

Global mapping report on multisectoral actions to strengthen the prevention and control of noncommunicable diseases and mental health conditions

Experiences
from around the world





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actions to strengthen the prevention and
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mental health conditions**

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Global Coordination Mechanism on the Prevention and Control of NCDs (GCM/NCD)

Global NCD Platform (GNP)

Global mapping report on multisectoral actions to strengthen the prevention and control of noncommunicable diseases and mental health conditions: experiences from around the world

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Executive summary

There is growing understanding and high-level endorsement of the importance of strong collaborative multisectoral approaches to address a broad range of social, economic and governance issues for the prevention and control of noncommunicable disease (NCDs) and mental health conditions. In 2019, World Health Organization (WHO) Member States requested the WHO Director-General to provide an analysis across countries of successful approaches for the prevention and control of NCDs that used multisectoral action. This report describes the experiences of different countries, areas and territories in implementing multisectoral actions to tackle NCDs and is the first step to address their request for an analysis of such efforts.

In March 2022, WHO launched a call for submissions to gather examples of and map country initiatives that incorporated multisectoral action for the prevention and control of NCDs and mental health conditions. The call was disseminated through WHO channels and promoted through relevant contacts and social media. Submissions closed on 30 June 2022.

A guiding framework on multisectoral action for the prevention and control of NCDs and mental health conditions was developed to inform and support this global mapping process and the formulation of case studies. It serves as a reference on NCD and mental health action and intervention areas and highlights key enabling actions for multisectoral collaboration. This framework was adapted from the draft WHO report on sustainable multisectoral collaboration to address the social determinants of health, equity and well-being and other WHO documents. A questionnaire was designed using mainly closed-ended questions with predetermined responses to collect details of country experiences using multisectoral actions across key elements of the guiding framework. Submissions were allowed from national or subnational government agencies, ministries, secretaries or municipalities, either from the health or other sectors (such as finance,

agriculture and education) or a third-party on behalf of the government. For submissions to be considered, they had to: be sent by or on behalf of governments; involve at least two sectors; and include at least two of the four pillars of multisectoral action.

A total of 127 submissions were received, of which 95 were included in the assessment as they were complete and met all the inclusion criteria. Forty-six countries, areas and territories of all WHO regions were represented, with

This report describes the experiences of different countries, areas and territories in implementing multisectoral actions to tackle NCDs.

the WHO Region of the Americas submitting nearly one third of experiences. Most submissions (77%) were received from low- and middle-income countries including 24% from lower middle-income countries and 12% from low-income countries. The majority of submissions (73%) were made directly by government representatives, and more than half (55%) were from the Ministry of Health or equivalent, for example a national public health agency. Sixty per cent of the submissions reported national initiatives, 23% reported local (city/municipality) initiatives and 8% subnational (state, province and regional) initiatives; in 8% of submissions the level of the initiative was not specified.

Together, the reported experiences covered all strategic action areas. Tobacco use was the risk factor most reported and cardiovascular disease the most reported disease (cited in 70% of the initiatives). Almost all initiatives (93%) reported using more than two areas for

NCD and mental health interventions with 44% reporting more than five interventions. Advocacy and communication campaigns were reported in 83% of initiatives. Most initiatives (68%) involved three to 10 government sectors (health and others), and participation of more than 10 government sectors was reported in 20% of initiatives. Beyond the health sector, education was the second most reported government sector involved (in 68% of initiatives), followed by women, children and youth affairs (45%), and the office of the central government (42%).

The guiding framework, as described earlier, includes four pillars of multisectoral action: governance and accountability; leadership at all levels; ways of working; and resources and capabilities. Each pillar includes a series of actions that aim to enable and strengthen collaborations among government sectors. Most initiatives had two or more multisectoral actions, with the leadership pillar having the most actions reported. Commonly mentioned actions included:

- multisectoral coordination mechanisms in the *governance and accountability* pillar (used in 81% of initiatives);
- networking with professionals through informal or formal meetings in the *leadership at all levels pillar* (used in 85% of initiatives);
- including diverse stakeholders from different government sectors in activities that promote adoption of co-design and co-benefit approaches in the *ways of working* pillar (used in 80% of initiatives); and
- having dedicated personnel with knowledge and experience on the prevention and control of NCDs in the *resources and capability* pillar (used in 84% of initiatives).

Variations in multisectoral actions implemented were seen across the WHO regions and country income groups. The least used multisectoral action across all country income groups was identifying champions to promote multisectoral action across government sectors (used in 41% of initiatives). This was particularly seen in upper middle-income countries where only 21% of the initiatives reported using this action.

There is a need for further research and monitoring, knowledge-sharing and capacity development around multisectoral action. Enhancing the understanding of the concepts embedded in the pillars of multisectoral action and their practical application is also required. This can be supported by networks, training programmes, mentoring and similar approaches. In addition, certain terms, including multisector and multistakeholder, need to be clarified.

This global mapping report provides an overview of the implementation of multisectoral actions to tackle the burden of NCDs and mental health conditions. It highlights the multisectoral actions that have been widely applied and others that have not been much used and should be developed and implemented more extensively. In the next stage of WHO's response to the request of Member States, case studies will be developed to show in more depth how multisectoral actions have been implemented to promote knowledge collaboration and capacity development, and foster action on the ground for the prevention and control of NCDs and mental health conditions.





Box 1

Terminology of multisectoral action

The prevention and control of noncommunicable diseases (NCDs), including their associated determinants and inequities, require collaboration within and between government sectors beyond health. This approach is referred to in the literature as multisectoral action, intersectoral or cross-sectoral action, or Health in All Policies or whole of government. Each of these concepts has a focus on strengthening collaborative engagement across public agencies to deliver healthy public policy outcomes, including the prevention and control of NCDs.

Note: While this important approach is increasingly being adopted, the terms are still fluid, imperfectly defined, and often used interchangeably. In this document, the term multisectoral action has been used to refer to collaboration within and between government sectors. Core elements of multisectoral action are described in this document.

Introduction

Recognition is growing across the global public health community that strong collaborative, multisectoral action – that is, collaboration within and between government sectors (Box 1) – is required to respond to complex health and social challenges, including noncommunicable diseases (NCDs) and mental health (1,2).

WHO Member States have acknowledged the importance sharing information, knowledge, and best practices on implementing multisectoral actions for NCDs.

This awareness is reflected in the Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (3), which states that governments need to address a broad range of social, economic and governance issues to prevent and control NCDs and mental health conditions. Similarly, the World Health Organization's (WHO's) Global action plan for the prevention and control of NCDs 2013–2030 (4) emphasizes that effective NCD prevention and control requires leadership, coordinated multisectoral and multistakeholder engagement across a broad range of sectors, and partnerships with relevant civil-society and private-sector entities. This approach is reinforced in the WHO implementation roadmap 2023–2030 for the NCD global action plan (5), which calls on countries to accelerate their capacity in multisectoral and multistakeholder collaborations, provide strategic leadership and promote policy coherence and coordination through whole-of-government and Health in All Policies approaches.

WHO Member States have acknowledged the importance of implementing multisectoral NCD responses and sharing information, knowledge, best practices, approaches, and successes and challenges on the implementation of national policies and programmes to prevent and control NCDs and promote health¹.

This commitment to multisectoral NCD responses is demonstrated in the 2021 WHO NCD country capacity survey (7), where 144 Member States reported having either an operational multisectoral national NCD policy, strategy or action plan, or an operational national multisectoral commission, agency, or mechanism to oversee NCD engagement, policy coherence and accountability of sectors beyond health.

This report provides an overview of the global mapping of experiences of multisectoral action for the prevention and control of NCDs and mental health conditions², conducted by WHO among its Member States. This project is a first step and part of a broader WHO initiative to develop a collection of case studies, highlighting practices and approaches in implementing multisectoral action for the prevention and control of NCDs. This activity responds to the request Member-States reiterated to WHO at the Seventy-Second World Health Assembly to provide an analysis of successful initiatives in member countries for the prevention and control of NCDs that used multisectoral action (resolution WHA72 (11), 2019).

This global mapping report will help describe which multisectoral actions governments are implementing to foster and/or strengthen collaboration across government sectors for the prevention and control of NCDs and mental health conditions. The ultimate goal of this mapping is to disseminate the experiences of Member States, identify case studies, and promote knowledge collaboration and capacity development among governments and other stakeholders on multisectoral action, as part of their response to NCDs and mental health conditions.

¹ See for example, the WHO Europe report (6).

² Mental health conditions include: mental, neurological and substance use disorders, suicide risk, and associated psychosocial, cognitive and intellectual disabilities.

Guiding framework

A guiding framework on multisectoral action for the prevention and control of NCDs and mental health conditions (Figure 1) was developed to inform and support this global mapping exercise and the formulation of case studies. The framework builds on the WHO toolkit for developing a multisectoral action plan for NCDs (8) and was adapted from the draft WHO report on sustainable multisectoral collaboration to address the social determinants of health, equity and well-being (9) and other WHO documents (5,10).

Addressing the burden of NCDs and mental health conditions is an integral part of achieving the Sustainable Development Goal (SDG) 3 through target 3.4: by 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being (11). The guiding framework serves as a reference on NCD and mental health action and intervention areas and highlights key enabling actions for multisectoral collaboration.

The framework combines the principles and elements that underpin WHO's approach to reducing NCDs and achieving the highest standard of mental health and well-being. It incorporates fundamental multisectoral actions that aim to improve collaborative efforts across governments to deliver NCD responses.

The framework shows the relationship between the modifiable risk factors associated with the leading NCDs and mental health conditions and their respective interventions, and the main elements of multisectoral action.

A world free of the avoidable burden of NCDs and the highest standard of mental health and well-being.

The foundations

The foundations of the framework include three elements that set the parameters for good practice when collaborating on multisectoral actions for the prevention and control of NCDs and mental health conditions. These elements are: (i) the ultimate goal of implementing the WHO global action plan on NCDs, 2013–2030 (4) and achieving SDG 3.4; (ii) the principles of NCD approaches (4); and (iii) the principles of collaboration (12) (see Figure 1).

The vision: A world free of the avoidable burden of NCDs and the highest standard of mental health and well-being.

Principles underpinning NCD approaches

- Life course approach – opportunities to prevent and control NCDs are relevant across the life course from maternal health (including preconception) to healthy ageing.
- Empowerment of people and communities – people should be empowered and involved in all interventions for the prevention and control of NCDs, including the meaningful engagement of people with lived experience of NCDs, the co-creation, co-design and implementation of interventions, and accountability for the outcomes (13).
- Evidence-based strategies – strategies and practices need to be based on the latest scientific evidence and/or best practice, cost-effectiveness, affordability and public health principles, taking cultural factors into account.
- Universal health coverage – all people should have access to basic promotive, preventive, curative and rehabilitative health services, and essential, safe, affordable, effective and good-quality medicines.
- Management of real, perceived or potential conflicts of interest – multiple actors need to be engaged to tackle NCDs effectively. Policies, strategies and actions must be protected from vested interests, and real,

potential and perceived conflicts of interest need to be managed.

- Human rights approach – the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, as enshrined in the Universal Declaration of Human Rights (14).
- Equity-based approach – the unequal distribution of NCDs is a result of the unequal distribution of the social determinants of health; action on these determinants is essential to create inclusive, equitable, economically productive and healthy societies.
- National action and international cooperation and solidarity – the primary role and responsibility of governments in addressing NCDs is recognized, as is the importance of international cooperation.
- Multisectoral action – effective NCD prevention and control requires leadership, coordinated actions across government sectors and multistakeholder (that is, non-State actors) engagement for health, both at the government level and at a broader level including a wide range of actors.

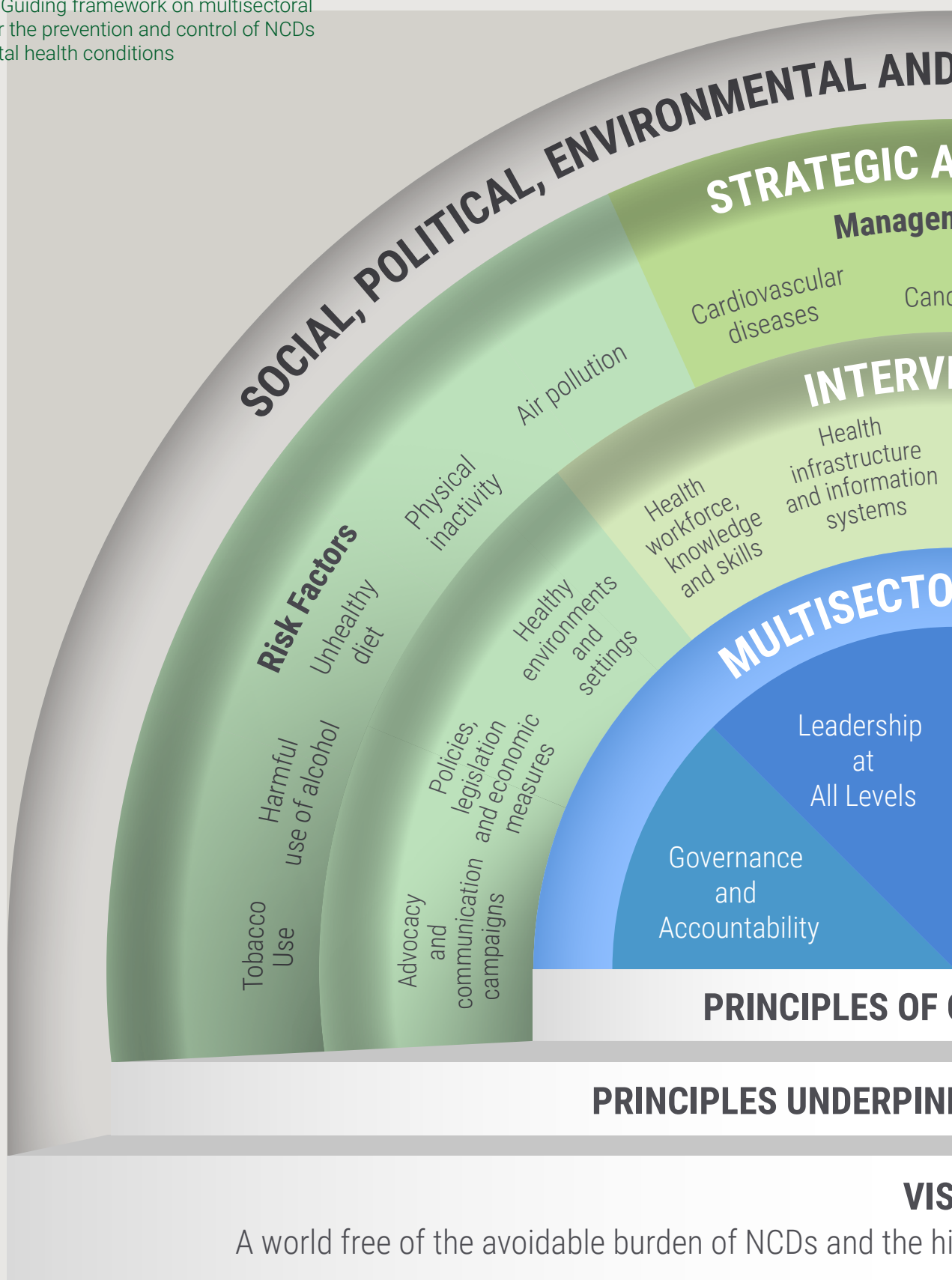
Principles of collaboration

- Investment in building trust and relationships – having dedicated staff, with time and space to build strong trusting relationships with other sectors, supports effective collaboration.
- Flexibility and adaptability – partnerships need to be aware of, and actively respond to, partners' changing needs and political realities. Policy imperatives can change and adaptability to a new policy environment is essential.
- Respectful environment responsive to partners' needs – understanding,

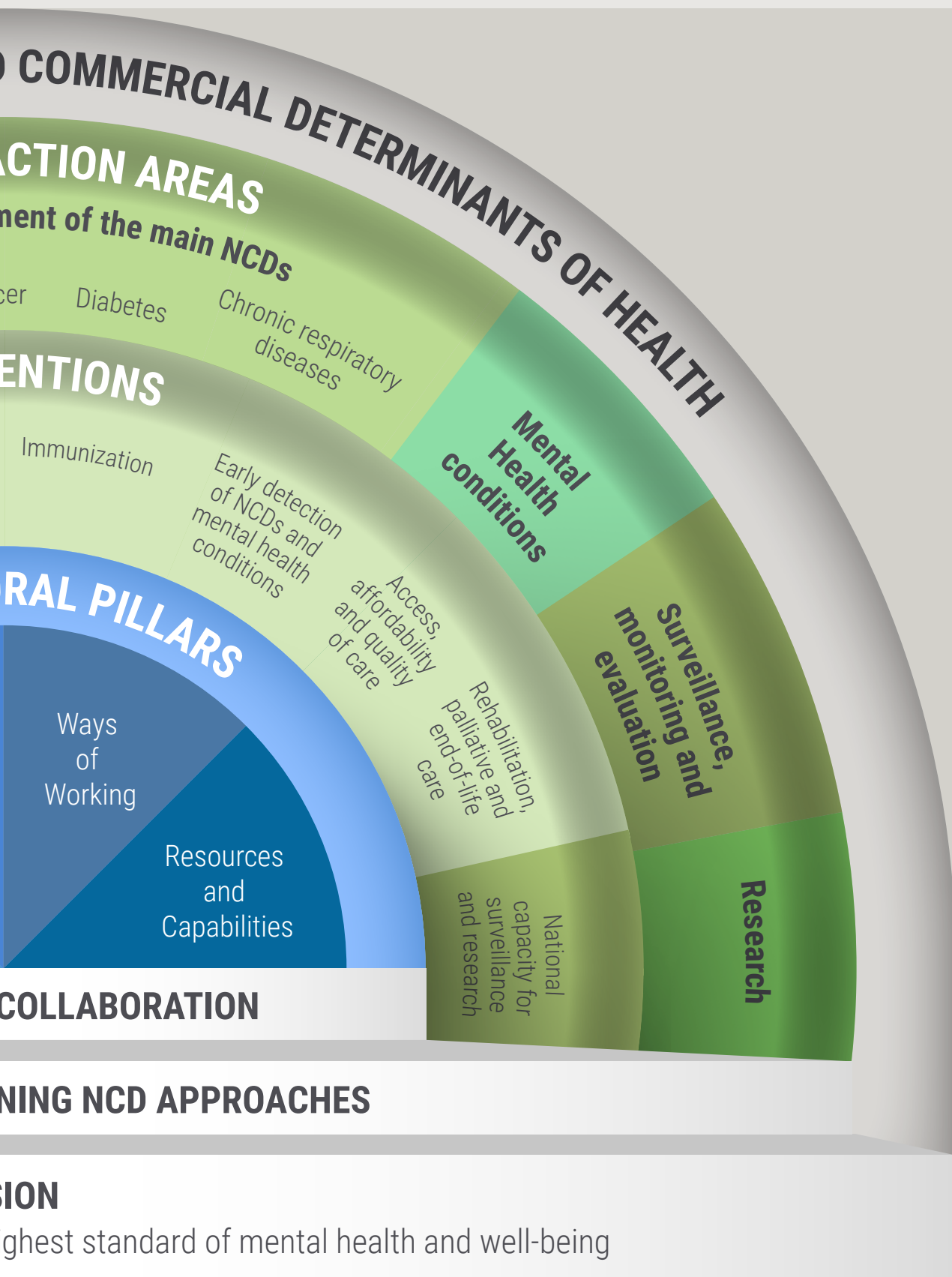
acknowledging and respecting the expertise and policy agendas of all sectors, and responding to their needs are important in the partnership and co-design process. Such an environment fosters collaborative relationships based on trust.

- Transparent and open communication – open conversations and a professional and honest approach to addressing issues help ensure strong trusting relationships and the best outcomes for all.
- Skilled workforce for multisectoral action – recognizing and fostering the diplomacy, negotiation and political science skills of a workforce for multisectoral action is essential.
- Joined-up approaches – implementing mechanisms to facilitate co-defining, co-designing and co-delivering policy and practice enables multisectoral action.
- Focus on health interests – working to position health issues and interests within policy deliberations of other government sectors, taking into account national health priorities and objectives to achieve Sustainable Development Goal (SDG) 3.4, while managing risks and conflicts of interest, helps safeguard multisectoral action.
- Focus on public value – ensuring citizens are at the centre of policy and service design and delivery safeguards positive societal and environmental impact.
- Systemization and institutionalization – embedding multisectoral action attitudes into the ethos and structure of government decision-making by formalizing processes and practices of multisectoral action in legislative, administrative and political structures of government strengthens cooperation and collaboration.

Figure 1. Guiding framework on multisectoral action for the prevention and control of NCDs and mental health conditions



NCD: noncommunicable disease.



Four pillars of multisectoral action

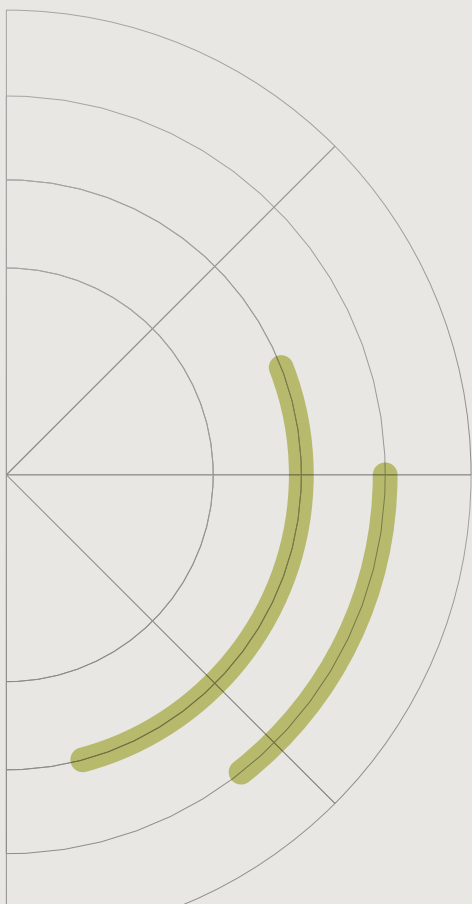
At the centre of the framework are the four pillars of multisectoral action that support a successful approach to multisectoral collaboration: (i) governance and accountability; (ii) leadership at all levels; (iii) ways of working; and (iv) resources and capabilities. The four pillars are based on published evidence and practical experience of multisectoral action in a range of countries and regions and were tested by the WHO Collaborating Centre on Advancing Health in All Policies Implementation (15). The pillars are also described in the WHO draft document on sustainable multisectoral collaboration to address the social determinants of health, equity and well-being. The multisectoral actions in each of the four pillars are outlined in the following subsections.

Governance and accountability

Strong governance mechanisms provide the authorizing environment and mandate for multisectoral action, including supporting the development, implementation and sustainability of the approach. Strong governance also facilitates a culture of collaboration and systemizes multisectoral action by enabling the establishment and maintenance of supportive structures. It also helps avoid and/or manage risks, including conflict of interest.

Examples of multisectoral action in the governance and accountability pillar include the following actions.

- Seeking a mandate, endorsement or supportive legislation for multisectoral action through a government statement, or national and subnational policies or plans; developing a memorandum of understanding, decree or agreements between government sectors.
- Establishing multisectoral coordination mechanisms or other formal structures such as high-level cross-sectoral committees, working groups and alliances.
- Utilizing existing cross-sectoral policies or plans to promote and expand multisectoral action.
- Developing reporting structures and accountability measures on cross-sectoral policies or programmes such as key performance indicators on multisectoral action and annual reports.
- Ensuring accountability to the public through public reporting on agreed shared goals, activities and outcomes related to multisectoral collaboration; confirming transparency in the provision of information to the public on multisectoral action by the government.



Leadership at all levels

Leadership at all levels – political, executive, managerial and operational – is important to create and support a culture of multisectoral action to sustain collaborative practice. Leadership should encourage and publicize a culture that supports and facilitates collaboration and change. Government officials who advocate for and support multisectoral action across government can shift actions towards more collaborative practices. Strong leaders with a focus on collaborative practice can connect across disciplines and agencies, cultivating both collaboration and accountability at all levels of agency hierarchies, which then strengthens coordinated multisectoral action across government.

Examples of multisectoral action in the leadership pillar include the following actions.

- Networking with professionals through informal or formal meetings of policy officers across government sectors.
- Identifying champions to promote multisectoral action across government sectors.
- Establishing incentives or recognition of the importance of multisectoral action through, for example, documents, speeches, sponsorships of multisectoral actions, reward mechanisms for good multisectoral collaboration, and performance indicators.
- Setting standards for multisectoral action through shared goals and tools that cross multiple sectors, such as policy briefs, health impact assessments (16) and health lens analyses (17).
- Acknowledging the commitments of other sectors to encourage further action and collaboration.

Ways of working

The ways of working are the behaviours, attitudes and practices used to collaborate and form partnerships. Ways of working includes the tools and processes used to implement, embed and sustain multisectoral action. They describe how to operationalize the principles of collaboration (see the foundations mentioned earlier). Effective communication, working collaboratively in partnerships, and understanding the drivers and agendas of partners are all important ways of working. These three elements are fundamental to the establishment and maintenance of trusting and respectful relationships.

Examples of multisectoral action in the *ways of working* pillar include the following actions.

- Developing communication tools, processes or activities that foster transparency and collaboration to build trust.
- Implementing formal and/or informal activities that nurture relationship-building with people in other sectors and ministries.
- Establishing knowledge collaboration activities among government sectors to ensure sustainability of multisectoral action and relationship-building.
- Including diverse stakeholders from different government sectors in activities that promote the adoption of co-design and co-benefit approaches, including shared decision-making.

Resources and capability

Establishing and maintaining multisectoral action need appropriate and dedicated personnel and financial resources. These resources can be either a dedicated budget for multisectoral action or mechanisms for joint financing with partners to support commitment to co-production. Capabilities are developed and/or strengthened through dedicated resources.

Capabilities include the skills and knowledge of personnel, including health diplomacy and negotiation skills. The time required to build capabilities and capacity also needs to be considered, for example, building trusting relationships takes time but is important as trust plays a vital role in successful collaborative outcomes.

Examples of multisectoral action in the resources and capability pillar include the following actions.

- Having dedicated personnel within health and across government with knowledge and experience of working on the prevention and control of NCDs.
- Having dedicated personnel within health and across government with knowledge and experience of working on multisectoral activities, programmes or initiatives.
- Implementing training and/or mentoring programmes or other activities to enhance knowledge and experience of multisectoral action across relevant government sectors.
- Encouraging dedicated funding to support multisectoral action on NCDs.
- Building capacity for multisectoral action, for example, training and mentoring.

The arches

The three arches provide the parameters and focus areas within which multisectoral action operates. They describe the main interventions recommended for both the prevention and control of NCDs and multisectoral collaboration.

First arch: social, political, environmental and commercial determinants of health

The first arch recognizes the powerful and all-encompassing influence of the determinants of health on the prevention and control of NCDs, as well as how both health systems and governments operate. This arch indicates the importance of external factors beyond health that affect modifiable risk factors and related NCDs, and the importance of working in the interests of public health.

Second arch: strategic action areas

The second arch includes the five main areas in which governments are implementing multisectoral action in this context:

- risk factors: tobacco use, harmful use of alcohol, unhealthy diet, physical inactivity and air pollution
- management of the main NCDs: cardiovascular disease, cancer, diabetes and chronic respiratory diseases
- mental health conditions
- surveillance, monitoring and evaluation
- research.

Third arch: interventions

The third arch summarizes the overarching areas for interventions based on the strategic action areas used to support the prevention and control of NCDs and mental health conditions, including, but not limited to:

- advocacy and communications campaigns
- policies, legislation and economic measures
- healthy environments and settings
- health workforce knowledge and skills
- health infrastructure and information systems
- immunization
- early detection of NCDs and mental health conditions
- access, affordability and quality of care
- rehabilitation, palliative and end-of-life care, and
- national capacity for surveillance and research.

These interventions are embedded in the WHO global action plan on NCDs 2013–2030 (4) and the WHO Special initiative for mental health (18) which cover the responses required to tackle NCDs and mental health conditions.

Methods

WHO launched a call for submissions in March 2022 to collect and map country-level experiences on multisectoral actions for the prevention and control of NCDs and mental health conditions. The call was disseminated to relevant NCD focal points in the Ministries of Health or equivalent through WHO channels (regional and country offices) and promoted through additional networks, contacts and social media. Submissions were allowed until 30 June 2022.

An online questionnaire was developed in English, French and Spanish to collect the experiences in multisectoral action, and the content was based on the guiding framework discussed earlier. Section 1 included questions about the background of the applicant/government and a brief overview of the experience of multisectoral action for the prevention and control of NCDs and mental health conditions. Section 2 had questions on the government level (national, subnational, local) and other actors (nongovernmental organizations, academia) involved. Section 3 focused on the strategic action areas, including NCD risk factors, related diseases or mental health conditions, and the corresponding interventions. Section 4 comprised questions related to the pillars of multisectoral action and key outcomes, as well as questions on sustainability, replicability, evaluation and dissemination of the experiences. Most questions had a partially closed-ended format (multiple choice), which included a set of predetermined responses and an "other" response category. Two open-ended questions asked respondents to provide further observations on their initiatives.

WHO accepted submissions from national or subnational government agencies, ministries, secretaries or municipalities, from the health or other sectors (such as finance, agriculture and education) or a third party on behalf of the government (WHO regional or country offices, other UN agencies, academia, and nongovernmental organizations).

The questionnaire was accessible online at WHO's Dataform platform. Consent to participate in the call for submissions was given by reading the online informed consent form and clicking on an "agree" button in the introductory section of the questionnaire. Descriptive analysis was used to determine group differences and assess the distribution of the responses and trends.

The inclusion criteria for accepting submissions were as follows:

- application sent by governments or on behalf of governments (mandatory);
- at least two different government sectors involved as part of the experience of multisectoral action, one from the health sector and the other from another sector such as finance, education and agriculture (mandatory);
- at least one of the five risk factors covered (tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol and air pollution); and/or
- at least one of the four main NCDs covered (cancer, cardiovascular disease, diabetes and chronic respiratory diseases), or mental health conditions; and
- at least two of the four pillars of multisectoral action included (governance and accountability, leadership at all levels, ways of working, and resources and capabilities) (mandatory).

The findings on the use of multisectoral actions under each of the four pillars were grouped and stratified based on the income level of the countries according to World Bank definitions, namely low-income, lower middle-income, upper middle-income and high-income countries (19).

Review process

A project working team was established across the WHO headquarters and WHO Collaborating Centre for Advancing Health in All Policies Implementation to screen the submissions. All submissions were first assessed for completeness, that is, that all required information in the online questionnaire was completed, including contact details of the respondent and a description of the initiative. Of the 127 submissions received, 111 were complete. All complete submissions were verified twice by two panel members who reviewed each submission separately to determine which fulfilled the minimum inclusion criteria outlined before. Inconsistent or unclear information was found in 52 submissions and these respondents were contacted to clarify some aspects of their initiatives. Of these submissions, 34 provided the necessary

clarification; the other 16 did not meet the minimum requirements and were not included in the pool of valid submissions. One experience was submitted twice by different public departments and, after clarification with the respondents, only one was considered in the final pool of submissions.

After this initial screening, 95 submissions were deemed complete and within the scope, and were selected to be part of this global mapping report on multisectoral actions. A summary of each of the 95 country experiences complements this report (see Web Annex). From the pool of 95 submissions, WHO selected 20 experiences to be further developed into case studies. These case studies, which are under development at the time of the preparation of this report, include analysis of the approaches and experiences implementing multisectoral actions for the prevention and control of NCDs and mental health conditions.



Findings

A total of 95 submissions from 46 countries, areas and territories were included in the assessment (Table 1). Most initiatives were active at the time of the call for submissions (86%) and 60% were funded by the public sector alone.

Geographic coverage

The number of submissions from the WHO regions were: 30 from the Region for the Americas; 20 from the African Region; 20 from the Eastern Mediterranean Region; 11 from the Western Pacific Region; nine from the European Region; and five from the South-East Asian Region.

Several countries submitted more than one experience from the national and/or subnational levels: 19 experiences were submitted by Colombia; eight by Saudi Arabia; five by the Philippines; four by Kenya; three each by Brazil, Finland, Iraq and Thailand; and two each by Argentina, Burkina Faso, Canada, Ethiopia, Liberia, Islamic Republic of Iran, Jordan, Mozambique and Japan. Most submissions (60%) covered nationwide initiatives, 23% covered local level (city or municipality) initiatives and 8% subnational level (state, province, or region). Some submissions did not report the extent of their coverage (8%). The majority of submissions (73%) were made directly by government representatives, and more than half (55%) were from the ministry of health or equivalent.

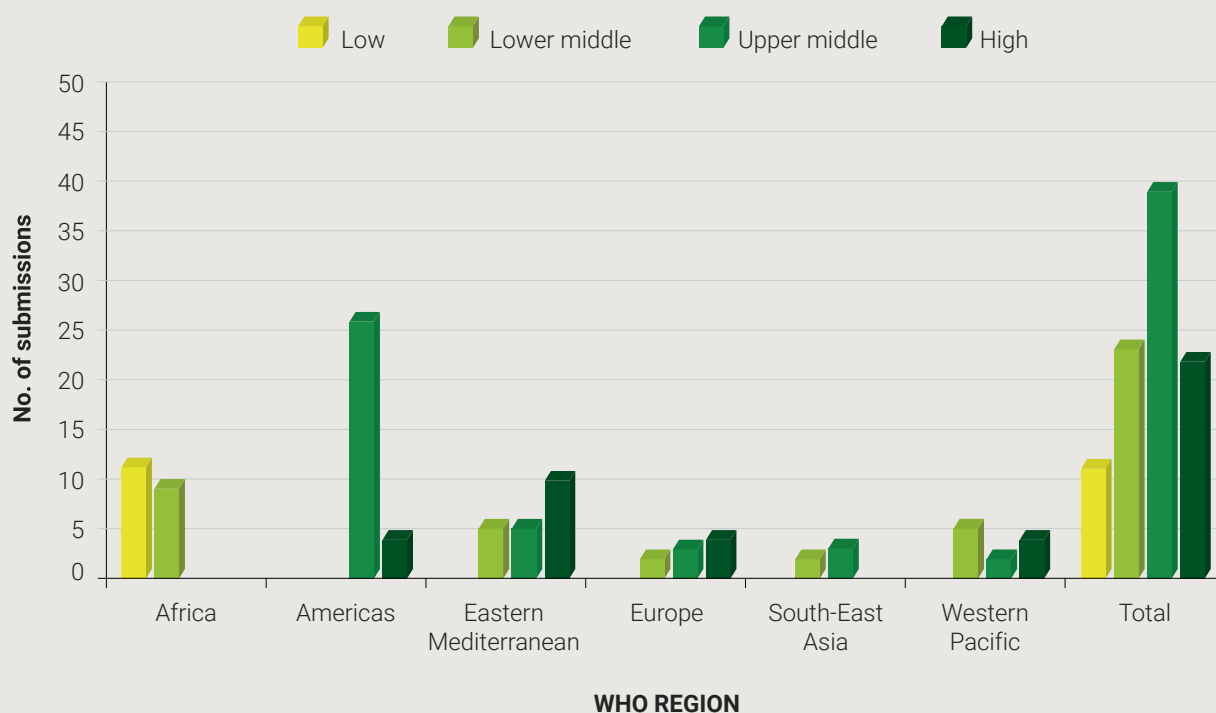
Of the 95 submissions, 73 (76%) were received from low- and middle-income country groups, specifically 39 (41%) from upper middle-income, 23 (24%) from lower middle-income, and 11 (12%) from low-income countries (Figure 2). The remaining 22 submissions came from high-income countries (23%).

Table 1. Submissions received, by WHO region and country, area and territory

| WHO region | No. of submissions | WHO region | No. of submissions |
|---------------------------------------|--------------------|--|--------------------|
| Americas (n = 30) | | Eastern Mediterranean (cont.) | |
| Argentina | 2 | Jordan | 2 |
| Aruba | 1 | Lebanon | 1 |
| Brazil | 3 | Oman | 1 |
| Canada | 2 | occupied Palestinian territory, including east Jerusalem | 1 |
| Chile | 1 | Saudi Arabia | 8 |
| Colombia | 19 | Tunisia | 1 |
| Cuba | 1 | Europe (n = 9) | |
| Paraguay | 1 | Armenia | 1 |
| Africa (n = 20) | | Finland | 3 |
| Algeria | 1 | Kazakhstan | 1 |
| Burkina Faso | 2 | Kyrgyzstan | 1 |
| Burundi | 1 | Netherlands (Kingdom of the) | 1 |
| Ethiopia | 2 | Tajikistan | 1 |
| Ghana | 1 | Türkiye | 1 |
| Kenya | 4 | South-East Asia (n = 5) | |
| Liberia | 2 | India | 1 |
| Mozambique | 2 | Sri Lanka | 1 |
| Niger | 1 | Thailand | 3 |
| Nigeria | 1 | Western Pacific (n = 11) | |
| Rwanda | 1 | Australia | 1 |
| Senegal | 1 | Brunei Darussalam | 1 |
| United Republic of Tanzania | 1 | China | 1 |
| Eastern Mediterranean (n = 20) | | Japan | 2 |
| Bahrain | 1 | Palau | 1 |
| Iran (Islamic Republic of) | 2 | Philippines | 5 |
| Iraq | 3 | Total | 95 |

WHO: World Health Organization.

Figure 2. Number of submissions, by WHO region and country income level



Scope of the initiatives using multisectoral action

Strategic action areas

More than a quarter of the initiatives reported in the submissions addressed only one of the four modifiable behavioural risk factors (tobacco use, physical inactivity, unhealthy diet, or harmful use of alcohol), and 37% addressed all four of these risk factors. Tobacco use was the most common risk factor mentioned (in 70% of all initiatives), followed by physical inactivity (64%) and unhealthy diet (59%). Other risk factors reported were harmful use of alcohol (in 46% of initiatives), air pollution (16%) and metabolic risk factors (10%).

Overall, 36% of the initiatives using multisectoral action named all the four main NCDs (cardiovascular diseases, cancers, chronic respiratory diseases and diabetes), and 28% mentioned one of these four or mental health conditions. The management of cardiovascular diseases was reported in 67% of the initiatives. Diabetes was the second most reported in 64% of the initiatives, followed by cancer (48%), mental health conditions (48%), chronic respiratory diseases (46%), and others (20%) such as sickle-cell disease, trauma and injuries, and haematological conditions.

Almost all the initiatives reported in the submissions (93%) used more than two types of NCD intervention and 7% indicated the use of only one intervention (Table 2). The most cited intervention was advocacy and communication campaigns, which was reported in 83% of the initiatives in the submissions. Almost two thirds

of the initiatives included interventions related to policies, legislation and economic measures, and early detection of NCDs and mental health conditions, and 63% included interventions that focused on health workforce knowledge and skills, and access, affordability and quality of

care. In addition, just over half of the initiatives focused on health infrastructure and information systems that support national strategies on the prevention and control of NCDs and mental health conditions.

Table 2. NCD interventions reported in the initiatives

| NCD intervention | % (n = 95) |
|--|-------------------|
| Advocacy and communication campaigns | 83 |
| Policies, legislation and economic measures | 65 |
| Early detection of NCDs and mental health conditions | 64 |
| Healthy environments and settings | 63 |
| Health workforce knowledge and skills | 62 |
| Access, affordability and quality of care | 62 |
| Health infrastructure and information systems | 55 |
| National capacity for surveillance and research | 36 |
| Rehabilitation, palliative and end-of-life care | 20 |
| Immunization | 15 |
| Other interventions ^a | 10 |
| No. of interventions reported | |
| 1 | 7 |
| 2–5 | 48 |
| > 5 | 44 |

NCD: noncommunicable disease.

^aExamples: partnership building and patient empowerment.

Government sectors

Most of the initiatives included multiple government sectors beyond health (Table 3). In 68% of the initiatives, between three and 10 government sectors were represented in the multisectoral action and in 20%, more than 10 government sectors were involved. The participation of the health sector and only one other sector was reported in 12% of submissions.

The sector most often represented in the multisectoral action beyond health was the education sector, whose involvement was reported in 68% of initiatives. Other frequently cited government sectors were women, children and youth affairs (in 45% of initiatives), office of the central government (42%), economy/finance (39%), and recreation/sports (36%). The least cited government sectors were home affairs (in 17% of initiatives), foreign affairs (11%) and housing (11%).

Table 3. Government sectors involved in the multisectoral action initiatives

| Government sector | % (n = 95) |
|-----------------------------------|------------|
| Health | 100 |
| Education | 68 |
| Women, children and youth affairs | 45 |
| Office of central government | 42 |
| Economy/finance | 39 |
| Recreation/sports | 36 |
| Communication | 35 |
| Other ^a | 34 |
| Trade/industry | 32 |
| Social welfare | 30 |
| Social and economic development | 27 |
| Justice/security | 27 |
| Employment/labour | 26 |
| Agriculture | 25 |
| Legislature | 25 |
| Food | 24 |
| Urban planning | 22 |
| Home affairs | 17 |
| Foreign affairs | 11 |
| Housing | 11 |

^a Examples: municipalities, transport, environment, defence, culture, planning, and national committee on tobacco control.



More than three quarters of the initiatives included the participation of non-State actors, including nongovernmental organizations, academia, philanthropic organizations, the private sector, or international organizations. Nongovernmental organizations were the most cited non-State actor (66%) participating in the initiatives reported in the submissions received.

Multisectoral action pillars

Each of the four pillars (governance and accountability; leadership at all levels; ways of working; and resources and capabilities) includes a series of actions that aim to enable and strengthen collaboration among government sectors. See Annex 1 for the multisectoral actions reported under each of the four pillars.

Table 4 shows the number of multisectoral actions reported in the submissions according to multisectoral action pillar. Most initiatives reported using two or more multisectoral actions under each pillar.

Governance and accountability

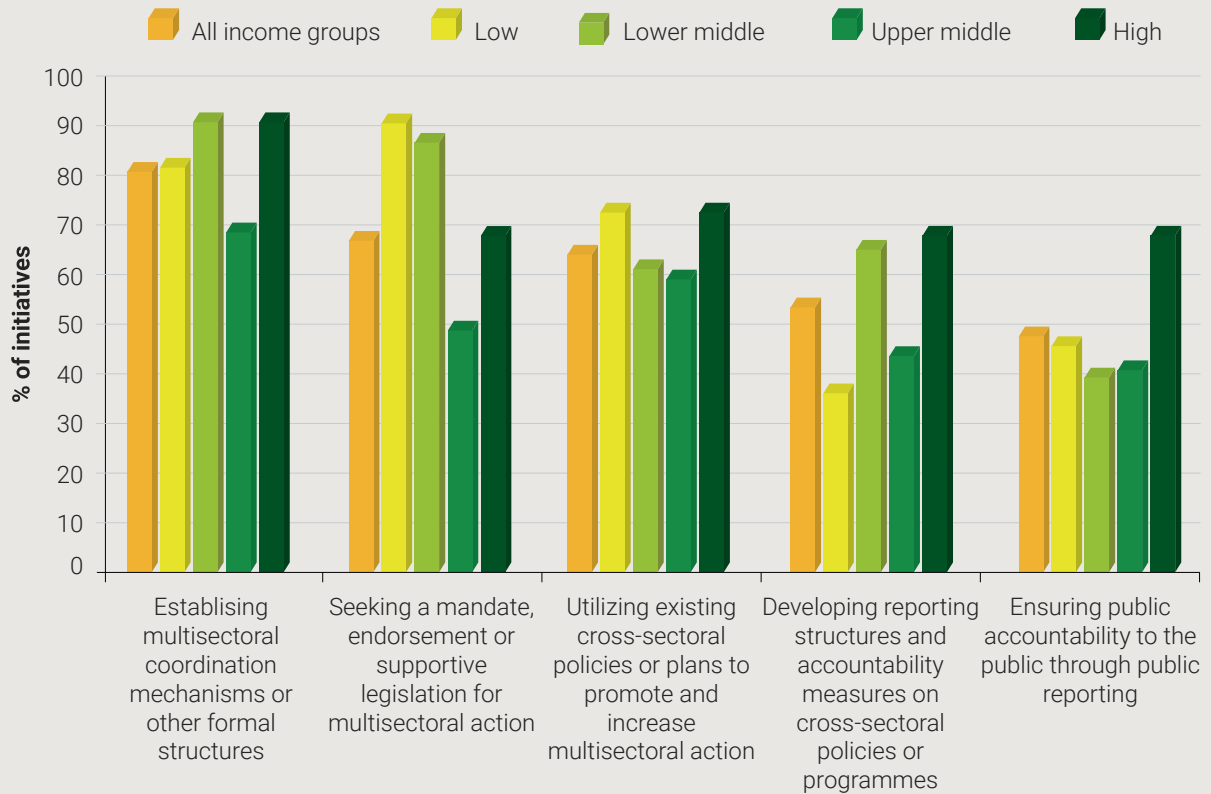
A well-structured governance and accountability system supports an enabling environment for the development, implementation and sustainability of multisectoral actions for NCD prevention and control and mental health conditions. Most of the initiatives in all country income groups indicated that establishing multisectoral coordination mechanisms was the most used multisectoral action in the governance and accountability pillar; used in 81% of the initiatives overall (Figure 3).

Equally important, 91% of the submissions from low-income and 87% from the lower middle-income countries indicated that seeking a mandate, endorsement or supportive legislation was the most used multisectoral action. The least cited action across country income groups was ensuring public accountability through public reporting on agreed shared goals, activities and outcomes (used in 47% of the initiatives overall). Developing reporting structures and accountability measures was the least used action in low-income countries (used in 36% of the initiatives overall).

Table 4. Number of multisectoral actions reported, by pillar of multisectoral action

| Pillar of multisectoral action | Number of initiatives reporting | | |
|--------------------------------|---------------------------------|--------------------------|-----------------------------------|
| | No multisectoral actions | One multisectoral action | Two or more multisectoral actions |
| Governance and accountability | 1 | 14 | 80 |
| Leadership at all levels | 0 | 20 | 75 |
| Ways of working | 3 | 12 | 80 |
| Resources and capability | 1 | 11 | 83 |

Figure 3. Multisectoral actions reported for pillar 1 (governance and accountability), by country income group



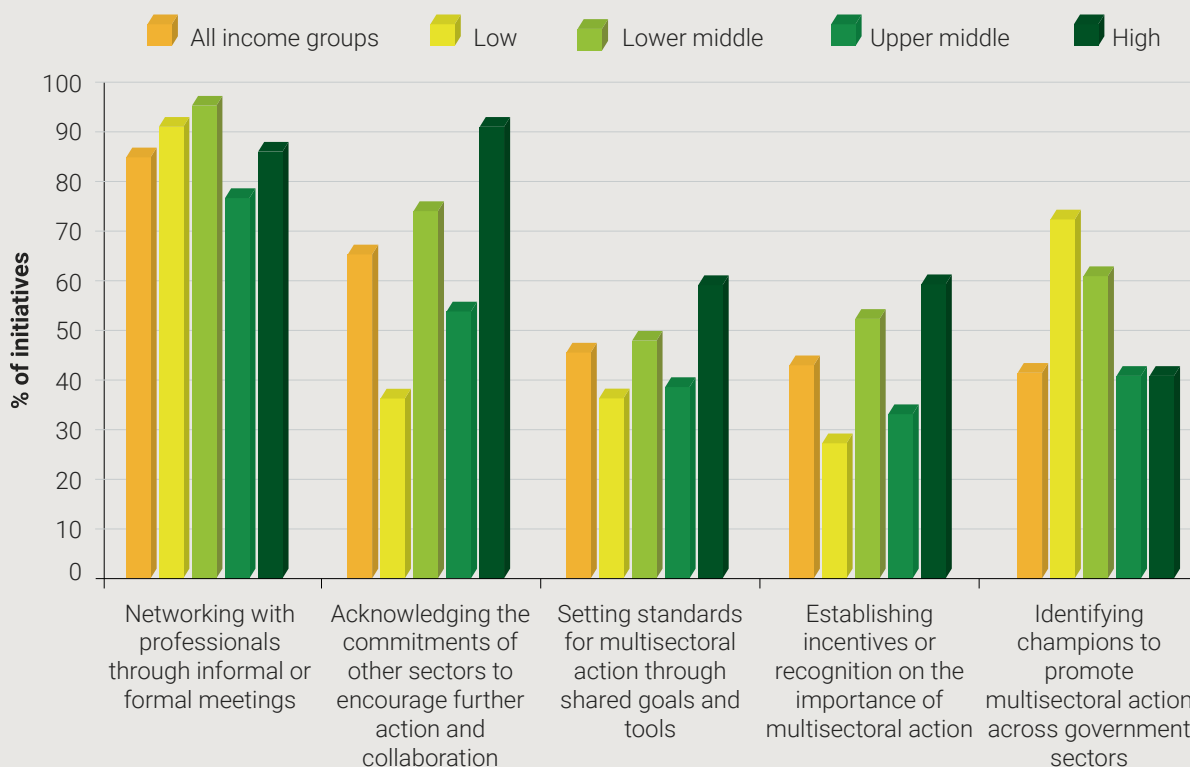
Leadership at all levels

Leadership is an enabler to generate change, create or strengthen a collaborative environment and inspire collaborative approaches with different levels of the government. The most used multisectoral action in the leadership pillar across country income groups was networking with professionals through informal or formal meetings (Figure 4); used in 85% of the initiatives overall. This was true in low-income (used on 91% of the initiatives), lower middle-income (used in 96%) and high-income (used in 86%) countries. Acknowledging the commitments

of other sectors to encourage synergy was the most reported action in high-income countries (used in 91% of the initiatives).

The least used multisectoral action across all income groups was identifying champions to promote multisectoral action across government sectors; used in 41% of the initiatives overall. In the high-income countries, only 21% reported using this action. In low-income countries, establishing incentives or recognition of the importance of multisectoral action was the least reported action used; only 27% of low-income countries reported the use of this multisectoral action.

Figure 4. Multisectoral actions reported for pillar 2 (leadership at all levels), by country income group

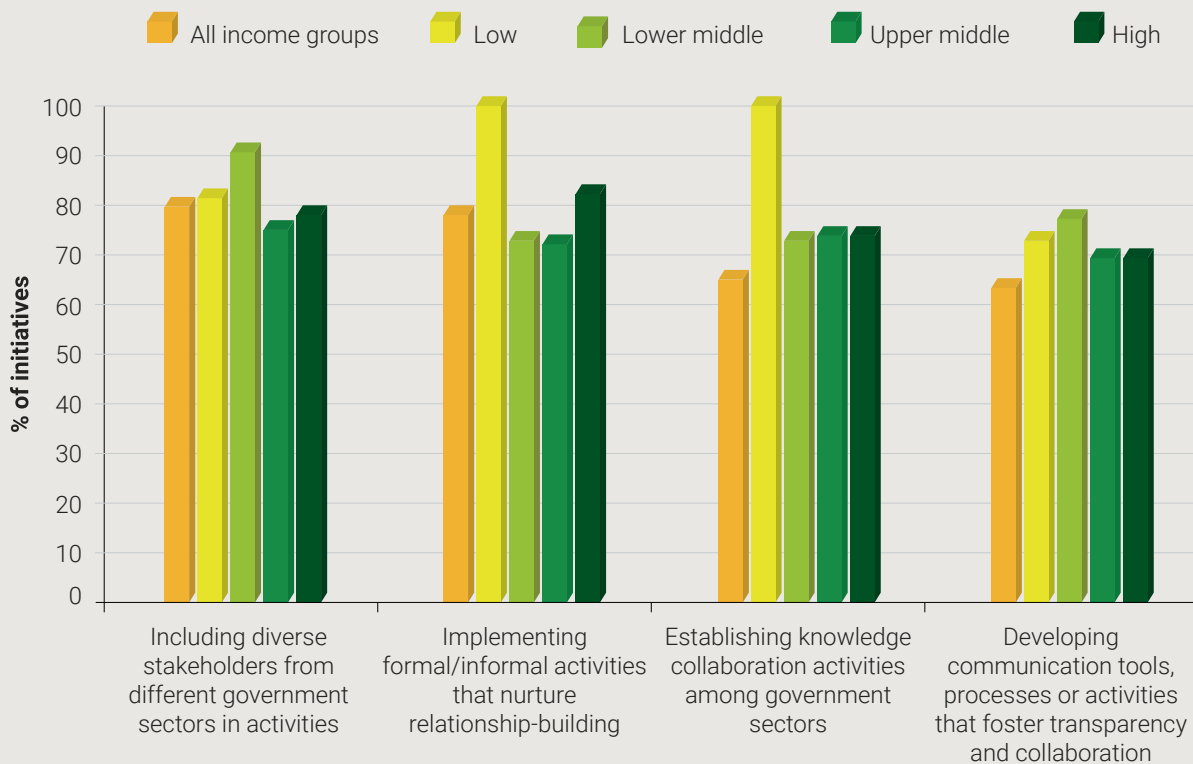


Ways of working

The ways of working are the behaviours, attitudes and practices necessary to operationalize multisectoral collaboration. Of the four multisectoral actions shown in Figure 5, including diverse stakeholders from different government sectors was the most used action across all country income groups; used by 80% of the reported initiatives overall. This was particularly true for lower middle-income countries, where this action was reported in 91% of the initiatives.

In low-income countries, two actions – formal/informal activities that nurture relationship-building and establishing knowledge collaboration activities among government sectors – were used in all the reported initiatives (100%). In contrast, in upper middle-income countries, only 48% of the initiatives used the multisectoral action on establishing knowledge collaboration in government sectors.

Figure 5. Multisectoral actions reported for pillar 3 (ways of working), by country income group



Resources and capability

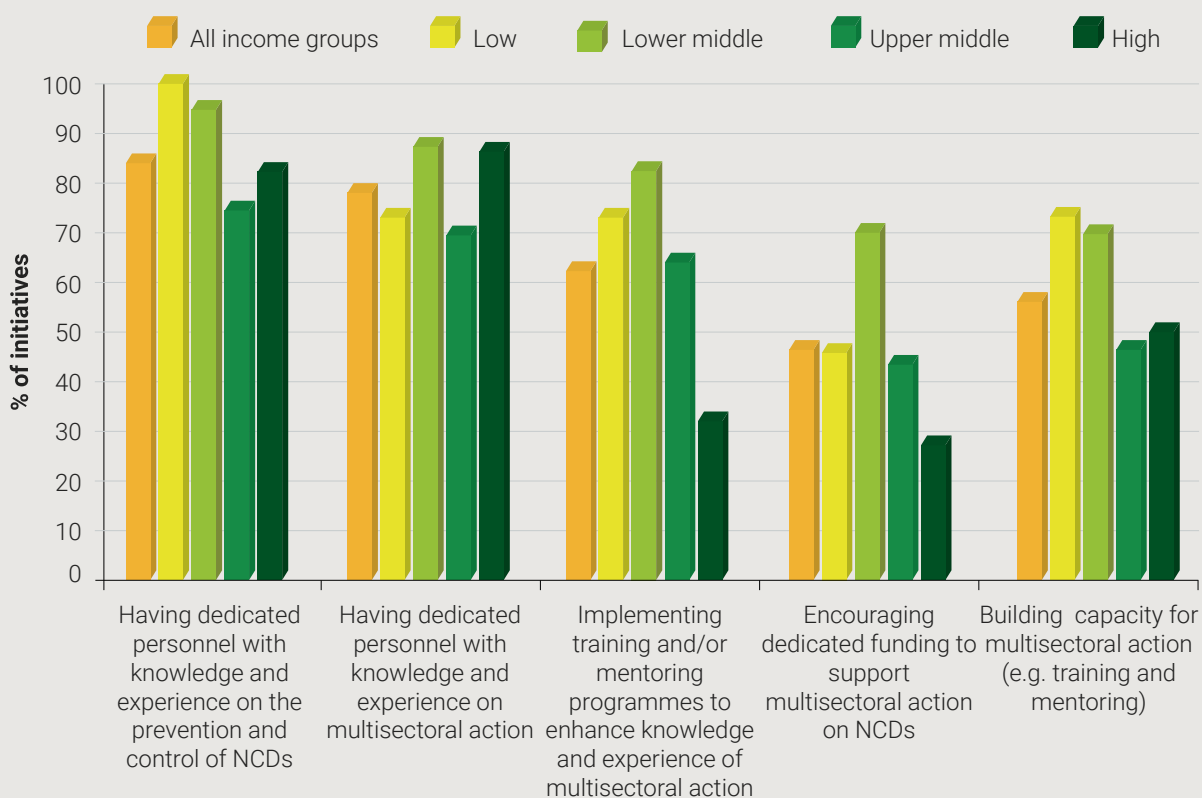
Implementing multisectoral actions requires appropriate and dedicated personnel with appropriate skills and knowledge, as well as financial resources to support the development and implementation of multisectoral collaboration, including sustaining commitment and accountability for co-production.

As shown in Figure 6, the most reported action across all country income groups was having dedicated personnel with knowledge and experience on the prevention and control of NCDs; reported in 84% of the initiatives overall. In particular, 100% of the initiatives in low-income

countries and 96% in lower middle-income countries reported the use of this multisectoral action.

Having dedicated personnel with knowledge and experience on multisectoral activities was reported in 86% of the initiatives in high-income countries and in 87% in lower middle-income countries. The least reported action overall was encouraging dedicated funding to support multisectoral action and collaborative action on NCDs; used in 46% of initiatives overall. Implementing training and/or mentoring programmes to enhance knowledge and experience on multisectoral action was reported in only 32% the initiatives in high-income countries.

Figure 6. Multisectoral actions reported for pillar 4 (resources and capabilities), by country income group



Multisectoral actions within the four pillars in the WHO regions

Table 5 presents the distribution of multisectoral actions within the four pillars in the WHO regions. Networking with professionals through informal or formal meetings was the action most reported overall; used in 85% of all initiatives. The exception was in the South-East Asia Region, where only 20% of initiatives in this region reported using this action. In the European Region, implementation of three particular multisectoral actions were reported in all initiatives (100%) – establishing multisectoral

coordination mechanisms (governance and accountability); networking with professionals through informal or formal meetings (leadership at all levels); and implementing formal and/or informal activities that nurture relationship-building (ways of working).

The least used multisectoral action across all six WHO regions was identifying champions to promote multisectoral action across government sectors (used in 41% of initiatives overall), with the lowest level of implementation in the South-East Asia Region (used in 20% of the initiatives) and Region of the Americas (used in 27% of the initiatives). Box 2 summarizes the most and least used multisectoral actions overall.

Box 2

The five most and least reported multisectoral actions used

Most used

- Networking with professionals through informal or formal meetings (leadership at all levels)
- Having dedicated personnel with knowledge and experience on the prevention and control of NCDs (resources and capabilities)
- Establishing multisectoral coordination mechanisms or other formal structures (governance and accountability)
- Including diverse stakeholders from different government sectors in activities that promote the adoption of co-design and co-benefit approaches (ways of working)
- Implementing formal and/or informal activities that nurture relationship-building (ways of working)

Least used

- Identifying champions to promote multisectoral action across government sectors (leadership at all levels)
- Establishing incentives or recognition on the importance of multisectoral action (resources and capabilities)
- Setting standards for multisectoral action through shared goals and tools (governance and accountability)
- Encouraging dedicated funding to support multisectoral action on NCDs (ways of working)
- Ensuring accountability to the public through public reporting (ways of working)

Table 3. Government sectors involved in the multisectoral action initiatives

| Pillar of multisectoral action/ multisectoral actions | WHO region, % | | | | | | All regions (n = 95) |
|--|--------------------|----------------------|--|-------------------|--------------------------------|--------------------------------|-------------------------|
| | Africa (n = 20) | Americas (n = 30) | Eastern Medite- rranean (n = 20) | Europe (n = 9) | South- East Asia (n = 5) | Western Pacific (n = 11) | |
| Governance and accountability | | | | | | | |
| Seeking a mandate, endorsement or supportive legislation for multisectoral action | 90 | 43 | 90 | 67 | 20 | 73 | 67 |
| Establishing multisectoral coordination mechanisms | 90 | 67 | 95 | 100 | 40 | 82 | 81 |
| Utilizing existing cross-sectoral policies or plans to promote multisectoral action | 70 | 57 | 65 | 78 | 80 | 55 | 64 |
| Developing reporting structures and accountability measures | 40 | 37 | 75 | 78 | 40 | 73 | 54 |
| Ensuring accountability to the public through public reporting | 40 | 50 | 60 | 78 | 20 | 18 | 47 |
| Leadership at all levels | | | | | | | |
| Networking with professionals through informal or formal meetings | 95 | 80 | 90 | 100 | 20 | 91 | 85 |
| Identifying champions to promote multisectoral action across government sectors | 60 | 27 | 35 | 44 | 20 | 64 | 41 |
| Establishing incentives or recognition on the importance of multisectoral action | 40 | 33 | 50 | 67 | 20 | 55 | 43 |
| Setting standards for multisectoral action through shared goals and tools | 35 | 40 | 70 | 56 | 20 | 36 | 45 |
| Acknowledging the commitments of other sectors to encourage further action and collaboration | 55 | 57 | 80 | 67 | 80 | 73 | 65 |

| Pillar of multisectoral action/ multisectoral actions | WHO region, % | | | | | | All regions (n = 95) |
|--|--------------------|----------------------|--|-------------------|--------------------------------|--------------------------------|-------------------------|
| | Africa (n = 20) | Americas (n = 30) | Eastern Medite- rranean (n = 20) | Europe (n = 9) | South- East Asia (n = 5) | Western Pacific (n = 11) | |

Ways of working

| | | | | | | | |
|---|----|----|----|-----|----|----|----|
| Developing communication tools, processes or activities that foster transparency and collaboration | 80 | 43 | 70 | 78 | 80 | 55 | 63 |
| Implementing formal and/or informal activities that nurture relationship-building | 90 | 67 | 85 | 100 | 80 | 55 | 78 |
| Establishing knowledge collaboration activities among government sectors | 95 | 40 | 75 | 89 | 40 | 55 | 65 |
| Including diverse stakeholders from different government sectors in activities that promote the adoption of co-design and co-benefit approaches | 85 | 73 | 90 | 89 | 60 | 73 | 80 |

Resources and capability

| | | | | | | | |
|---|----|----|-----|----|----|----|----|
| Having dedicated personnel with knowledge and experience on the prevention and control of NCDs | 95 | 70 | 100 | 78 | 80 | 82 | 84 |
| Having dedicated personnel with knowledge and experience on multisectoral action | 75 | 77 | 85 | 89 | 60 | 73 | 78 |
| Implementing training and/or mentoring programmes to enhance knowledge and experience of multisectoral action | 80 | 53 | 65 | 56 | 60 | 55 | 62 |
| Encouraging dedicated funding to support multisectoral action on NCDs | 55 | 30 | 40 | 44 | 80 | 73 | 46 |
| Building capacity for multisectoral action, e.g. training and mentoring | 80 | 43 | 65 | 56 | 0 | 55 | 56 |

NCDs: noncommunicable diseases.



Discussion

National and subnational governments and Ministries of Health play a fundamental role in the development of well aligned, NCD-specific, sector-wide policies and programmes. This role includes strengthening government capacity to engage, support, and where appropriate, lead planning and coordinating activities for the implementation of coherent policy responses for the prevention and control of NCDs (20) and mental health conditions (18). This global mapping report provides an overview of actions implemented by governments to promote, establish and/or strengthen collaboration across multiple government sectors for the prevention and control of NCDs and mental health conditions.

Strategic action areas

The determinants of health, shown as the broad arch of the guiding framework (Figure 1), were barely mentioned in the submissions, despite the clear relationship between the social, economic, environmental and commercial determinants of health and health outcomes, including on the prevention and control of NCDs and mental health conditions (21). In that regard, two submissions are worth noting. The first is Canada's Intersectoral Action Fund initiative, which focuses on providing funding to build capacity in communities for intersectoral action on social determinants of health. The second is the experience of the municipality of Paipa in Colombia, where an integrated information system of public management was implemented to reduce poverty and inequities based on health in all policies and community participation approaches. The focus of the Colombian initiative was to counteract the centralized and hierarchical decision-making structures in government, which result in independent, vertical action by government sectors, without tackling the determinants of health and poverty that span many sectors.

Most submissions reported initiatives that addressed more than one NCD risk factor.

Unsurprisingly, **tobacco use** was the most commonly reported risk factor in the initiatives. With the widely embraced WHO Framework Convention on Tobacco Control (WHO FCTC) (22) and substantial evidence, including best practices on multisectoral action for tobacco control (23), the benefits of involving other sectors, such as agriculture, education, finance, justice, trade and communication, are now well established. Countries, including Brazil, Colombia, Ethiopia, Iraq, Kyrgyzstan, Mozambique, Netherlands (Kingdom of the), Philippines and Saudi Arabia, listed multiple sectors as partners in multisectoral action initiatives and gave good examples of multisectoral actions to support tobacco control measures. These actions included: national multisectoral commissions or mechanisms; tobacco tax policies; plain packaging; cessation services; bans on tobacco sales to minors; smoke-free prisons; and comprehensive approaches to smoke-free pregnancy, among others. The government of Saudi Arabia, for example, reported seven different tobacco control initiatives.

Physical inactivity was the second most reported NCD risk factor, although only a few countries – Colombia, Finland, Japan and Philippines – described specific experiences focusing mainly on physical activity. Colombia's Healthy Habits and Lifestyle Programme, led by the Ministry of Sports, engages with multiple government sectors, community agencies and the private sector to increase physical activity among the population, particularly among women. In the Philippines, several government sectors are engaged to create healthy environments and settings to address not only physical inactivity but also air pollution. Finland's Coordination Mechanism for Sports Policy, which includes representations from 11 ministries, aims to strengthen cooperation between different ministries to tackle the growing number of inactive people.

Unhealthy diet was the third most cited risk factor addressed by multisectoral action and was usually associated with obesity,

diabetes and cardiovascular diseases such as experiences from Brazil, Colombia, Japan, Kenya, Sri Lanka and Thailand. Sri Lanka reported comprehensive multisectoral action to tackle diabetes and cardiovascular diseases, which included diet-related policies such as warning labels on sugary drinks, banning of advertisements for alcoholic drinks at main sporting events and sugar taxes, among other policies. Japan's Strategic Initiative for a Healthy and Sustainable Food Environment, which is led by the Ministry of Health, Labour and Welfare, focuses on the reformulation of food products to reduce sodium intake in the population. This initiative involves collaboration with multiple government sectors, the food industry and academia. Brazil's 2021 *Proteja – Childhood Obesity Strategy* consolidates actions to prevent childhood obesity and promote healthier cities. The strategy's multisectoral approach includes actions by government sectors (for example, education, social welfare, agriculture, justice/security, trade/industry, urban planning, and recreation/sports, among others) and the city council to plan and implement initiatives that enable a favourable environment for children and their families to make healthier choices.

Harmful use of alcohol was often referred to in combination with other risk factors including tobacco use, unhealthy diet and physical inactivity and their associated NCDs (cardiovascular diseases, cancer, diabetes, chronic respiratory diseases) and mental health conditions. This was typically in relation to a broad approach to NCDs, often as part of the development or implementation of a national NCD strategy or action plan. Kenya's National Strategy for the Reduction of Harmful Use of Alcohol was the only initiative tackling primarily the harmful use of alcohol. The strategy recognizes the fundamental role of other sectors beyond health (such as education, women, children and youth, justice/security, and the office of the central government) in the development and implementation of policies and mechanisms to ensure coordination, multisectoral engagement and multisectoral action.

A number of initiatives reported in the submissions focused exclusively on one or more main NCDs or mental health conditions. Initiatives in Colombia, Iraq, Tajikistan and Saudi Arabia targeted cardiovascular diseases and engaged sectors such as: education; women, children and youth affairs; recreation/sports; and urban planning. In the Municipality of Paz de Rio in Colombia, the focus was the identification of cardiovascular risks in the population through a multisectoral approach. This initiative reportedly improved understanding in government sectors about their roles and the benefits of working collaboratively. Tajikistan reported an initiative to strengthen NCD service delivery through a basic benefit package. Based on previous experience of multisectoral mechanisms, the health ministry brought together other government sectors to support the implementation of the initiative. These sectors included economy/finance, communications, social welfare, social and economic development, legislature and the office of the central government.

Initiatives on **diabetes** also addressed cardiovascular diseases, such as experiences from Argentina, Armenia, Colombia, Thailand, Liberia, India (State of Assam), United Republic of Tanzania, Türkiye and the occupied Palestinian territory, including east Jerusalem. The municipality of Barranquilla in Colombia has taken a multisectoral approach to reducing diabetes in pregnant women. It has worked with several sectors such as communications, education, social and economic development, and women, children and youth affairs to support advocacy and communication campaigns, healthy environments and settings, and health workforce skills. The government of Assam in India has taken a multisectoral approach to tackle NCDs, including diabetes, which is led by the government in collaboration with national and international stakeholders. The initiative aims to strengthen NCD services and includes a state-wide school health programme to increase awareness of NCD risk factors among students and teachers. The initiative includes the use of mobile medical units to screen people for diabetes and hypertension

in hard-to-reach areas, and the training of primary health care professionals on clinical management of diabetes. In the municipality of Khon Kaen in Thailand, the government developed a plan including local authorities from different sectors to tackle the increase in new cases of hypertension and type 2 diabetes in the population.

Some initiatives reported in the submissions focused on **cancer**, including experiences from Burundi, Colombia, Ethiopia, Mozambique and Philippines. Although interventions were disease-oriented, they included multiple sectors such as economy/finance, agriculture, communications, employment/labour, and recreation/sports. In Burundi, for example, a multistakeholder association that includes several government sectors has helped increase awareness and knowledge of cancer and its social and economic impact. As a result, various sectors, such as the Ministry of Finance, have been included in discussions on policy development to support cancer-related interventions. Ethiopia's Combat Cervical Cancer initiative arose from recognition of the weak commitment to, and limited intersectoral collaboration on, cervical cancer prevention. The Ministry of Health worked with government and nongovernment representatives to improve screening and treatment.

Several initiatives on **mental health** from Burkina Faso, Chile, China, Colombia, Islamic Republic of Iran, Japan, Jordan and Kenya, outlined actions with multiple sectors (such as finance, education, employment, social welfare and justice) to develop, implement and/or advance policies, advocacy and human rights regarding mental health, and scale up good-quality mental health interventions and services for the population. For example, China's National Comprehensive Management Pilot Project for Mental Health established a cooperation mechanism that included national and city-level government to improve multisectoral collaboration. In Colombia, the Multisectoral Strategy for Mental Health, 2020 engaged 14 different government sectors to improve

understanding of mental health and coordination for more inclusive, results-oriented and efficient mental health services. Jordan's experience is part of the WHO Special Initiative for Mental Health (2019–2023) to accelerate and expand access to mental health care services globally. In Jordan, a multistakeholder committee was used to support the development of the National Mental Health and Substance Abuse Plan (2022–2026).

Areas for NCD and mental health interventions

Almost all the initiatives reported in the submissions indicated that at least two interventions from the guiding framework were implemented, the most commonly reported being: advocacy and communication campaigns; policies, legislation and economic measures; early detection of NCDs and mental health conditions; and healthy environments and settings. These interventions are particularly suited to multisectoral action, while others, such as rehabilitation, palliative and end-of-life care, and immunization are driven primarily by the health sector. Health workforce knowledge and skills, and access, affordability and quality of care, which are also health-driven, were reported in at least 62% of the initiatives submitted. Details on how multisectoral action is supporting such interventions were not asked for in the questionnaire and could be the focus of future enquiry.

National capacity for surveillance and research is a basic component of a comprehensive NCD strategy or implementation plan. It helps countries monitor and evaluate emerging patterns and trends in NCDs and supports governments to set priorities and develop targeted policies and programmes. Several submissions reported surveillance and research as one of the main interventions using multisectoral actions. The initiatives in Iraq and Oman, for example, included monitoring and

evaluation frameworks for NCD prevention and control and highlighted the use of multisectoral action, such as multisectoral committees to build a national, multisectoral surveillance system to ensure accountability, and raising policy-makers' awareness of the importance of tackling the NCD burden. When developed in a culture of collaboration, monitoring and surveillance systems can be an effective way to encourage multisectoral action and accountability across different government sectors.

Government sectors

Encouragingly, countries are recognizing the benefits of engaging with multiple sectors for enhanced NCD and mental health responses. Almost all initiatives in the submissions reported engagement with more than three government sectors. Unsurprisingly, initiatives related to the development of a strategy or plan for multisectoral action on NCDs reported the most engagement with other sectors, as collaboration with and commitment from different sectors is particularly important for such a strategy. In most initiatives reported in the submissions, the education sector was a partner, which suggests that community education for the prevention of the modifiable risk factors and NCD management, such as cancer screening or education of health practitioners, is widely used to tackle NCDs.

Canada, for example, has engaged with over 20 departments to develop the Quality-of-Life Framework, which aims to incorporate quality-of-life measurements into decision-making and budgeting across different government sectors. In Nigeria, recognizing that NCD prevention and control strategies lie partly in sectors outside the health sector, the Federal Ministry of Health engaged with more than 10 different ministries to develop the National Multisectoral Action Plan for the Prevention and Control of NCDs. The inclusion and commitment of these stakeholders ensured a strong plan with

strategies within and outside the health sector.

It is worth noting that the terms multisectoral and multistakeholder appear to be used interchangeably. The term **multisectoral** refers to the engagement with different government sectors which work together collaboratively. In relation to NCDs, it typically involves the health sector in partnership with sectors such as finance, agriculture, education and community services. The term **multistakeholder** refers to engagement with non-State actors who come together to participate in dialogue, consultation, decision-making (when appropriated) and implementation of joint actions to address an issue, such the prevention and control of NCDs and mental health conditions. Involving multiple stakeholders does not necessarily mean actors beyond health. Several submissions described disease-focused interventions with stakeholders who appeared to be mainly from the health sector, often including health-focused nongovernmental organizations, including professional organizations, multidisciplinary workers and academics.

Multisectoral action pillars

Governance and accountability

Actions related to the governance and accountability pillar, which are crucial to enable multisectoral action, were consistently mentioned in the initiatives reported in the submissions. The most reported action in this pillar was establishing multisectoral coordination mechanisms, which was also widely reported in all six WHO regions. Similarly, the 2021 WHO NCD country capacity survey (7) found that 89 of 194 (46%) Member States of WHO reported an operational national multisectoral commission, agency or mechanism to oversee NCD engagement, policy coherence and accountability of sectors beyond health. In Tasmania, Australia, the Premier of Tasmania provides the authorizing environment for the



work of the Premier's Health and Wellbeing Advisory Council – established to provide advice on cross-sectoral and collaborative approaches to improving the health and well-being of Tasmanians. The Premier invites different ministers to participate in meetings and consider the connections between their areas of responsibility and health and well-being outcomes.

NCD strategies or plans that prioritize engagement with other sectors beyond health provide a strong mandate for multisectoral action and an opportunity to utilize existing policies and plans. In Nigeria, the National Multisectoral Action Plan for the Prevention and Control of NCDs is led by the Federal Ministry of Health and has three levels of coordination: National NCD Governing Council; National NCD Expert Technical Working Group; and an Expanded Technical Working Group. In the Islamic Republic of Iran, the country's National Action Plan for the Prevention and Control of Noncommunicable Diseases was endorsed by high-level government authorities in the country including the President, the Speaker of the Parliament, the Vice-President and many government ministers.

Finland's Advisory Board on Public Health is an example of an accountability mechanism to ensure not only the coordination and implementation of multisectoral actions, but also their monitoring. Members of Finland's Advisory Board come from various administrative branches and represent different ministries, regional state administrative agencies, towns and cities, organizations, universities, and research and development institutes. Their roles are to develop national health and social policy and monitor health and well-being and policy implementation to promote and strengthen well-being, health and safety. Establishing an accountability mechanism is essential in multisectoral collaboration, as without appropriate and consistent monitoring of multisectoral actions, there is a risk that good intentions fail to be delivered in practice.

Leadership at all levels

All 95 submissions included at least one action from the leadership pillar. As expected, the health sector has an important leadership role in addressing NCDs and mental health conditions because of the obvious policy and financial responsibilities of the health sector. On the other hand, applying leadership actions in the prevention of NCDs requires a different role for the health sector. This role includes enabling, facilitating and encouraging other sectors to lead, develop, adapt and/or implement policies and practices that contribute to improved public health.

The leadership-related action – networking with professionals and policy officers – was the most commonly reported action across the four pillars of multisectoral action and the WHO regions. Engaging with key people in other sectors is important to establish trust and develop a shared understanding and common purpose among partners (24). Ongoing networking, information-sharing and relationship-building contribute to building sustained multisectoral action (25).

Identifying champions to promote multisectoral action across government sectors was the least reported action in the leadership pillar and across the four pillars of multisectoral action. Champions can be of great value for multisectoral action, because: they bring relevant stakeholders to the policy table; they act as listeners and conveners; they can exert influence, particularly among decision- and policy-makers; and they communicate across sectors to foster governmental use of multisectoral action. In Liberia, the value of champions in progressing their Non-Communicable Diseases and Injuries Policy and Strategy was noted as supporting capacities to deliver results in a resource-limited setting. The government appointed coordinators to champion NCD and injury prevention with different stakeholders from within and outside the Ministry of Health. Mozambique's Cervical Cancer Elimination initiative chaired by the First

Lady increased advocacy and mobilization for better collaboration among government sectors on cervical cancer and its integration into universal health coverage. Brunei Darussalam engaged multisectoral non-health influencers and leaders to assist with coordination, resource requirements, and enhancement of whole-of-government awareness of the NCD burden, and the prevention and control of NCDs.

Ways of working

Ways of working is an important indication of having the right attitudes and practices for multisectoral collaboration. Including diverse stakeholders from different government sectors in activities that promote adoption of co-design and co-benefit approaches was among the top five most reported actions across the four pillars and the WHO regions. Submissions from Algeria, Brazil, Brunei Darussalam, China, Colombia, Ghana, Islamic Republic of Iran, Kenya, Mozambique, Tajikistan, Philippines and Saudi Arabia reported engagement with five to 10 government sectors.

Jordan's Partners for Non-Communicable Diseases Response to prevent and control NCDs among refugees in camps and host communities noted the value of planning and co-designing initiatives using multisectoral action. This approach helps to minimize the risk of overlapping activities with other sectors and has the benefit of increasing national ownership of the initiative and the likelihood of sustainability. Kenya's Non-Communicable Diseases Inter-Agency Coordinating Committee initiative also noted that recognizing expertise and capitalizing on other sector's co-benefits enables the committee to take ownership and participate in multisectoral actions.

In Japan's Healthy and Sustainable Food Environment initiative, the use of communication tools to foster transparency and collaboration helped strengthen the conviction that multiple government sectors and stakeholders are crucial to joint efforts on the prevention of NCDs as a single strategic national goal.

In the United Republic of Tanzania, the initiative Building the Full-Scale National Response towards Diabetes and other NCDs implemented capacity-building activities on NCD-related issues, including Health in all Policies, with multiple stakeholders, such as the Ministry of Education, the Prime Minister's Office, people living with NCDs, academia and sports institutions. These multistakeholder meetings have enabled the Ministry of Health to include the NCD agenda in the existing parliamentary committee on HIV/AIDS, TB and substance abuse to help advocate for prioritization of an NCD-related agenda within parliament.

Resources and capability

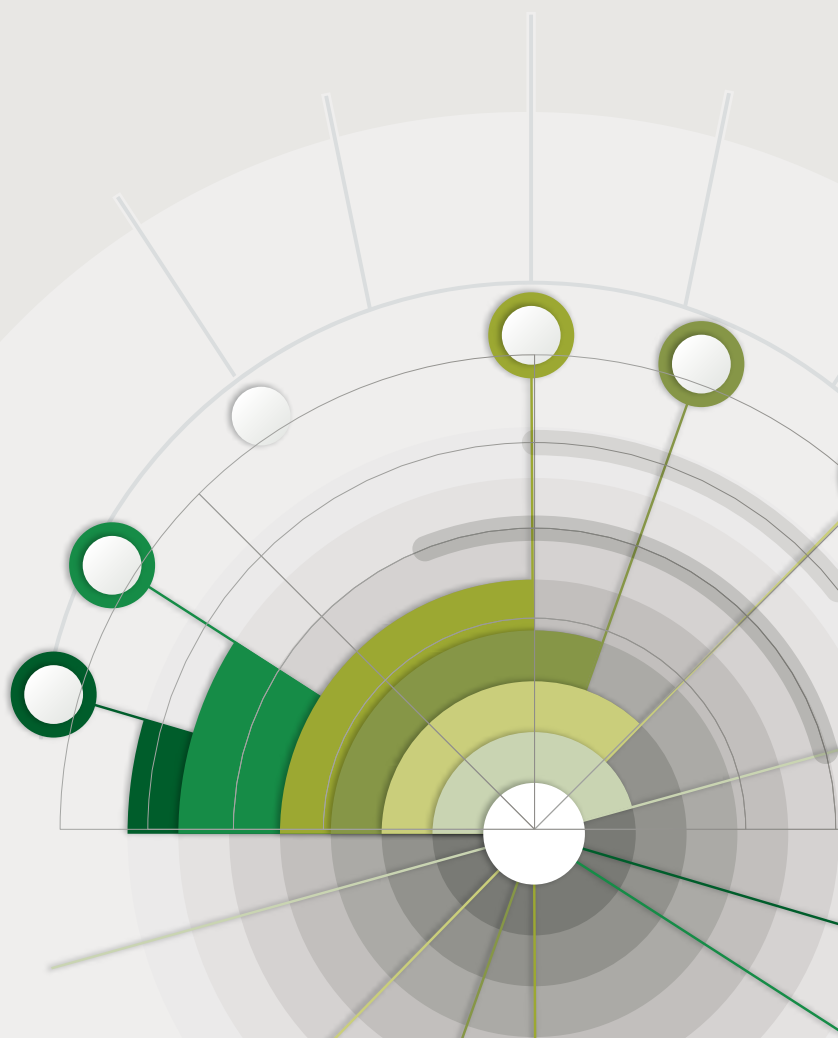
More than three quarters of the initiatives reported in the submissions indicated they had dedicated people with knowledge and experience of multisectoral action. This finding is encouraging as these dedicated resources are a prerequisite for well implemented and sustained multisectoral initiatives for NCD prevention and control, especially as capability, including negotiation and diplomacy skills, and experience with multisectoral action take time to develop.

It is interesting to note that implementing training and/or mentoring programmes to enhance knowledge and experience on multisectoral action was reported in very few initiatives in the submissions, including in high-income countries. It may be that multisectoral action is commonly covered in professional development and training in high-income countries, making specialized programmes less necessary. Canada's Intersectoral Action Fund was an exception, as it reported a future focus on elements such as strengthened partnerships, increased understanding of social determinants of health, and more tools, training and resources for intersectoral action. Canada's fund is also focusing specifically on providing dedicated funding to support multisectoral action and collaborative action. Colombia's Multisectoral

Implications of the findings

Strategy for Mental Health highlighted the importance of developing a common purpose and language when working with the 14 different sectors involved in improving the social inclusion of people at risk of and with mental health conditions. A common purpose helps enhance knowledge and improve the coordination and efficiencies of the other sectors involved. In Rwanda, building resources and capability was an integral part of the work of the country's Inter-Ministerial Anti Narcotic Drugs Committee in which 15 sectors are involved.

At the Seventy-Second World Health Assembly (WHA 72) in 2019, Member States reiterated their request to WHO's Director-General to "present, based on a review of international experiences, an analysis of successful approaches to multisectoral action for the prevention and control of noncommunicable diseases, including those that address the social, economic and environmental determinants of such diseases" (resolution WHA72(11)). This global mapping report of country-level experiences is part of WHO's response to this request. In addition, the Organization will develop case studies of selected country-level experiences from this mapping exercise, showcasing in more depth how multisectoral actions and approaches have been implemented with the aim of further promoting knowledge collaboration and capacity development, encouraging action on the ground.



Limitations

The online questionnaire was developed to collect the experiences on multisectoral action and provides self-reported, high-level insights on the implementation of multisectoral action for NCDs and mental health at a specific point in time. An exercise of this nature had not been conducted previously among WHO Member States and the results of this report provide important baseline information for enhancing future activities.

The analysis of this report contains experiences from 46 countries, areas and territories even though 144 countries reported having either an operational multisectoral national NCD policy, strategy or action plan, or an operational national multisectoral commission, agency, or mechanism (7). In addition, one country, Colombia, submitted 19 experiences, a fifth of all experiences, covering the national level (3 experiences), subnational level (3 experiences) and local level (13 experiences). Therefore, caution might be necessary when making generalizations of the findings. Nevertheless, Colombia's approach in disseminating the call for submissions to existing networks of cities/municipalities through the Ministry of Health and the PAHO/WHO country office provides a good example of mobilization of local governments in participating in global initiatives.

Despite the explanation provided in the guiding framework (Figure 1), and with no universal

language on multisectoral action, assessing the validity of the responses and the level and scope of understanding and implementation of multisectoral action in countries was challenging. For example, the questionnaire does not lend itself to understanding important details of applying multisectoral action, including: (i) how trusting cross-sectoral relationships are established and maintained; (ii) how differences are navigated and resolved; or (iii) what attitudes and skills are essential for successful multisectoral action. The interchangeable use of the terms multisectoral and multistakeholder in global health may also have led to misinterpretation of which partner was meant (multisectoral – government sectors; and multistakeholder – non-State actors).

A convenience sample was used and the invitation to submit experiences was channelled through WHO networks. Consequently, nearly all submissions came from the health sector.

Finally, among the submissions received, some referred to using multisectoral actions for the development of NCD plans or strategies, while others indicated supporting implementation of specific policies, health services and/or programmes. It was not possible or even appropriate to infer the success of these experiences.

Future directions

The guiding framework on multisectoral action for the prevention and control of NCDs and mental health conditions (Figure 1) was developed to support this global mapping process and the development of the upcoming case studies. Even though the development of the framework was based on extensive experience of the health in all policies approach, the framework requires further adaptation and validation, and alignment with the WHO toolkit for developing a multisectoral action plan for NCDs (8) to strengthen its application in countries.

Research and monitoring, knowledge-sharing, and capacity development within and across countries are necessary for the successful application of multisectoral actions for the prevention and control of NCDs and mental health conditions. Implementation research may provide further guidance to help increase understanding of the concepts embedded in the pillars of multisectoral action and their application, including challenges and opportunities in using multisectoral action. Such knowledge will help foster replication of multisectoral action in different countries and settings.

Establishing networks and mechanisms can facilitate knowledge collaboration and offer opportunities to share examples of success, problem-solving and expertise. Countries are increasingly requesting practical guidance (“how to”) on implementing multisectoral actions in the context of prevention and control of NCDs and mental health conditions. Training programmes,

mentoring, webinars and other mechanisms can link decision-makers, researchers and practitioners across the world.

WHO periodically conducts an assessment of national capacities for the prevention and control NCDs through, for example, the NCD country capacity survey, which captures some aspects of multisectoral collaboration (7). Opportunities to expand the assessment of multisectoral collaboration through the NCD country capacity survey with the lessons learnt from this global mapping exercise would allow better understanding and monitoring of the implementation of multisectoral actions to advance NCD prevention and control.

WHO recognizes the importance of knowledge sharing and will continue to collect country-level experiences in implementing multisectoral action for NCDs, particularly those targeting the least reported multisectoral actions (Box 2). This effort will contribute to identifying and compiling best practices and lessons learnt and will advance the development of policies and guidance on multisectoral action.

Additional insights include the importance of continuing to build essential capacity in multisectoral action for the prevention and control of NCD and mental health conditions including through the following actions.

- Work towards increased understanding and use of a common language on the concepts of multisectoral action and multistakeholder action.

Conclusions

- Support countries in continuing to establish governance mechanisms for implementation of multisectoral actions through shared goals, monitoring systems, reporting structures and accountability measures to the public.
- Develop guidance and tools for enhanced capacity to implement and monitor multisectoral actions and outcomes for the prevention and control of NCD and mental health conditions.
- Foster champions of multisectoral action in NCD and mental health responses and build and support leaders and policy makers with expertise in multisectoral action to promote this approach across government sectors.
- Establish incentives for, and recognition of, successful implementation of multisectoral action and acknowledgment of the commitments of other sectors to encourage cooperation and collaboration.
- Build evidence and support knowledge collaboration among government sectors through exchange of information, knowledge and best practices on multisectoral action for prevention and control of NCDs and mental health conditions, and ways of achieving positive outcomes for all sectors involved and NCD prevention and control.

WHO Member States are seeking to increase their understanding of the application of successful approaches to multisectoral action for the prevention and control of NCDs and mental health conditions, including those that address the determinants of such diseases.

Policy-making and implementation are essential components of the NCD and mental health responses, and require ministries of health and other health authorities to connect with other sectors. Developing policies with multiple sectors necessitates collaboration, which takes time, and the right combination of attitude, expertise and experience, as well as investment. Technical expertise related to health is important, but it is insufficient for the successful implementation of multisectoral action.

Further capacity development, including research and monitoring, advocacy, and knowledge-sharing is needed to strengthen country capacity and capability for multisectoral action for the prevention and control of NCDs and mental health conditions.

This report presents an overview of the implementation of multisectoral action in 46 countries, areas and territories that submitted their experiences through the WHO call for submissions. The analysis described in this report will be enhanced by the more in-depth information gained from the case studies referred to earlier, which will be published in a separate report.

References

1. Lin V, Kickbusch I, Baer B. Introduction. In: Government of South Australia, World Health Organization, editor. Progressing the sustainable development goals through health in all policies: case studies from around the world. Adelaide: Government of South Australia; 2017 (<https://www.who.int/publications/m/item/progressing-the-sustainable-development-goals-through-health-in-all-policies>, accessed 12 February 2023).
2. Tangcharoensathien V, Srisookwatana O, Pinprateep P, Posayanonda T, Patcharanarumol W. Multisectoral actions for health: challenges and opportunities in complex policy environments. *Int J Health Policy Manag.* 2017;6(7):359–63. doi: <https://doi.org/10.15171/ijhpm.2017.61>
3. Resolution 73/2. Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases. New York: United Nations; 2018 (<https://digitallibrary.un.org/record/1648984?ln=en>, accessed 15 November 2021).
4. Global action plan for the prevention and control of NCDs 2013–2030. Geneva: World Health Organization; 2013 (<https://apps.who.int/iris/handle/10665/94384>, accessed 15 November 2021).
5. Political declaration of the third high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases. Report by the Director-General. Geneva: World Health Organization; 2022 (https://apps.who.int/gb/ebwha/pdf_files/EB150/B150_7-en.pdf, accessed 24 February 2023).
6. Multisectoral and intersectoral action for improved health and wellbeing for all: mapping of the WHO European region. Copenhagen: WHO Regional Office for Europe; 2018 (https://www.euro.who.int/_data/assets/pdf_file/0005/371435/multisectoral-report-h1720-eng.pdf, accessed 12 February 2023).
7. Assessing national capacity for the prevention and control of noncommunicable diseases: report of the 2021 global survey. Geneva: World Health Organization; 2023.
8. Toolkit for developing a multisectoral action plan for noncommunicable diseases: overview. Geneva: World Health Organization; 2022 (<https://apps.who.int/iris/handle/10665/353163>, accessed 5 April 2023).
9. Working together for equity and healthier populations: sustainable multisectoral collaboration based on Health in All Policies approaches. Geneva: World Health Organization; 2023.
10. Goals. 3. Ensure healthy lives and promote well-being for all at all ages. Targets and indicators [internet]. New York: United Nations; 2015 (<https://sdgs.un.org/goals/goal3>, accessed 1 March 2023).
11. The WHO special initiative for mental health (2019–2023): universal health coverage for mental health. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/bitstream/handle/10665/310981/WHO-MSD-19.1-eng.pdf?sequence=1&isAllowed=y>, accessed 13 February 2022).
12. Adelaide statement II on health in all policies: implementing the Sustainable Development Agenda through good governance for health and well-being: building on the experience of health in all policies. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/331585>, accessed 18 December 2021).
13. Nothing for us without us. Opportunities for meaningful engagement of people living with NCDs: meeting report. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/340737>, accessed 21 February 2022).

14. Universal declaration of human rights. New York: United Nations; 1948 (<https://www.un.org/en/about-us/universal-declaration-of-human-rights>, accessed 18 December 2021).
15. WHO collaborating centre for advancing health in all policies [website]. Adelaide: SA Health; 2022 (<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/about+sa+health/health+in+all+policies/who+collaborating+centre+for+advancing+health+in+all+policies>, accessed 18 December 2022).
16. Health impact assessment (HIA) tools and methods [website]. Geneva: World Health Organization; 2022 (<https://www.who.int/tools/health-impact-assessments>, accessed 18 December 2021).
17. Delany T, Harris P, Williams C, Harris E, Baum F, Lawless A, et al. Health impact assessment in New South Wales & health in all policies in South Australia: differences, similarities and connections. BMC Public Health. 2014;14:699. doi: <https://doi.org/10.1186/1471-2458-14-699>
18. WHO Special initiative for mental health [website]. Geneva: World Health Organization; 2019 (<https://www.who.int/initiatives/who-special-initiative-for-mental-health>, accessed 13 February 2022).
19. World Bank country and lending groups [internet]. Washington, DC: World Bank; 2019 (<https://datahelpdesk.worldbank.org/knowledgebase/articles/906519>, accessed 13 February 2023).
20. WHO global meeting to accelerate progress on SDG target 3.4 on noncommunicable diseases and mental health, 9–12 December 2019, Muscat, Oman: meeting report. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/334384>, accessed 15 November 2021).
21. Commission on the Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization; 2008 (<https://apps.who.int/iris/handle/10665/310981>, accessed 12 February 2023).
22. WHO Framework Convention on Tobacco Control [website]. Geneva: World Health Organization (<https://fctc.who.int>, accessed 18 December 2022).
23. MPOWER [website]. Geneva: World Health Organization (<https://www.who.int/initiatives/mpower>, accessed 30 November 2022).
24. Williams C, Galiki C. Health in all policies in South Australia: lessons from 10 years of practice. In: Government of South Australia, World Health Organization, editors. Progressing the sustainable development goals through health in all policies: case studies from around the world. Adelaide: Government of South Australia; 2017 (<https://www.who.int/publications/m/item/progressing-the-sustainable-development-goals-through-health-in-all-policies>, 12 February 2023).
25. Government of South Australia and Global Network for Health in All Policies. The global status report on Health in All Policies. Adelaide: Government of South Australia; 2019 (<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/about+sa+health/health+in+all+policies/sustainable+development+goals/global+status+report+on+health+in+all+policies>, accessed 6 December 2022).

Annex 1

Distribution of multisectoral actions reported for each pillar, by country income group

| Pillar of multisectoral action/ multisectoral actions | Income group | | | | |
|--|-----------------|------------------------------|------------------------------|------------------|------------------------|
| | Low (n = 11) | Lower- middle (n = 23) | Upper- middle (n = 39) | High (n = 22) | All groups (n = 95) |
| Governance and accountability | | | | | |
| Seeking a mandate, endorsement, or supportive legislation for multisectoral action | 91 | 87 | 49 | 68 | 67 |
| Establishing multisectoral coordination mechanisms | 82 | 91 | 69 | 91 | 81 |
| Utilizing existing cross-sectoral policies or plans to promote multisectoral action | 73 | 61 | 59 | 73 | 64 |
| Developing reporting structures and accountability measures | 36 | 65 | 44 | 68 | 54 |
| Ensuring accountability to the public through public reporting | 46 | 39 | 41 | 68 | 47 |
| Others ^a | 0 | 0 | 5 | 5 | 3 |
| Leadership at all levels | | | | | |
| Networking with professionals through informal and/or formal meetings | 91 | 96 | 77 | 86 | 85 |
| Identifying champions to promote multisectoral action across government sectors | 73 | 61 | 21 | 41 | 41 |
| Establishing incentives or recognition of the importance of multisectoral action | 27 | 52 | 33 | 59 | 43 |
| Setting standards for multisectoral action through shared goals and tools | 36 | 48 | 39 | 59 | 45 |
| Acknowledging the commitments of other sectors to encourage further action and collaboration | 36 | 74 | 54 | 91 | 65 |
| Others ^b | 0 | 4 | 8 | 5 | 5 |

Ways of working

| | | | | | |
|---|-----|----|----|----|----|
| Developing communication tools, processes or activities to foster transparency and collaboration | 73 | 77 | 50 | 70 | 63 |
| Implementing formal and/or informal activities that nurture relationship-building | 100 | 73 | 73 | 83 | 78 |
| Establishing knowledge collaboration activities among government sectors | 100 | 73 | 48 | 74 | 65 |
| Including diverse stakeholders from different government sectors in activities that promote adoption of co-design and co-benefit approaches | 82 | 91 | 75 | 78 | 80 |
| Others ^c | 0 | 5 | 3 | 4 | 3 |

Resources and capability

| | | | | | |
|---|-----|----|----|----|----|
| Having dedicated personnel with knowledge and experience on the prevention and control of NCDs | 100 | 96 | 74 | 82 | 84 |
| Having dedicated personnel with knowledge and experience on multisectoral activities | 73 | 87 | 69 | 86 | 78 |
| Implementing training and/or mentoring programmes to enhance knowledge and experience of multisectoral action | 73 | 83 | 64 | 32 | 62 |
| Encouraging dedicated funding to support multisectoral action on NCDs | 46 | 70 | 44 | 27 | 46 |
| Building capacity for multisectoral action, e.g. training and mentoring | 73 | 70 | 46 | 50 | 56 |
| Others ^d | 0 | 0 | 0 | 14 | 3 |

NCD: noncommunicable disease.

^a Joint publication of results.

^b Awareness-raising and capacity-building among community leaders on health promotion; development of documents outlining expected roles and activities by different sectors.

^c Establishing knowledge collaboration activities among different sectors, sharing decision-making, and identifying prominent authorities within communities and collaborating with them to deliver NCD prevention and control activities led by the community.

^d Sharing experiences with regional health organizations, encouraging dedicated funding to support multisectoral action and collaborative action on social determinants of health, and building capacity of individuals and families to improve their health.



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