategy on child and adolescence health and a big peak in 2013 which can be explained with documents on social determinants on health, which is more the less all about multisectoral and intersectoral action.

The category noncommunicable diseases have the highest share of multisectoral words through the whole period. This is as expected as earlier explained because of the nature of the 4 risk factors and to some extent the 4 diseases . Even if the best buys in the NCD GAP mainly addresses the health sector, most of the solutions lies beyond this sector and have to be achieved through multisectoral plans and actions. 77 documents (18% of all documents in the period). The share of words was high even in periods with few documents on the topic.

There has been a shift in use of words expressing the awareness of multisectoral actions in the period from 1999-2014.

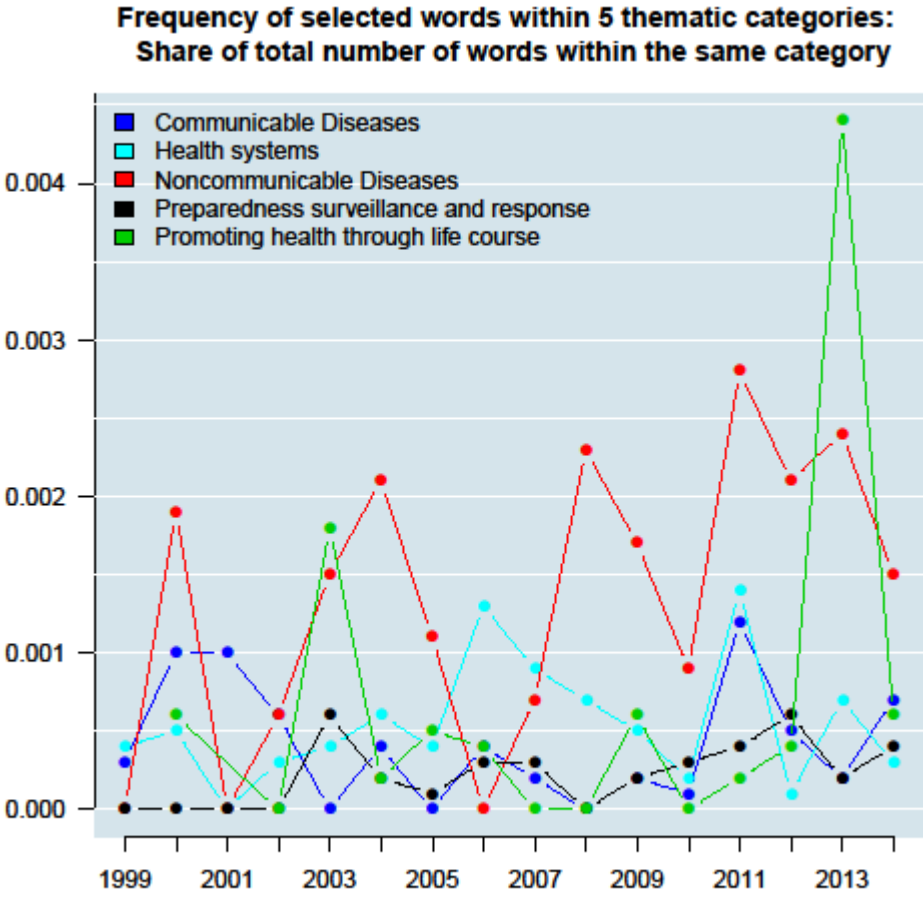


Figure 11 Frequencies of words expressing multisectoral action

Figure 11 shows that multisectoral have been high in frequency the whole period and rapidly increasing since 2011. Health in all policies was surprisingly infrequent and might be a more selected expression very much linked to NCD. Intersectoral and multisectoral seems to be at the same frequency until 2011 when multisectoral had a huge increase with a subsequent decrease in intersectoral. I expected to see a reflection of the Commission on Social Determinants of Health with an additional increase in intersectoral but it seems that this conceptual wave first got visible with the development of Health in all Policies with a modest increase in that term and only traceable since 2006. Across sector is a new expression occurring from 2013.

The two last figure from the word analysis shows absolute number (figure 12) of words for multisectoral action in all categories and also the use of private sector in all programmes per year. Figure 13 shows share of all words for the two words per year (figure13). These are counted independently, and there is not necessarily any communicational link between them in the texts. Thus with this method we cannot document any dependency in their common usage, only evaluate their correlation in frequencies. From these two independent graphs it seems that both of them are increasing. **This can indicate that multisectoral more and more also include a multistakeholder perspective that also accommodate private sector.** Another explanation of the increase in private sector is that WHO have had an discussion since 2010 about the organization’s relation with non-state actors to agree on a framework for engagement.

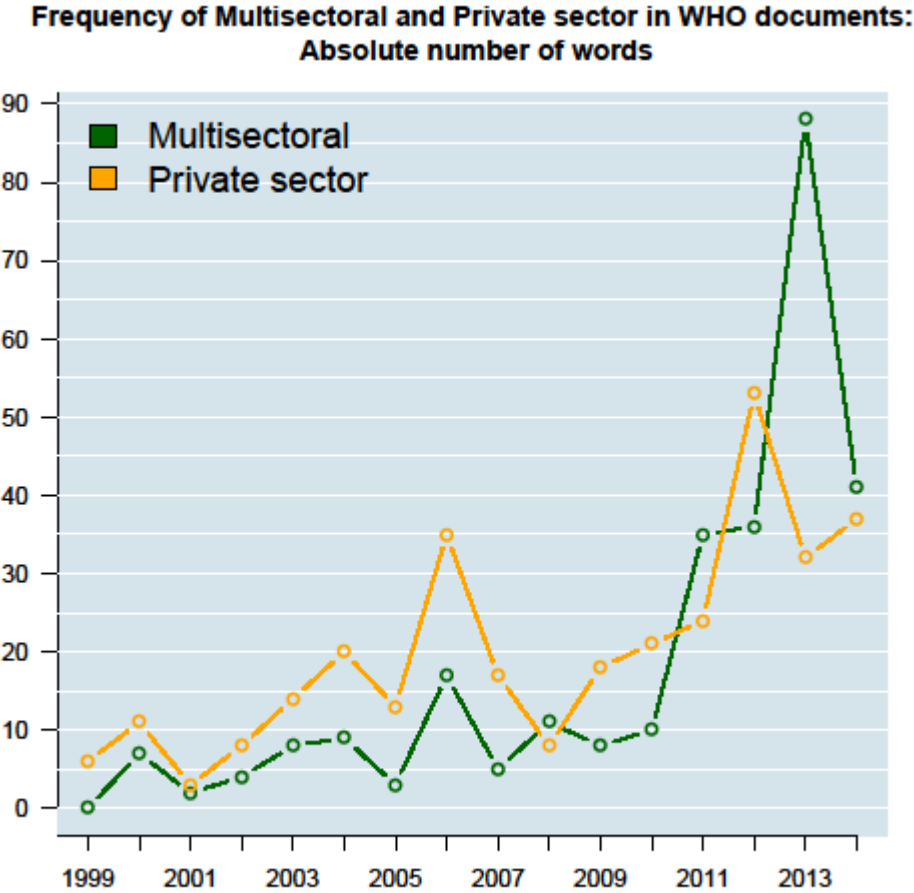


Figure 12 Private sector and multisectoral action – absolute number of words

**Frequency of Multisectoral and Private sector in WHO documents:
Share of total number of words**

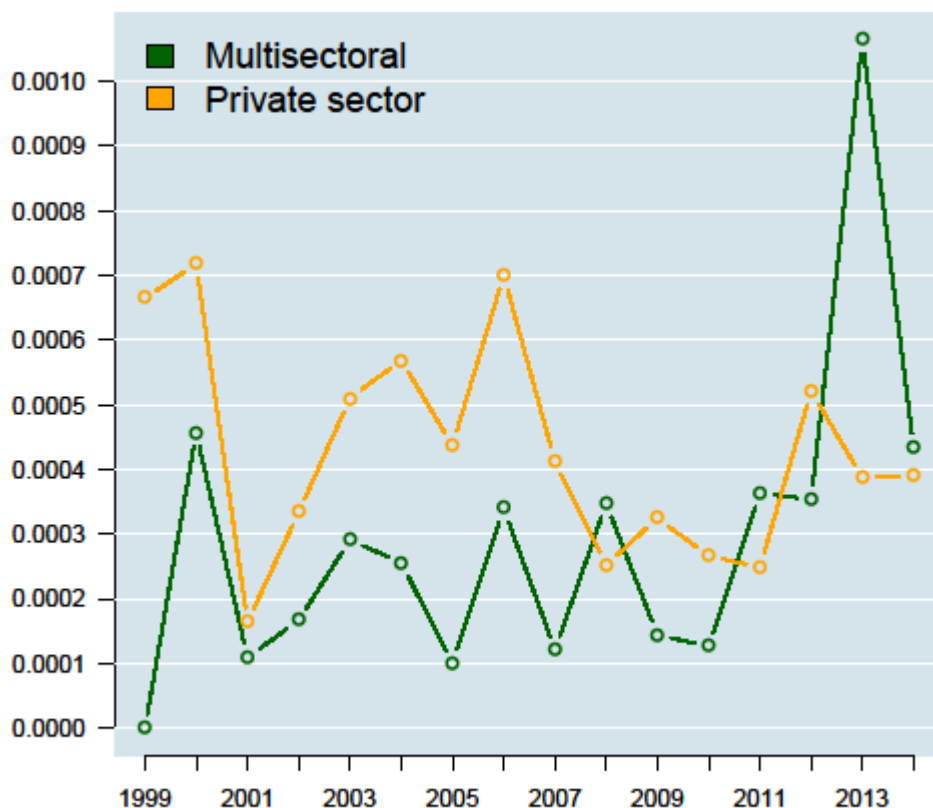


Figure 13 Private sector and multisectoral action – share of total number of words

6.2 Towards a framework for actions across sector?

As been discussed in the former chapters (4.1, 4.2.2) Heads of States and Governments have committed through The Political Declaration on NCD in 2011 (UNGA 2011), reaffirmed commitments in UNGA 2014 (UNGA 2014) and through several resolutions adopted by the WHA to develop and implement multisectoral plans on NCDs to implement the NCD Global Action plan and to attain the 9 global targets on NCD. At the same time we know from the Secretary General of the UN’s report to the UNGA in 2014 (UNGA 2014) that at the time of the review only 72 out of 192 Member States had developed a multisectoral plan and only 43 countries had an operational multisectoral plan covering the 4 major NCD diseases and the 4 risk factors. There is reasons to believe that there is a need for support to the Member States of WHO to accelerate their commitments towards 2016 where all member States should have set national targets and developed a multisectoral plan on NCD.

In this study I have addressed the most currently developed framework across sectors developed by WHO to be discussed at the 68th WHA in 2015; Second Draft of the Framework for Country Action Across Sectors for Health and Health Equity (WHO 2014). The methodology for the development of this framework is stated as follows on page 8 in the document (WHO 2015);

«To develop this framework, WHO first reviewed existing frameworks for action on related topics, produced by WHO and other international organizations. Some of the common elements of these frameworks are a background, definitions, values and principles, and specific actions. Many frameworks also include case-studies and links to tools for use in the development, implementation or evaluation of national action plans. WHO also reviewed past documents related to Resolution WHA67.12 (i.e. the resolutions, statements and commitments listed in the Background section).

In the next step, WHO used the review findings to produce a background paper, and then shared it with Member States for comment. The comments submitted were collated and used to inform this current draft, which is again open for comment.»

By using this framework I profited from the review done by the authors. In addition I have chosen to compare this framework with Chapter 10 in the Global Status Report on NCDs published in 2014; «Development and implementation of national multisectoral action plans to attain national targets» since this is produced at the same time by WHO and can be perceived as a kind of an overview and a «recipe» on how to develop multisectoral plans.

I have also chosen to compare the framework with the framework suggested in the publication “A path for policy makers to implement effective and sustainable intersectoral actions on Health” published as a policy brief as part of the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, 28-29 April 2011) (WHO 2011). This conference was one of the important events that made the Political Declaration on NCD possible.

The framework on how to include NCD into the UN Development Assistance Framework (UNDAF), developed by WHO in collaboration with UN Development Programmes (UNDP) (WHO/UNDP 2014) is also used as a source for the analysis of components.. The UNDAF is the strategic programme framework that describes the collective response of the UN system to national development priorities. UNDAF's typically run for three years and include reviews at different points and is an important measure to get different sectors to work together through

the assistance of all the UN organisations working in the country under the leadership of a UN Country Team (UNCT). The effect of the UNDAF will also facilitate multisectoral actions.

The NCD into UNDAF guidance note 2014 makes a current status on how well NCDs are included in UNDAFs: WHO reviewed 62 UNDAFs rolled out in 2012 and 2013. UNDAFs were reviewed in terms of whether NCDs were referenced as a priority (in the Executive Summary, Introduction or Support/Focus Area under UNDAF results), as an outcome (in the UNDAF Outcomes section), or as part of the results matrix (in the Results Matrix).

The results of the analysis are shown in the table below (from WHO/UNDP 2014). The results demonstrate that NCDs are not currently well represented in UNDAFs.

NCDs referred in the UNDAF as:	Number of countries(n=62)
a priority	16 (26%)
an outcome	4 (6%)
part of the results matrix	15 (24%)
a priority and outcome	1 (2%)
a priority and as part of the results matrix	3 (5%)
an outcome and as part of the of the results matrix	2 (3%)
a priority, an outcome and as part of the results matrix	0 (0%)

To address if any of the core components from the framework are being assessed or could be assessed in WHO I have also looked at the components measured by the GCCS and the newly launched database The Intersectoral Action for Health Equity Case Studies database (ISACS). This database is built on the concepts from The Commission on Social Determinants of Health (SDH) (WHO 2008).

I have analyzed the different frameworks by using the suggested key elements from the draft Framework of actions across sectors. In addition I have looked at the current measures that are available in WHO to see if they can be useful in the monitoring of the development of the multisectoral plan (two last rows of the table). The Global Monitoring framework for NCDs

with its 9 targets, 26 indicators and additional process and progress indicators will be useful for the situational analysis, to set national targets and to track outcome of policies and plans.

The result from this exercise is shown in this table:

Figure 14 Framework analysis

	Key components						
	Need and priorities	Supportive structures and processes	Frame planned actions	Facilitate assessment and engagement	Build institutional capacity	Establish monitoring and evaluation mechanism	Implement actions
Global Status report , multisectoral planning	Mobilize commitment and resources Conduct a situation analysis	Map and engage internal and external stakeholders Focus governance (1 key domain); Determine priorities, targets, roles and cost	Prevention and control – best buys (2 key domains)	Prepare draft action plan, disseminate, revise Inclusive process	Obtain endorsement of plan Evidence based Practicality and feasibility Stepwise approached described	Surveillance and monitoring one of 4 key domains of the plan	Human resource mapping Effective management of public expenditure Sound fiscal policy Implementing capacity
NCD into UNDAF 2014	Conduct a country analysis; existing plans, business case, conflict of interests	Build the roadmap; Align the roadmap with key UN frameworks , strategies and action plans Agree on a time frame, lead agencies and roles and responsibilities for tasks assigned	Prepare a strategic plan and develop a result matrix; comparative advantage for the UN system and individual agencies, global and regional momentum NCDs with links to other programmes	Engage across government, across the UN system and with other stakeholders		Develop a monitoring and evaluation plan; Use national data for monitoring Use existing structures where possible Check assumptions and risks in the results matrix	Identify and organize Results Group(s)
Intersectoral action,	Self-assessme	Select an engagement	Use a framework	Enhance community	Strengthen governance	Develop a monitoring	

	Key components						
	Need and priorities	Supportive structures and processes	Frame planned actions	Facilitate assessment and engagement	Build institutional capacity	Establish monitoring and evaluation mechanism	Implement actions
NCD 2011 – identical with ISA, Kobe 2011	Health Impact assessment Analyse areas of concerns	approach; Issue/ sector or opportunistic approach Develop an engagement strategy and policy	to foster common understanding between sectors ³	participation	structures, political will and accountability mechanisms Identify good practices	and evaluation plan	
Capacity Survey (GCCS)		Branches, units and departments responsible for NCD Multisectoral action, Operationalised NCD plan integrated in the National Health Plan	Plans and policies Strategies all 4 diseases and risk factors Level of integration between NCDs		Full staff members working in NCDs NCD components in primary health care Availability of essential NCD medicines Funding Fiscal interventions	Health information systems and monitoring and surveillance (dedication MOH involvement level of disaggregation cancer registry.)	Collaborative/partnerships arrangements for implementation Mapping of key stakeholders
ISAC – database of country cases	Geography, timing, socio-economic context Policy issue that drove multisectoral approach Detailed description of policy solution	Formal and informal structures to facilitate multisectoral actions	Planned actions	Engagement model described Roles of different actors governmental and non-governmental		Evaluation criteria	Implementation of the policy solution The use of impact assessment

1. Before the NCD Global Action Plan was developed (2013)

The result from the mapping of the Second Draft of the Framework for Country Action Across Sectors for Health and Health Equity (WHO 2014) against other existing frameworks and instruments to measure impact and progress is summarised in figure 14.

All the frameworks shows a combination of a stepwise approach to “what to do” to establish a multisectoral plans and to some extent describe some key domains of content of such plans. It is an uneven level of details in the frameworks and in general, difficult to see a link to a theoretical conceptual framework on which these frameworks are based. There is very little elaboration of “how to” elements; context assessments, guidance on when to use a health in all policy approach and when to use a more issue specific approaches, how to assess feasibility, how to builds a business case, guidance in engagement models and guidance in governance needed to sustain multisectoral action, to mention some examples. The level of intersectoral engagement is not part of the framework, neither is a clear description on upstream, midstream or downstream elements (Solar and Irvin 2007), (Whitehead and Dahlgren 2006). The framing of the planned actions is defined by the best buys from the menu of policy actions in the NCD Global Action plan Appendix 3.

The Global Capacity Survey contains most components from the new framework and is well placed to monitor the existence of the key steps described. By supplementing the GCCS with questions about need and priority assessments and involvement in assessment and engagement in development of the plan, most key components are covered. The GCCS does not in itself provide any real impact assessment of the multisectoral action. The Global Monitoring Framework on NCDs where NCD Objective, targets, indicators, process and progress indicators will be measured through the period of the NCD GAP represents an end point assessment of all actions to implement the NCD GAP. The ISAC database provides elements to map assessments, policy solutions and engagement models and have more obvious links to “how to” and what works in setting up intersectoral actions.

6.3 Case studies on applying the framework

I have addressed 4 countries out of 43 that have reported in the Global Country Capacity Survey to have an operational, multisectoral plan in place which addresses all 4 major MCDs and all 4 risk factors (GCCS. 2013). I have chosen among those who have published their plan and looked for two low-income countries and two high income countries according

to the World Bank income groups. The four countries are Bangladesh, Mozambique, Malta and Trinidad and Tobago. Most web published plans tend to belong to the high or upper middle income countries.

By applying the draft of the Framework for Country Action Across Sectors for Health and Health Equity published before the WHA 68/2015 I was able to see if the key components of the framework was covered in these national plans. I have no information if they have used any framework or other guidance in development of their plan or from whom they may have received guidance when developing their plans. There are no documented available reporting progress of the outcome of the implementation of the plan on the 9 NCD targets or other indicators. The exercise is more like a reality check on the current alignment between a proposed framework for across sector action and the product – an operational, national multisectoral plan on NCD. The result from the review (6.3.1, 6.3.2, 6.3.3 and 6.3.4) is summarized in the two figures at the end of the result chapter.

6.3.1 Bangladesh

The World bank states in their policy brief from 2011 (World Bank. 2011);

«NCDs now impose the largest health burden in Bangladesh. In terms of the number of lives lost due to ill-health, disability, and early death (DALYs)², NCDs (inclusive of injuries) accounts for 61 percent of the total disease burden while 39 percent is from communicable diseases, maternal and child health, and nutrition, all combined»

and further;

«A comprehensive national NCD plan, the Strategic Plan for Surveillance and Prevention of Noncommunicable Diseases in Bangladesh, 2007–2010, has been adopted. However, implementation has been stalled by several issues including lack of clear lines of responsibility, absence of dedicated financing, and competing priorities.»

Bangladesh is a low-income country according to the World Bank income groups and the World Bank the Out of Pocket expenditure on Health was 46% and the government spending on Health was 3,5 % in 2008. When we address the plan, it covers the major NCDs, give priorities to prevention and have several measures to increase access to health care. The government has a lead role but there is also allocated roles for ministries of Family welfare, education, local governments and Ministry of Information. They have defined partners in academia and also among NGOs both for surveillance and data collection among other things.

Several UN organisations are involved with specified roles and responsibilities and there are private public partnership set up. The plan is very comprehensive and have all the key elements from the framework. The least developed seems to be budgeting (3 words in document) and funding (two word in document). In the introduction of the Strategic Plan for Surveillance and Prevention of Non-Communicable Diseases in Bangladesh 2007-2010 (MOH Bangladesh. 2007) it states that;

«Appropriate strategies under high level of political commitment and necessary funding to facilitate the prevention of NCDs as part of the integrated development and health agenda of Bangladesh are essential. Implementation of prevention activities is also a big challenge because of diverse nature of strategies that need to be organized under one umbrella.»

6.3.2 Mozambique

I have addressed their plan National Strategic Plan for the Prevention and Control of Non Communicable Diseases: 2008–2014 (MISAU. 2008), and a case study about NCD and Mozambique published in 2012 by Carla Silva-Matos and David Beran. (Matos/Beran. 2012)As they say in their introduction to the case study;

«Mozambique is located on the East Coast of Africa bordering South Africa, Zimbabwe, Zambia, Malawi and Tanzania and is one of the poorest countries in the world. Currently NCDs account for 28% of deaths in Mozambique. Risk factors such as tobacco and alcohol use and poor diet are present in both urban and rural settings. Diseases such as hypertension and diabetes affect large proportions of the population, but people are often unaware of their condition or poorly managed. Data from studies on diabetes highlight the financial burden for NCD management in Mozambique for both the individual and health system. The National Strategic Plan for the prevention and control of NCDs in Mozambique has as its aim to create a positive environment to minimise or eliminate the exposure to risk factors and guarantee access to care. The plan has as its overall objective to reduce exposure to risk factors and morbidity and mortality due to NCDs and has 4 areas of intervention: 1) Prevention and health education with regards to NCDs; 2) Access to quality care, treatment and follow-up; 3) Prevention of disability and premature mortality and 4) Surveillance, research, monitoring and evaluation and advocacy for NCDs. The Ministry of Health developed projects for diabetes and hypertension and used these as key lessons that could then be applied to other NCDs. Mozambique, through political commitment from the Ministry of Health and the dedication of local champions, has been able to garner international support to improve care for people with diabetes and then use this to develop its National Plan for NCDs. Despite this increase in attention resources available do not match the challenge of NCDs in Mozambique. Mozambique's experience provides a practical example

of actions that can be undertaken in a resource poor country to tackle the emerging burden of NCDs.»

This is an excellent case for the purpose of the thesis. The country have most of the key components and enabling factors proposed by the Framework in place. It is amazing that they manage to act on NCD while communicable diseases is very pronounced and well known;

«The prevalence of HIV/AIDS in adults aged between 15–49 years of age continues to increase at a national level and is approximately 16.1% [8]. The top 5 causes of mortality are Malaria, HIV/AIDS, Diarrhoeal diseases, Lower Respiratory Infections and Perinatal Conditions representing 57% of total deaths [9]. Despite the main causes of mortality being communicable diseases a study in 1994 showed that of a total of 8,114 deaths classified in the autopsy register in Maputo city 1,834 (22.6%) were due to non-communicable diseases (NCD) [10].» (Mapo/Beran.2012).

The publication describe step by step how this country build a response to the NCD situation from 2003 by establish need and priorities by doing surveys and mapping out barriers to care to build a case and decide on priorities, establish a department in the Ministry of Health that have responsibility for both communicable and non-communicable diseases with task of establishing a comprehensive infrastructure from registration, capacity building through monitoring and surveillance. They have worked with civil societies to establish laws to subsidy NCD medicines on diabetes as well as with international stakeholders, including non- state actors. The National Strategic NCD plan was approved in 2008. The Ministry of Health is the lead Ministry of the intersectoral work. There is an implementation strategy in place with NCD focal points in every province. At a primary health care level it seems to be integration between communicable and noncommunicable diseases. There is less information on multisectoral activity between Ministries.

6.3.3 Malta

The Strategy for the Prevention and Control of Noncommunicable Disease in Malta was approved April 2010 (MOH Malta.2010). From the document;

“Intersectoral participation is needed to ensure the prevention and control of disease, the promotion and maintenance of health, the ensuring of a healthy lifestyle and health-conducive economic and social environment, and the provision of health services appropriate to people's needs. Such action implies co-operation among government departments, agencies, voluntary organisations, and other sectors such as business and industry, labour unions, local councils and professional groups. It also implies a constant search for quality and cost-effectiveness.”

The plan are comprehensive and all main components from the Framework is possible to identify. The plan is explicit on the link to environment and also the implications for health equity. These perspectives strenghten the explicit need for multisectoral action from education, transportation, energyconsumptuion and the food chain. Framing and prioritation of actions on the 4 NCDs and the 4 risk factors have a strong focus in the plan. I addition to the technical focus there are some elements of governance and implementation.

6.3.4 Trinidad and Tobago

Trinidad and Tobago is reckoned as high income countries by the World Bank. The countries of the Caribbean was making a strong and early call for action against NCDs because of their pioneer experience with the NCD epidemic and was important in creating the momentum that led to the Political Declaration among the world leaders NCD in 2011. With the Declaration of Port-of-Spain emanating from the 2007 CARICOM Summit on Chronic Non-Communicable Diseases, “Uniting to Stop The Epidemic of Chronic Non-communicable Diseases”; forms part of the Caribbean Cooperation in Health Initiative. The WHO Pan American Health Region (PAHO) established the regional strategic work on NCD as a consequence. The Strategic Plan of Action for the Prevention and Control of Chronic Non-communicable Diseases for Countries of the Caribbean Community (CARICOM) was established from 2011-2015. The Minister of Health has the leading role at the national level. Intersectoral NCD commissions with local NCD focal points is appointed part of the organization.

The strategic plan is comprehensive covering all key components. In the strategic plan the relation between the regional initiative and the national responsibility is explained as follows;

«The Strategic Plan of Action for the Prevention and Control of Chronic Non-Communicable Diseases (NCDs) in the Countries of the Caribbean Community (CARICOM) is intended to form a road map for action and resource mobilisation at both the regional and country levels. The Plan also includes recommendations for country plans, and at the national level, countries need to own the Plan by adapting it according to their priorities, adopting it and identifying their own sustainable funding for NCDs, e.g., a National Health Fund. Regional funds can and may be injected.»

A couple of new mechanisms is set up in this plan; A mechanism is set up to provide a multistakeholder The Healthy Caribbean Coalition has been established as the civil society umbrella organisation for the Region, to support implementation of the NCD Summit Declaration of Port-of-Spain to *«include advocacy, and coalition building, public education and media campaigns, monitoring and evaluation, support for existing country level networks and activities, and support for Caribbean Wellness Day (CWD).»*

The Caribbean Association of Industry and Commerce (CAIC) is a regional umbrella private sector organisation. The goal of the Trinidad and Tobago Partners Forum is to act as both a catalyst and a mechanism for multi-sectoral action to promote health and reduce the burden of chronic diseases on the population. With the appointment of this Partners Forum, Trinidad and Tobago has become the first in the region to implement this new approach spearheaded by PAHO. The Forum was established to create partnerships between the various sectors, create synergies and catalyze environmental, social and policy changes that promote health and prevent chronic diseases.

From the Forum's web site (Minister of Health Partner Forum) the objectives is layed out and among those:

Joint planning and implementation of actions and policies guided by the Ministry of Health and supported by public sector, private sector, NGOs, civil society and other regional and international partners to reduce the burden of CNCDS in Trinidad and Tobago, identify best practice, to mobilize resources from all sectors to support joint actions, develop and implement joint, integrated, coordinated actions in support of promoting health, reducing risk factors and improving management.

6.3.5 Summary of the findings of case studies

In figure 14 and 15 I have tried to summarize the findings from the country cases.

The framework provided to be a good assessment tool of the 4 country plans, which by nature were very different both in depth and breadth. The key components were in place to some extent in all 4 countries. In general the plans contained little information about implementation mechanisms or strategies. Since Ministry of Health was put as the lead agency in all countries, it would be good to know more about how the multisectoral action

was governed between sectors. The Trinidad and Tobago plan provided some concrete solutions to this. Among the enabling factors mentioned in the framework, management of conflict of interest was not mentioned in any of the 4 plans.

Figure 15 Key components to implement actions across sectors (Framework across sector 2015)

CORE COMPONENT	Framework across sector	Bangladesh	Mozambique	Malta	Trinidad & Tobago
Key components to implement health actions across sectors	Establish need and priorities for action across sectors	ok	ok	ok	ok
	Identify supportive structures and processes	ok - not funding	ok	some	Ok Multisector Private sector
	Frame planned actions	ok	ok	ok	ok
	Facilitate assessment and engagement	ok	ok	some	ok
	Build institutional capacity	ok	ok	ok	ok
	Establish a monitoring and evaluation mechanism	ok	ok	Seems in plac	ok
	Implement action	NA	ok	NA	ok

CORE COMPONENT	Framework across sector	Bangladesh	Mozambique	Malta	Trinidad & Tobago
Enabling factors (Sector roles and responsibilities)	Lead agency	Ministry of Health	Ministry of Health	Ministry of Health	Minister of Health, in a regional project
	Other government sector	yes	yes	yes	yes
	UN organizations	yes	yes	no	yes
	Community engagement	yes	yes	(yes)	yes
	Private sector	yes	yes	no	yes
	Management conflict of interest	NA	NA	NA	NA

Figure 16 Key component – enabling factors to implement actions across sectors (Framework across sector 2015)

7 Discussion

In this thesis I have addressed two different sets of research questions. First, I have explored whether there is an increased utilization of the concept of multisectoral action in the documents of the governing bodies of WHO during the last 15 years. Second, I have examined whether the new framework proposed by WHO is in line with the existing knowledge base and to what extent national plans are utilizing perspectives aligned with this framework.

The word analysis gives reason to believe that there has been a dramatic increase in the use of the words expressing multisectoral action in the documents discussed in the World Health Assembly from 1999 - 2014. The method used, a content analysis, shows differences between the different program categories both trend wise and in total share of words. The quantitative content analysis used in this thesis is described more in detail in the literature (Kriffendorf 2013). To treat words as data makes it possible to use statistical methods and resonate on the un-observed, underlying characteristics of the originator of the text.

The programme category of noncommunicable diseases being the category of health programmes with the largest share of multisectoral action and the programme category preparedness (natural and humanitarian crises) being the category of health programmes with the lowest share. There is a change of terms used to express multisectoral actions during the period which to some extent is related to conceptual frameworks developed during the period. There is a co-existing increase in the use of the words “private sector” and multisectoral action in the period from 1999-2014. The method used does not allow any further conclusions about the concomitant use of expressions “private sector” and “multisectoral action”.

To address how different programmes in WHO utilize and conceptualize multisectoral action, more detailed examination is needed. This would require extensive research in communication and the process of text generation and or by interviewing staff involved in different areas.

All the frameworks for multisectoral action addressed shows mainly a stepwise approach to “what to do” to establish a multisectoral plans and to some extent descriptions of some topical domains of content of the plan. There is no obvious link to a conceptual, knowledge

based framework and “how to do ” elements are less developed. As mentioned the background chapter: Skankardass states the following in his scoping review of intersectoral action for health equity involving governments; *“However, much of the key material is not based on academic analysis or scholarly research.”* (Skankardass.K 2012) This seems to be confirmed also by my analysis.

From the literature there are ideas that can be important for policy development in general and for intersectoral or multisectoral policy development. Most of this knowledge comes from the social sciences, while many of the menus for policy options in NCD comes from medical sciences or public health. A conceptual framework for intersectoral action for equity was developed by Solar et al, based on typologies for intersectoral action (Solar 2009). Many of the key elements in this conceptual framework seem important to include in a framework on multisectoral action or actions across sectors on NCD. One example is to identify the initiation context. Kingdon identifies this as a “window of opportunity” when Problems, Politics and Policies converge (Kingdon 1984). The ISAC database is set up to capture this initiation context. Another dimension is whether the actions should be universal or issue or target based. The framework called “a path for policymakers” included this dimension (WHO 2011). Another dimension is to be able to address and differentiate horizontal and vertical intersectoral actions and also levels of across sectors; global, regional, national and local. There are several publications that discuss the community level or the primary health care level as an ideal level for multisectoral action. And yet another dimension could be to address different purpose for different kind of interventions. Whitehead and Dahlgren offers a typology for this (Whitehead and Dahlgren 2006). They suggest that upstream interventions are aimed at fundamental social and economic reforms for redistribution of wealth, power, decision- making capacities while mid-stream aims to reduce risky behaviors or exposure to hazards and downstream interventions being mitigating impacts of upstream and midstream actions as to increase equitable access to medicines and health care systems. The current frameworks for action across sectors and the frameworks addressed in this thesis represent a mixture of upstream, midstream and downstream without being clear of purpose of the interventions or what more specifically to achieve by multisectoral actions. It seems that the nature of the frameworks addressed is mainly down- and midstream interventions.

In the current proposed framework to the WHA there are some examples of structures that can be implemented to foster collaborative work across sectors (inter-ministerial committees,

support units , networks etc). Still, there are only premature thoughts about governance and governance structures in the different frameworks. There may even be necessary to differentiate the different mechanisms according to; targeted level, breadth or in depth approaches (the integrated NCD plan as such or only on tobacco), upstream, mid - or downstream. Target setting and accountability beyond health sector might also be another measure to achieve multisectoral action and should be part of the discussion. Today, accountability for all the indicators of the NCD Global Action Plan lies with the Ministry of Health.

One of the bottlenecks experienced in NCD is policy incoherence (for example; policies on tobacco in ministry of finance, trade and health can be incoherent). Interventions to overcome policy incoherence should be part of the discussion on how to achieve multisectoral actions.

The last point of discussion is about monitoring and evaluation of the multisectoral plans. All framework prescribe this and all country cases reflect this as one important step. The question is if it is necessary to monitor the impact of the multisectoral action plan itself or only the end results. The Global Capacity Survey on NCD contains most of the key components from the framework and is well placed to monitor the existence of the key steps described for development of a multisectoral plan. The Intersectoral Action for Health Equity Case Studies database (ISAC database) provides elements to map context assessments, policy solutions and engagement models and have more obvious links to “how to” and what works in setting up intersectoral actions. It seems like a good idea to monitor the existence of the elements of the plans according to the framework but at the same time document country cases and apply an impact assessment of the multisectoral mechanism itself to gain more knowledge to refine the frameworks further.

The Second Draft of the Framework for Country Action Across Sectors for Health and Health Equity (WHO 2014) proposed to the World Health Assembly in 2015, proved to be a good assessment tool of national multisectoral plans. The key components from this framework were in place, at least to some extent, in all 4 countries analysed (Bangladesh, Mozambique, Malta, Trinidad and Tobago). In general the plans contained less information about multisectoral implementation mechanisms or strategies. Management of conflict of interest was not mentioned in any of these plan but is suggested to be included in the new proposed framework. It would also be of interest to know to what extend Member States of WHO seek guidance on development and implementation of multisectoral policies and plans

in general or in different parts of the process and what their more specific need are. It is reason to believe that there is a need for technical support and guidance since only 43 out of 192 Member States have developed an operational multisectoral action plan on NCD while they have committed to do so by 2016.

It was a surprise that the frequency of private sector followed the development of the frequency of multisectoral plans. There have been a discussion and intergovernmental negotiations over the last three years to try to get an agreement about framework on the relationship between WHO and non-state actors including the private sector. The word count might reflect this discussion to some extent. The impression is that it is a recent development to include the private sector in the multistakeholder discussion. In NCD it is a clear mandate to include the private sector and call for action from the government on specific topics like healthy work places, on access to essential medicines and healthy food (WHO 2011). While the understanding of the need to institute multisectoral actions and actions beyond health, including non-state actors, is present and growing, the governance systems seems not well suited to tackle this challenges at least not at the global and national level. Policy incoherence is a problem both at the national and at the global level. There are mechanisms and reforms in place to respond to this at all levels. At a global level reforms like one - UN and WHO reform are implemented to mitigate fragmentation and foster integration. Still the UN system is mainly organized in vertical programmatic areas although within more thematic areas, cross cutting activities also exist (UNDP, UNOG, UNFPA). In NCD the UNIATF is set up to overcome this by bringing all the UN organizations to the table and to define joint programmes as well as organizing UN missions to countries to use an “outside-in” strategy to foster multisectoral actions (UNIATF 2013). The WHO GCM is set up to provide a strategic arena for all stakeholders including non- state actors with NGOs, the private sector, academia, philanthropies and the UN agencies to: *“is to enhance the coordination of activities, multi-stakeholder engagement and action across sectors in order to contribute to the implementation of the WHO Global NCD Action Plan 2013–2020.”* (WHO GCM/NCD 2014). At the same time many non-state actors is globally owned and run and do not necessarily comply with national regulations and agreements nor the global governance structure for health.

Shankardass says in his conclusion: *“Our scoping review has identified scholarly and grey literature that begins to clarify the strategies, actors, tools and structures that have been used*

by governments to implement intersectoral approaches to health equity across a range of global context over the last 60 years. Yet, the description of these complex, multi-actor processes was generally superficial and sometimes entirely absent.”

It is important to bear in mind that the focus on multisectoral action is relatively “new” and that it is necessary to take into consideration that although the documents in WHO increasingly reflects multisectoral action over the last 15 years Skankardass shows in his scoping review that most literature (60%) on intersectoral action appears in the last decade (Skankardass 2012). It can be claimed that multisectoral action is a new area that are under development and that more deep understanding of most aspects is needed. The framework examined in this thesis is aligned with the current knowledgebase but there is obvious existing knowledge gaps that have to be filled.

The need for multisectoral action is understood, there is a high level of political awareness and commitment to develop multisectoral action in many areas and especially in NCDs. The focus on multisectoral action is reflected in the documents to WHO governing body although there are differences between programmes. There are existing frameworks and monitoring in place developed by the WHO. There is still a need to fill knowledge gap and gain experience to make it happen.

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