Health Equity Through Intersectoral Action: An Analysis of 18 Country Case Studies

Contributions

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Executive Summary

The vision of the Commission on Social Determinants of Health, launched by the World Health Organization (2005-2008), is “a world in which all people have the freedom to lead lives they have reason to value”. The complexities of the social, political, economic and environmental factors that influence health and inequalities in health, and the fact that most of these determinants lie outside of the exclusive jurisdiction of the health sector, requires the health sector to act in collaboration with other sectors of government and society in order to more effectively address those factors that influence health and well-being. Recognition of the intersectoral dimensions of the determinants of health has stimulated international efforts on systematic learning about how the action of different sectors can positively influence health and health equity.

The World Health Organization (WHO) and the Public Health Agency of Canada (PHAC) have supported the development of this collaborative work by jointly commissioning a set of 18 case studies from high, middle, and low income countries. The case studies outline diverse experiences of action across sectors with positive impacts for health and health equity. This paper, part of a joint multi-phase initiative of PHAC and the Secretariat to the WHO Commission on Social Determinants of Health, provides an analysis of key learnings from those 18 case studies.

The case studies analyzed here represent a broad array of initiatives that ranged from relatively small-scale programs that used a community development approach with a marginalized group in one city, to broad, policy-focused initiatives from national governments. Socio-political, economic and cultural contexts are important in each of the case studies reviewed, creating the landscape within which intersectoral action was initiated and carried out. The plethora of approaches reflects the different contexts in which initiatives arose, the specific priorities that they addressed and the resources that were made available to them. Analysis of these case studies suggests a number of key themes, observations and learnings for intersectoral action for health and health equity:

- **The goals of intersectoral action vary.** Not all case studies defined the issue as one of inequities in health among population groups. Instead, some conceptualized their goal as the improvement of health among a particular disadvantaged group or population. In some cases, the goal was not necessarily to improve health per se, but instead to have a direct impact on one or more of the determinants of health. How the issue was framed had an impact on the strategies implemented, the partners invited to the table, and the ways in which outcomes were defined. Framing complex health issues broadly (and, in some cases, as a social indicator rather than a health indicator) allows people from all sectors to more easily define their roles and engage in working toward solutions.
- **Intersectoral action looks different at different levels of decision-making.** Initiatives were planned and implemented at national, regional and local levels. The complexity of government structure had a tendency to affect the level of response. National-level ‘whole-of-government’ approaches appear easier in government structures where the division of responsibilities surrounding health or key determinants of health is relatively linear. However, in more complex policy environments, where those responsibilities are shared or less clear, regulations that have an impact on the determinants of health can be contradictory from department to department, or can address different territorial entities, making the implementation of intersectoral action at the national level more challenging.

  Whole-of-government approaches that originate at the national level may be limited in their capacity to influence social determinants of health if such initiatives are not supported by comprehensive, ground-up initiatives at local levels. This local level work, that often facilitates active public participation in community planning and program development, appears vital to addressing health inequities. Ideally, such initiatives are supported by a funding mechanism

and accountability structure that allow the initiative to ebb and flow as necessary, based on the changing needs of the community.

In the 18 case studies reviewed here, true cooperation in planning, implementation and evaluation was facilitated when it took place at several levels simultaneously, especially if the work at each of those levels was integrated through policy or legislation.

- **Building a strong case for intersectoral action is vital.**
Key to effective intersectoral action with engaged and committed participants is a shared recognition that intersectoral action is a good way to address a particular problem, which may or may not be identified as health inequity. Throughout the case studies, it was clear that a strong rationale for an intersectoral approach was absolutely necessary to get activities off the ground. Various parties that were initiating or leading intersectoral action built the case for intersectoral action by:
    - Building on public concern for the health and well-being of a disadvantaged group;
    - Using political champions to advocate for intersectoral action;
    - Framing of the issue in a way that all sectors could relate to;
    - Building on international leadership;
    - Creating a platform for researchers;
    - Building on concerns about the need to use scarce resources more efficiently;
    - Acknowledging the limitations of previous approaches, especially those that involved sectors working alone;
    - Taking advantage of political transitions to reassess roles and begin to work better together; and,
    - Building consensus via shared gatherings, such as conferences or community meetings.

  Representatives from a broad range of sectors were engaged by setting up a process in which decision-making was shared, and through the provision of specific funding dedicated to intersectoral work. In some cases, sectors have been mandated to work together through national or state legislation.

- **Building trust is key to developing and maintaining intersectoral action.** Building and nurturing trust among all partners has been a challenging and time-consuming task in many countries, but it has also ensured a strong foundation for effective working relationships. Those relationships can help to understand the contribution of individual mandates within the context of intersectoral work, so that service gaps and overlaps across the system can be identified. To build these important relationships some intersectoral action initiators found it essential to specify the type of collaboration expected from partners in the initiative, and to define what that collaboration looked like. Once a process of partnership development had been established, some found it useful to draw up formal agreements and Memorandums of Understanding between partners.

- **Models and structures to organize intersectoral action take a variety of forms.** Due to the complexity of government roles and responsibilities, and the traditional silos often operating between government departments, all the cases describing the implementation of 'whole-of-government' approaches developed a formal model to guide their intersectoral work. These models have helped to clearly demonstrate how action to reduce inequities cannot be implemented by one sector acting alone. Those cases where initiatives were strictly at the local or regional level tended to have a more flexible, 'organic' structure for intersectoral action that could respond to community needs and preferences with agility.

  Actors in the case studies analyzed here chose a wide variety of concrete ways to organize their work. A common structure was one in which inter-ministerial committees were formed.

In some cases, countries built an elaborate system of committees and other structures to solidify intersectoral action. This helped to lend credibility to the health issue and to a cooperative approach to addressing health inequities, but such an approach did have the potential to create confusion and add unnecessary bureaucracy. While it seems that, at both the local and national levels, bringing people from diverse sectors together to discuss issues and come up with common goals is necessary, it does not appear to be sufficient to foster effective intersectoral action.

- **Monitoring the processes and outcomes of intersectoral work is challenging.** The relative dearth of systematic evaluations of intersectoral action reflected a lack of standardized measurement tools and methods. At the same time, almost all of the case studies reported some positive outcomes that were thought to be attributable to intersectoral collaboration. It is premature to draw conclusions about the overall effectiveness of intersectoral action for health and health equity from the research presented here, as many initiatives have been implemented relatively recently and there has not been sufficient time for effects to accrue and be evaluated.
- **The role of the health sector needs to be flexible.** To what extent the health sector can (or should) take the lead role in planning and implementation of intersectoral work for health equity depends in large part on the issue being addressed. The following three scenarios were evident in the case studies analyzed:
  - When dealing with issues in which the health sector has the greatest degree of knowledge, experience and control over the strategies to improve health equity, it is reasonable for the health sector to take the lead role. This is the case in those initiatives that focus on improving access to the health care system or to other prevention-specific programs, including those associated with primary health care.
  - When the initiative focused on issues where the health sector has knowledge about effective measures to improve health equity, but does not control the arena or means to implement the measures, the health sector may take a lead role in promoting strategies, but ensure close cooperation and ownership of the initiative with other sectors.
  - When the initiative is attempting to directly address core social determinants of health (e.g. education, poverty) beyond those directly related to the health system, the primary role for the health sector is to be a policy partner in its development and implementation. In these circumstances, the health sector on its own neither controls the means to implement strategies nor has the greatest knowledge in how activities should be framed.

  The health sector's vision of health also affected the extent to which it could play a role in any of these scenarios. In general, where the vision of the health sector was to control disease or to modify individual's risky behaviour, it was not in a position to offer much leadership on intersectoral action on the determinants of health.

Conclusion

Health inequities develop from, and are maintained by, a complex set of factors. The breadth of the case-studies, across many countries, cultures and levels of development demonstrates the importance that is attached by many health sector providers and by the affected populations themselves to intersectoral action. From the slums of India and remote villages of Brazil and Iran to the capitals of Norway, Canada, England and Australia, governments at all levels are working towards the development of intersectoral action for health and health equity. Given the frequently more complicated administrative structure required to support intersectoral action, and the associated potential for resource requirements, it is vital that countries carefully assess (and continually reassess) their initiatives. These 18 case studies have helped to provide some clues to guide these efforts.

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1 Introduction

The vision of the Commission on Social Determinants of Health, launched by the World Health Organization (2005-2008), is "a world in which all people have the freedom to lead lives they have reason to value" (WHO, 2007). Implicit in the realization of this vision are improvements in a wide range of determinants of health and health equity, including control over decision making and social participation, through multiple strategies. The complexities of the social, political, economic and environmental factors that influence health and inequities in health, and the fact that most of these determinants lie outside of the exclusive jurisdiction of the health sector, necessitate working across sectors of government and society. Recognition of the intersectoral dimensions of the determinants of health has stimulated international efforts on systematic learning about how the action of different sectors can positively influence health and health equity. International experience in initiating, sustaining and evaluating the impact of intersectoral efforts for health in a variety of decision-making contexts has provided rich opportunities for learning.

The Secretariat to the WHO Commission and the Public Health Agency of Canada (PHAC) has supported those efforts by engaging in a multi-phase initiative to learn more about the use of intersectoral action for health and health equity as it is implemented internationally. One of the first phases of this work involved a literature review entitled *Crossing Sectors – Experiences in Intersectoral Action, Public Policy and Health* (PHAC, 2007). That review assessed what was currently known related to intersectoral action, what knowledge needed to be developed, and potential frameworks for moving those investigations forward. The literature review highlighted a number of key learnings from research and previously documented on-the-ground experiences in more than 15 countries, reflecting the effect of the broader context on issues for (and approaches to) intersectoral action, the wide range of health problems which intersectoral action can address, the resource intensiveness of effective intersectoral action, and the increasing difficulty of intersectoral action in more complex environments.

As another part of this joint initiative, WHO and PHAC jointly commissioned a set of 18 case studies from high, middle, and low income countries and from a mix of different social and political contexts. The case studies outline those countries' diverse experiences with the use of intersectoral action for health and health equity, and identify a wide variety of mechanisms and models that have been used to develop integrated, intersectoral initiatives for health. They were developed according to a common set of questions, which are grouped by theme, including the context for action, approaches taken, and the impact on health inequalities. Please see Appendix A for the complete Terms of Reference for the development of case studies on intersectoral action. The case studies, written in 2007, are presented in a narrative style, to emphasize <u>how</u> intersectoral action has been undertaken in those countries. Please see Appendix B for brief summaries of all 18 case studies. All case studies can be found in their entirety at: http://www.who.int/social_determinants/country_action/en/index.html

Following the completion of the case studies, an international meeting was held in conjunction with the June 2007 International Union for Health Promotion and Education (IUHPE) World Conference, held in Vancouver, BC, Canada. This dialogue was held so that those countries who submitted case studies could further share their experiences, to consider the implications of those experiences for future efforts, and to discuss next steps. A report (PHAC and WHO, 2007) was prepared that summarizes that Dialogue on Intersectoral Action.

This paper provides an analysis of key learnings from those 18 case studies. Specifically, the objective of this report is to identify characteristics and common themes of intersectoral action to benefit health and health equity in jurisdictions with differing levels of resources and administrative frameworks. The mechanisms, processes, and tools used to support intersectoral action are briefly

summarized here. The focus of this analysis is on transferability of learnings and insights, rather than on an attempt to generalize from the case studies.

It is expected that this report will help guide future action to implement intersectoral approaches for reducing health inequities. While much can be learned from the efforts of the 18 case studies as described here, each jurisdiction will need to apply those learnings to their own context.

1.1 Key Definitions Used in This Analysis

The following definitions of key terms used throughout this paper are based on the work of the WHO Commission on Social Determinants of Health.

Equity is the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically, or geographically. Health inequities, therefore, involve more than inequality—-whether in health determinants or outcomes, or in access to the resources needed to improve and maintain health. Health inequities also emphasize a failure to avoid or overcome such inequality that infringes human rights norms or is otherwise unfair.

Intersectoral action

Throughout the planning and execution of this project, including during the Vancouver Dialogue of experts, much discussion took place over a "formal definition" of intersectoral action. The case studies that were commissioned and analyzed for this work include a wide variety of approaches taken by multiple sectors, either working explicitly together or in a synchronistic way (i.e. each working on determinants that affect health, but not necessarily working collaboratively). Case studies were not screened for how they define intersectoral action, and examples from across the range of activities that can be considered intersectoral can be identified in this analysis. In other words, case studies were not selected based on their conformity to the traditional definition of intersectoral action, namely actions with a common objective. Rather, case studies were identified as intersectoral by the existence/nature of their collaborative or synchronistic efforts.

Toward one end of the spectrum examples can be identified of initiatives involving multiple jurisdictions who share information or coordinate activities, perhaps even through representative committees or other mechanisms, but who by and large remain operative within their respective sectors. An illustrative example of this is the experience in health improvement described in the Sri Lankan case study, where each sector simultaneously worked to improve a variety of conditions affecting health inequities while working independently, rather than as a coordinated, collective body. The authors of the Sri Lankan case study do acknowledge, however, the challenges with the lack of a consciously coordinated "programme of intersectoral action" that was geared to a common result. If that greater coordination of common goals existed, they said, the result could have been a more significant improvement in health outcomes.

Toward the other end of the same spectrum, other initiatives may be characterized by collaborative actions into which each sector inputs meaningful resources and expertise towards a shared outcome. For example, Cotacachi, a district within Ecuador, established an intersectoral health council (CIS) to coordinate and lead the collective work of a broad array of sectors (e.g. health, education, environment, labour, environmental sanitation, community organizations, etc.). The CIS offers a venue for dialogue and negotiation to design regional public policies. Annual work plans are prepared, with the members representing all sectors contributing financial, human, material and other resources. The common objective is to enhance health and well-being within that region.

Based on these and other observations from the analysis of these case studies, therefore, we understand “intersectoral action for health” to refer to actions undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector, on health or health equity outcomes or on the determinants of health or health equity.

This analysis and the definitions presented above do not pre-suppose the superiority of intersectoral action for health compared to single-sector action for health. The question of which approach is appropriate in a given set of circumstances is not a straightforward one. One key factor for consideration is the degree of control or influence over an intended target or outcome. If a single sector exercises complete or near-complete control over an issue, single-sectoral action may be appropriate. When multiple sectors share control over an issue, or when a sector wishes to influence a target over which it has less control, intersectoral action may be more appropriate. Other determining factors may include previous experience with bringing diverse sectors together, and other contextual supports examined in this analysis. However, when intersectoral action is deemed desirable and the context allows for it, the following analysis may be helpful in guiding that work.

2 Methodology

The analysis of the 18 case studies followed a qualitative approach using content analysis. Key themes present in each of the case studies were identified and organized in groups. A number of questions guided the analysis and theme identification. These questions, many of which were identified through the previous phases of this initiative, included:

a) What are some of the ways that each country’s socio-political, economic and decision-making contexts have an effect on how intersectoral efforts were conceptualized, planned, implemented and evaluated?

b) What kinds of models or frameworks for organizing intersectoral action exist, and what contextual elements make the emergence of different models more likely?;

c) What are examples of machinery, processes and tools that have been effective in implementing intersectoral action in the case studies?;

d) How has the demand for intersectoral action been built in the case studies?;

e) How have other sectors been motivated to buy-in to the notion of social determinants, and take action towards them?;

f) What has been the most useful role for the health sector?;

g) What benefit/detriment has the setting of targets demonstrated on successful intersectoral action?;

h) What attributes of intersectoral action are important for sustainability and scaling up?;

i) What are some particularly innovative practices that countries used to overcome challenges to intersectoral action for health?, and

j) What questions still remain? What further work still needs to be done to better understand those factors and processes that will best support intersectoral action?

To assist in the analysis, the research questions above were included in a template (see Appendix C). Members of the research team used the template to guide their reflection and analysis of each of the 18 case studies. The team then had a series of meetings to pull together common themes.

Please note that the focus of the analysis was on drawing out key learnings from the case studies, rather than drawing out a list of 'best practices'. It was acknowledged early on that it would not be possible to describe a one-size-fits-all model for intersectoral action for health, given that the social, economic and political contexts of this work vary considerably. Those contexts acted as 'lenses' for this analysis. It was also recognized that, despite the varying degrees of success reported for different intersectoral initiatives, it is possible to identify learnings from all case studies.

When analyzing the case studies, the research team was careful to observe not just what was said, but also what was not said explicitly. For instance, while the term 'health equity' was not often overtly defined, the ways in which that country's intersectoral initiative was approached and implemented said a lot about how the authors of the case study conceptualized 'health' and 'health equity'.

2.1 Limitations of This Analysis

The analysis of the 18 case studies had some important limitations. The most significant of those limitations is that the majority of case studies were written from one perspective only in most cases from the perspective of a representative of the health sector. The tone of the case studies was often positive (rather than critical), and we had no opportunity to determine what the opposing views, if any, might be. It would have been interesting to talk to other members of intersectoral committees to get their views of the initiatives in which they participated. In addition, each case study was of course written by a different author, and therefore all interviews were conducted by different researchers. There was therefore no standardization in how questions were asked, and while terms of reference were provided to guide the presentation of the information, in the end there was some variance in how information was presented.

This analysis mainly used the 18 case studies from which to draw conclusions. The primary literature was not routinely consulted during this analysis.

3 Key General Categories of Intersectoral Action for Health and the Importance of Context

The Kingdon model of policy making (Kingdon 1995) emphasises the importance of context in the creation of windows of opportunity. According to Kingdon "streams" of problems, policies (solutions) and politics (context) exist side by side. When they converge, "windows of opportunities" open for new policies or strategies to be developed. Such is the case with the development and implementation of intersectoral action for health in the case studies analyzed here.

The case studies analyzed describe a broad array of initiatives at local, regional/provincial and national levels and in a variety of political, social, and economic contexts. Context is important in each of the case studies reviewed, creating the landscape within which intersectoral actions were initiated and carried out. The success of various tools and/or methodologies as described in the case studies depends greatly on that context: a specific context might enable significant policy action that in a different context or at a different time might be unsuccessful. For example, Sri Lanka underwent a national transition after achieving independence which created a window of opportunity for simultaneous action by many sectors. Similarly, in Chile the transition from the dictatorship of Pinochet to a democratic government offered a time window of opportunity for action to improve health and society.

The case studies demonstrate that there is no single set of contextual characteristics that are absolutely necessary to support intersectoral action on the social determinants of health, although some characteristics appear to ease the development and implementation of strategies. The case studies demonstrate that the lack of some factors (such as national commitment to reduce health inequities, for example) could be compensated by the more vigorous application of others (like

strong public participation in intersectoral action at the local level, for example).

The types of initiatives described in the case studies fall naturally into two sets of categories. The first set describes the way in which the initiatives framed the health or social issue. Not all case studies defined the issue as one of inequities in health among population groups. Instead, some conceptualized their goal as the improvement of health among a particular disadvantaged group or population. In some cases, the goal was not necessarily to improve health per se, but instead to have a direct impact on one or more of the determinants of health. The other set of categories relates to the level of action described in the case studies. Initiatives were implemented at national, regional, and/or local levels.

The primary goals of intersectoral action and the level at which they are implemented serve as common threads throughout the rest of this analysis. Each of these two sets of categories is described below. Please note, however, that it is difficult to neatly place all case studies into categories; over time, the goal of the initiative may change, and the level of the intersectoral action as part of that initiative may also change over time. Examples are provided below when appropriate.

3.1 Framing of the Issue – Primary Goals of Intersectoral Action

The way that key goals are identified in the case studies determined what issues were addressed, what terms were used to describe the initiative, and what policy or program approaches were used. In general, the overall goals of the case studies fall into three main groupings:

- Intersectoral actions to improve health equity: A number of initiatives explicitly focus on reducing the gap in health status between specified groups. Inequity in this context includes gaps between income groups or social classes, or between mainstream and marginalized populations. Initiatives within this group involve programs that are targeted at a population of interest or use a combination of targeted and universal approaches. Examples of case studies that take this approach include:
  - Empowering sex trade workers in India to reduce HIV;
  - Enhanced education and training for Indigenous youth in Australia;
  - Housing and anti-poverty initiatives in England;
  - Integrated care units for adolescent health in El Salvador;
  - Improved mental health and addictions services for Indigenous youth in Australia;
  - Local agreements in England;
  - Belgium's multilevel approach to reducing disparities in life expectancy;
  - The three-year strategy developed by the European Union to strengthen strategies and actions to reduce health inequities;
  - New Zealand's whole-of-government approach to reducing health inequities, featuring the use a deprivation index; and,
  - The development of a national strategy to address the health gradient in Norway.
- Intersectoral action to enhance the health of the population: These are initiatives that explicitly identify the enhancement of health outcomes across the population as the primary objective. A reduction in the equity gap may or may not occur as a result of these initiatives but it was not the primary focus. In some cases these interventions were geographically focused, for example in rural and remote areas, but the focus is on the population within those areas rather than specific marginalized groups. Examples from the case studies include:
  - Infrastructure development (water, sewers) in Iran;
  - Development of health care clinics supported by broad-based citizen participation in Cuba and Brazil; and,
  - Primary health care reform in Malaysia.

- Intersectoral action to address a key determinant of health: A small number of case studies describe initiatives that are not explicitly directed at improving health outcomes. Instead, these initiatives aim to directly address a determinant of health. Health improvements may be noted as one of the potential benefits of these initiatives, but health benefits are not identified in the case studies as primary objectives. Examples from the case studies include:
  - Anti-poverty programs through economic plans in Malaysia;
  - Infrastructure development (water, sewers) in Iran;
  - The Family Violence Initiative in Canada;
  - The National Homelessness Initiative's Supporting Communities Partnership Initiative (SCPI) in Canada;
  - Social welfare initiatives focusing on inclusion and poverty in Chile;
  - Intersectoral efforts to improve living conditions in Columbia;
  - The development of an inclusive and transparent model for local development and participative democracy in Ecuador;
  - Transition to a more bottom-up model of governance and partnership in Morocco;
  - Uganda's intersectoral framework of district-level committees and sub-committees to decentralize decision making to the local level to assist those in need; and,
  - Sri Lanka's wide range of social welfare programs covering health, education, improvement of living conditions and reduction of poverty.

In some case studies, the focus of the intersectoral initiative is on health system redesign. These initiatives typically focus on primary and preventive care through either expanding the multi-disciplinary nature of services or expanding the role of public participation in establishing priorities and implementing measures. In Malaysia, for example, the development of the primary health care system includes a strong system of local participation in setting primary health care priorities and the development of preventive measures. In Brazil, public forums incorporating a variety of interests, approaches to health and sickness, and alternatives for formulating policies represent significant progress towards the acquisition of their constitutional right to health.

The use of a common model that views health and social issues from the 'lens' of the social determinants of health has been useful in some of the case studies in order to frame the issue and establish the impetus for intersectoral work. Such a framework can simplify complex issues in ways that people from all sectors can better understand and allow people from a variety of sectors to find their place in working toward solutions to complex problems. In some of the case studies, health equity was presented as a 'social indicator' that focuses less on health outcomes and more on social progress and the effectiveness of socio-economic policies. Other sectors outside of health can then see their contribution as one which improves the impact of their own policies. For instance, one of the key successes of the Canadian Family Violence Initiative has been the broad way in which the issue has been defined, allowing a broad range of sectors to come to the table and create an annual shared funding allocation to support the coordination of intersectoral activities.

In circumstances where health issues were defined or framed more narrowly (e.g. in terms of access to health care), the partners invited to the intersectoral table were more limited in their scope. In some cases, such as Malaysia, strongly focused primary care initiatives at the local level were accompanied by broader national strategies to address socio-economic and environmental issues.

3.2 Intersectoral Action at Different Levels of Decision-Making

Initiatives described in the case studies analyzed can also be categorized by the level at which action focused. Initiatives were planned and implemented at national, regional and local levels.

Two case studies (Uganda, Colombia) described special initiatives in which the capacity for intersectoral work was limited by crisis (e.g. violence, civil war). Initiatives of each type are described here.

3.2.1 Regional/Provincial and National Initiatives

The complexity of government structure is a critical contextual issue that has determined the type of response. This complexity is defined in terms of the number of levels of government as well as the distribution of jurisdictional responsibilities across the levels. The development of 'whole-of-government' approaches appears easier in government structures where the division of responsibilities surrounding health or key determinants of health is relatively straightforward. In at least one case (England) there has been substantial progress made on national issues such as housing and tax reform.

However, in more complex policy environments, where the responsibility for health or key determinants of health is less clear, regulations that have an impact on the determinants of health can be contradictory, or can address different territorial entities, making the implementation of intersectoral action at the national level more challenging. In Canada and Belgium, for example, different levels of government bear different responsibilities for health and social determinants such as education, labour and income assistance. In Canada, the division of responsibilities between provincial and municipal jurisdictions even differs between provinces. Mounting government-sponsored national initiatives can be difficult under these circumstances. One of the key barriers towards Belgium's implementation of a global comprehensive policy framework is that the responsibility for several social determinants of health is divided up among local, regional and national levels. Public health services, including prevention and health promotion, are the responsibility of the regional government, whereas the national government is responsible for treatment-oriented health care services. There has been no broad public debate in Belgium's parliament regarding health inequities, and intersectoral initiatives designed to reduce inequities have been chiefly focused at regional and local levels.

In a number of cases an enhanced commitment at a national level to addressing social determinants came from a political change that brought a new government to power with a broader or re-invigorated social justice agenda. For example, in Chile the election of a democratic government to replace the military ruler Pinochet led to a series of four successive social programs whose ambitious social welfare goals demanded joint action across government sectors and the web of national, regional and local social intervention networks. In Morocco, a new King and system of independence and alternating power has helped facilitate an economic process that has sought to be more responsive to social issues. In England, a newly elected Labour government was committed to a programme that extended social justice, addressed poverty and tackled health inequalities, including new ways of working together across government. Further exploration on the role of public opinion in increasing commitment to social determinants is worthwhile.

There is reason to speculate that whole-of-government approaches that originate at the national level are limited in their capacity to influence some key social determinants of health if such initiatives are not supported by comprehensive, ground-up initiatives that occur at the local levels. In England, for example, strong horizontal integration at the national level was accompanied by weaker vertical integration and inconsistent intersectoral action at the local level. This appeared to limit the impact of the overall strategy. Even in Cuba, which had a longstanding commitment to intersectoral action, local applications have had mixed success. Both of these cases suggest that insufficient involvement/consultation, or an outright lack of support, of local professionals and community members in the development of intersectoral action can limit the effectiveness of that

action, even when strong national support exists. Norway appears to be making a concerted effort to include local programs, but it is too soon to judge that initiative's outcome.

The disconnect between national and local levels may be attributable in part to their respective lenses and the difficulty inherent in creating quality spaces where participants at each level can see into and comprehend the other's context. For example, a national strategy to address inequity may not translate well to local, ground-level thinking. The ability of a national strategy or policy on health inequities to achieve its objectives may depend in large part on the degree to which local issues and experiences motivated or informed strategy formulation. A top-down approach to intersectoral action runs the risk of becoming or remaining a top-only approach to intersectoral action. In addition, when whole-of-government approaches have not yet taken root at local levels, they can be vulnerable to changes in government.

In some countries where society has traditionally valued equity, cross-government approaches to reduce health inequities through intersectoral work are described in the case studies. In Norway, England, Cuba and New Zealand, a 'whole-of-government' approach is being implemented, in which government departments at the highest levels have been directed to work together to improve population health.

3.2.2 Local-Level Initiatives

Some of the case studies describe initiatives at the local level that work to improve health of marginalized groups or geographic neighbourhoods. In some of these initiatives intersectoral teams work directly with marginalized groups using a community development approach. In India, for instance, the health and well-being of a group of sex workers is reported to have improved through an empowerment process. In other case studies, local community groups have been supported to complete a community assessment process, in which local people, local government, researchers and other policy makers gather together to set goals and come up with action plans to reduce inequities in that area. For example, in Ecuador the municipal government in the region of Cotacachi held a great assembly (in which over 700 persons participated) to identify the main lines for regional planning and development, beginning an intersectoral process. That process has been linked with improved health outcomes for residents in that region, including the absence of maternal or child deaths over a three year period and the eradication of illiteracy.

In all of these initiatives, active public participation is facilitated, and often the local community has been invited to define problems and develop strategies to approach inequities in that area. The role of municipal government is key to these initiatives. Local government often provides the initial invitation to begin an intersectoral approach, they take the first steps in bringing people to the table, and they provide a framework and other supports for intersectoral action to happen at the local level.

In cases where there was not strong national support for addressing social determinants for the purposes of eliminating health inequities, effective initiatives have still been developed at the local level, especially if there is strong local support and a willingness to build community empowerment. Local initiatives typically address specific issues or target groups (e.g. petrol sniffing among Indigenous youth in Australia, empowerment of adolescent girls in El Salvador). In these cases, the lack of a broad-based national strategy has not necessarily hampered the implementation of local strategies.

This local level work appears vital to effective action to reduce health inequities. As stated in the Belgium report, "as intersectoral action for health is a multilevel process, decentralization is needed to incorporate local context adequately in the strategies. Moreover, decentralisation increases

ownership by the local community" (Section 9). Most, but not all, case studies that focused on local-level initiatives incorporate a community development approach, in which members of the local community are invited to 'own' the planning and implementation of the chosen strategies. Advocacy, in which local communities try to influence policy at regional/provincial or national levels, is an important part of some of the work described in case studies. Such advocacy work, in which a 'push' comes from local levels 'up', represents a promising practice. Often multi-level initiatives to reduce health inequities are presented in a way that emphasizes how national level work can influence and support local level work – the case study presented in India illustrates that influence can (and should) operate in the other direction as well. Strong local level work has the potential to influence the development of intersectoral work at higher levels.

Bottom-up approaches as presented in some of the case studies demonstrate that they can be very successful, but that they require a great deal of time and energy. Ideally, such initiatives are supported by a funding mechanism and accountability structure that allow the initiative to ebb and flow as necessary, based on the changing needs of the community. As stated in the Ecuador case study, "citizen organization and participation do not arise on their own, it is necessary to support and guide them through mechanisms to provide logistical, technical, and financial support and continuous strengthening, and to link them to the real decision making power of local government" (p. 64).

Intersectoral strategies that require local implementation depend heavily on effective public participation and consumer empowerment. Various forms of public participation and consumer empowerment were used, but all require a willingness to share power with other government departments, civil society, business and citizens. Members of the public tend to bring a non-siloed perspective to issues, a perspective that supports intersectoral alternatives and challenges the intuitive siloed approaches more typical among governments.

3.2.3 Crisis-Oriented Initiatives

In some of the case studies studied here, violence and war have caused disruptions to those structures set up to facilitate intersectoral action, and any resources dedicated to that action have sometimes been diverted. Transportation, poor access to basic health, environmental and social services, and unreliable working conditions of intersectoral team members present significant challenges. Monitoring of health and other indicators is also difficult, making it almost impossible to determine if the intersectoral action implemented is effective. However, the emergency situations caused by instability can also serve as opportunities to draw attention to the plight of disadvantaged populations and garner support for concrete action, as indicated by the case study from Colombia:

> "*[e]mergencies are a clear call for action and reconstruction, but in contexts where the authority of the government is weakened, they are also opportunities for achieving greater control and self-sustainability in initiatives which, probably, would be unattainable with greater government presence*" (p.29).

Within these contexts, high-profile leadership by international non-profit and multi-lateral organizations provides much-needed support through funding and the coordination of activities.

3.2.4 Working Across and Between Sectors

In the 18 case studies reviewed here, intersectoral action and true cooperation in planning, implementation and evaluation was facilitated when it took place at several levels simultaneously, especially if the work at each of those levels was integrated through policy or legislation. This finding is consistent with the 2007 literature review (PHAC, 2007), which stated:

> "…*intersectoral action is strongest, and outcomes are best, when the collaboration is both*

vertical and horizontal … weaving these elements together yields a resilient and durable end product, and provides a shield against inaction, flagging interest, or disintegration. At the same time, because of the wide range of interests involved, additional effort and negotiation may be required to reach a shared understanding of goals, approaches, respective roles, and accountability for outcomes" (p. 7).

For example, in Colombia, the Intersectoral Action Plan for Development of a Strategy on Healthy Environments is a national public policy designed specifically to improve living conditions among the country's most vulnerable populations. The policy provides a framework with which to implement intersectoral action at the regional and local levels.

In some cases (Cuba for example), intersectoral action is described as the traditional way of 'doing business' in government. In other cases it has become a hallmark of a new approach to government. In Australia, for instance, a broad-based commitment to intersectoral action supports a social determinants of health-based initiative to address petrol sniffing among Indigenous youth despite the lack of an enunciated national commitment to addressing inequities in health. In this case, public and political support for addressing this problem has been mobilized through strong and consistent advocacy, including high profile media attention.

4 Key Mechanisms and Tools to Support Intersectoral Action for Health and Health Equity

The following describes learnings about the models, structures and concrete tools that have been used to plan, implement and monitor intersectoral initiatives, as described in the case studies. Again, concrete examples are given when appropriate.

4.1 Building the Case for Intersectoral Work

Key to effective intersectoral action with engaged and committed participants is a shared recognition that intersectoral action is a good way to address a particular problem, which may or may not be identified as health inequity. Throughout the case studies, it was clear that a strong rationale for an intersectoral approach was absolutely necessary to get activities off the ground. In many cases it took years to develop this rationale. The following are important components to 'building a case' for intersectoral action to improve health equity:

- **Building on public concern for the health and well-being of a disadvantaged group –** Many case studies referred to the need to build on public expectations for equity and social justice. Through the use of new research, consistently presented data highlighting inequalities, and especially clever use of the media, the public were informed that a population group within that country or region was suffering disproportionately. This increase in public concern led to an emergence of issues of health equity and the need for intersectoral action on the political agenda.

  In Belgium, demand for action was stimulated though published data in the media showing large socio-economic differences in healthy life expectancy. In Norway, a series of white papers and other publications over time pointed out the lack of, and need for, action to address health inequities, culminating in a new coalition government instituting a directorate to address those inequities.

- **Use of political champions to advocate for intersectoral action –** In many cases, senior government officials and politicians worked as champions, advocating for a cross-government approach and cross-sector approach at the community level. For example, the Canadian National Homelessness Initiative was led by a Minister of State who believed that homelessness required the engagement of all levels and departments of government and civil society. The issue of good quality homes for poorer communities, and its championing by the CEO of the Housing New Zealand Corporation, was also an important driver in the New

Zealand case.

- **Framing of the issue –** It is noted in some case studies that 'building the case' for an intersectoral approach for health was most effective when the issue was framed in a way that non-health sectors can understand and relate to (i.e. so that they could see their role in a concrete way). As mentioned above (Section 3.1), framing the issue in a way that emphasizes its social, economic and cultural aspects is often most helpful. As well, intersectoral action as a way to effectively reduce health inequities is presented as 'the way business is done today' in several of the case studies, citing the successes of other countries or regions as examples of effective and efficient practice.

Building on international leadership – High profile international sponsorship was useful in some of the case studies where there was not a high-level commitment by national governments. In both India and El Salvador, widespread apathy surrounding the issues of health among sex workers (India) and adolescent females (El Salvador) did not prevent the development of strong local intersectoral initiatives. In both cases, the active sponsorship by WHO, the United Nations and the Pan-American Health Organization (PAHO) were cited as key contributors to the initiatives' success. The international sponsorship brought attention to the issue within the country and created a desire to perform adequately on the international stage by a formerly ambivalent national government. International sponsorship by the WHO was also viewed as a supportive contextual factor in the Norway case study, where a strong history of support for social equity existed.

In other cases, international agreements played a significant role in facilitating a national role in intersectoral action. For instance, at the Fourth United Nations World Conference on Women held in Beijing in 1995, nations developed an ambitious proposal for action to achieve greater gender equity. Those countries that signed the Beijing agreement committed themselves to the effective integration of a gender perspective into their policy development and decision-making. In response to the Beijing agreement, the Government of Canada developed a national plan for gender equity, which included the use of gender-based analysis throughout all federal government departments and agencies.

Creating a platform for researchers – In some cases, leaders both within and outside government worked to create a platform or arena for researchers to present convincing data on the need to address health inequities and the potential success of an intersectoral approach. For instance, in Norway, the following scenario helped to effectively build the case:

> "*[w]hen researchers in 2002 were invited to a meeting to give advice to the government on action to tackle health inequalities, they were somehow reluctant to give clear advice. They called for more research and evidence. When the interdisciplinary expert group was set up in 2003 the Directorate for Health and Social Affairs experienced a rapid change in the dialogue with researchers. Given the researchers this arena for communication made them a strong voice into the policy process*" (p. 14).

Based on the Norwegian experience, it appears that researchers are most productively involved through ongoing participation in interdisciplinary decision-making bodies, rather than through one-time advisory sessions.

- **Building on concerns about the need to use scarce resources more efficiently –** Economic instability and a greater emphasis on fiscal accountability have been used in some countries to re-examine the use of existing resources, highlighting the siloed nature of current government work, and to build a case for developing frameworks to work cross-department and cross-sector. In some countries, this instability was linked to a crisis, like civil war or other episodes of violence.

- **Acknowledging the limitations of previous approaches -** The recognition of flaws or a lack

of success in current approaches can also help create demand for intersectoral approaches. Three initiatives described in the Canadian case study provide excellent examples. Healthy Child Manitoba arose from the recognition that existing service delivery models were not sufficiently meeting the needs of children, largely because they focused on a single disease or problem and failed to adequately consider the multiple influences on child well-being. Saskatchewan's Human Services Integration Forum similarly arose from a need to re-examine resource allocation, and meet an anticipated increasing demand based on: demographics, changing expectations from the population who expected involvement in planning and delivery, and previous intersectoral collaborations provincially. Finally, the Vancouver Agreement can also trace its roots to a growing sense of limited results or return creating public and political pressure to take a new approach.

Similarly, in Chile, the basis for intersectoral action was the recognition that diverse sectoral efforts were not reaching families or communities, producing little impact on social equity goals. An intersectoral approach was deemed necessary to coordinate and organize an adequate, opportune and relevant supply of benefits, goods and services to families at the lower end of the socio-economic spectrum with multidimensional problems.

- **Taking advantage of political transitions –** In some countries, champions of an intersectoral approach took advantage of government restructuring or the breakdown of government to encourage representatives from many sectors to reassess roles and begin to work better together. Out of a time of confusion came a greater emphasis on developing new partnerships. In Sri Lanka, for instance, multiple simultaneous initiatives began with a new fledgling government and society after independence. In Morocco a new King and system of alternating power ushered in an era of increasing responsiveness to social issues through a bottom-up governance model, resulting in intersectoral action to promote equity in health and integrated local development. A new Ecuadorian government with a platform of participative democracy (based on Indigenous principles) sponsored a citizen assembly to establish priorities for development, including the establishment of an intersectoral health council and the institutionalization of the participative process.
- **Building consensus via shared gatherings -** Consensus on the need for action can manifest as an outgrowth of conferences, platforms, and similar gatherings. In Iran, a series of Healthy Village conferences helped to clarify and crystallize the need for intersectoral collaboration as the preferred approach to address government strategy and priorities.

4.2 Engaging Other Sectors

The participation of a wide variety of sectors is, of course, key to effectively addressing health inequities, but facilitating that participation with groups of people and organizations who have little history with one another is challenging. Setting up a process in which power and decision-making was truly shared among a variety of sectors and organizations went a long way to attract and keep a variety of players at the table. For instance, intersectoral action was facilitated in Canada's Aboriginal Self-Government Agreement process by (1) the tri-level nature (federal, provincial, band) of the negotiation process, (2) the nature and scope of issues for negotiation which spanned multiple government departments, and (3) a need to collectively and definitively resolve Aboriginal issues to lessen the likelihood of any negative economic and political consequences.

In other cases, the government has forced sectors to come together through national or provincial/state legislation. In England, the Treasury oversees intersectoral action through its mandatory cross-government approach. The Canadian province of Quebec's Public Health Law requires all ministries and agencies to consult the Ministry of Health and Social Services when they are formulating laws or regulations which could have an impact on health, facilitated through an intra-governmental health impact assessment process.

The government of the district of Catacahi, in Ecuador, has been able to work quite closely with a number of community partners through the provision of specific funding set aside in each region to support intersectoral work. The authors of the Ecuadorian case study emphasized the need to support and guide representatives of all sectors (including community members) by providing logistical, technical, and financial support and continuous strengthening, and to link them to the real decision-making power of local government. In the Iranian case study, those supports included training in how to 'do' intersectoral action. The authors of that report found that such training increased the comfort and skill level of those partners involved in the initiative.

Interestingly, in the Indian case study, one sector (the local police) was involved in only a limited way in the process, given their traditionally difficult relationship with the key participants of the initiative (sex trade workers and their allies). The local police did not proactively support the initiative but agreed not to oppose its activities and to decrease their harassment of sex trade workers. The Indian experience suggests that opponents who cannot be persuaded to join the collaboration might at least be persuaded to remain neutral.

4.3 The Role of Civil Society, Multi-laterals and Public Participation

Non-governmental organizations (NGOs) played a significant role in supporting intersectoral action as described in the case studies. As mentioned above, the sponsorship of international organizations like the WHO has been helpful in a number of initiatives to bring attention to health inequities, provide necessary funding, and offer shared expertise in the planning and development of concrete strategies. In low income countries or those experiencing a crisis, like that described in the Ugandan case study, NGOs provide day to day leadership and influence.

The role of public opinion in determining the nature of intersectoral action for health and health equity is, not surprisingly, a common theme of local initiatives that focus on improving health among disadvantaged populations. However, strong participation by civil society was also facilitated in some initiatives which dealt with higher-level issues of health and health inequities at the national, regional and local levels. The case studies from Ecuador and Brazil offer the best examples of this approach.

In 1996, the municipal government of the region of Cotacachi, Ecuador, invited hundreds of citizens to participate in an assembly whose purpose was to identify the main lines of regional development jointly with civil society. One of the key decisions made at this assembly was to establish the Intersectoral Health Council (CIS), whose goals include the formulation of broadly-based health policies and the facilitation of public participation in health and social planning. The local mayor is the president of the CIS. Other members include representatives from local NGOs, and from other sectors, including private business, education and environmental management. The ability of the structure and function of the CIS in Cotacachi to facilitate public opinion in intersectoral planning for health is noted as a key success in the Ecuadorian case study. As the authors of that case study note, "citizen participation in the CIS has a marked impact, not just on the health sector. It promotes and mobilizes other sectors to build better health and living conditions together" (p. 62).

In Brazil, public participation in planning for the health care system is formally recognized in the country's constitution. Citizen participation is facilitated through municipal, state and national health conferences and councils. The emphasis on public participation in planning, implementation and monitoring of health programs is described in the Brazilian case study as a "source of national pride" (p. 16), led by a set of values that sees "participation … as a principle, a right whereby society decides on its future".

Yet the organizers of other initiatives described in case studies struggled with facilitating public

participation in intersectoral action planning and implementation. For instance, the authors of the Sri Lankan case study identify the lack of community-based, participatory approaches as a key hindrance to developing a more collaborative working model in which representatives from each sector worked together to achieve a common result. That case study included the following comment:

> "*…not sufficient attention was paid to community-based, participatory approaches. The linear programmes which were top down worked each in their territory to achieve their objectives. They had to come together at the level of the community to co-ordinate their work and address the problems which cut across their sectors. This type of co-operation would have emerged and become institutionalized if the opportunities for community participation were seized*" (p. 26).

4.4 Building on Working Together – Developing Effective Partnerships

A very clear theme for the case studies was the importance of building trust, a key element in developing and maintaining effective intersectoral action. Building and nurturing trust among all partners has been a challenging and time-consuming task for many initiatives, but it has also ensured a strong foundation for effective working relationships. Those relationships can help to understand the contribution of individual mandates within the context of intersectoral work, so that service gaps and overlaps across the system can be identified.

The case studies describe a number of challenges in developing and maintaining strong relationships among partners. Those challenges include:

- Many and varied mandates at the table;
- High turnover of staff, which can slow the partnership development process. Person-to-person relationships can be key to broader, organizational relationships;
- Cultural differences among various partners can make communication and coming together to agree on common goals difficult. Each sector or organization taking part in the initiative can have different philosophies, approaches, models of working, and terminology. Different information systems for each partner can also impede communication and data exchange;
- A history of poor working relationships can take a great deal of time to overcome. This challenge was most pronounced when the initiatives addressed the health status of Indigenous people, who have experienced displacement from their ancestral lands and discrimination as a result of colonialism. The initiatives described in the case studies from Canada, Australia, Colombia and New Zealand offer excellent examples of efforts to improve the health of Indigenous peoples.
- Bureaucratic regulations can make it difficult to share power across sectors. In Iran, for example, progress in building relationships has been slow, partly because of the deliberate rate of decision-making within the bureaucracy.

To overcome these challenges and build these important relationships, many case studies noted that it is essential to specify the type of collaboration expected from partners in the initiative, and define what that collaboration looks like. Once a process of partnership development had been established, some case studies describe a process in which it was useful to draw up formal agreements and Memorandums of Understanding between partners. In England and Australia local collaborators signed agreements which specified the contributions that each partner would make to the collaborative action. In one initiative described in the Canadian case study, where the vertical complexity of government was a challenge, the federal, provincial and local governments negotiated and signed the Vancouver Agreement which specified the contribution that each level would make to the initiative.

Staff and volunteers involved in beginning and maintaining intersectoral action as described in the case studies reported their need for guidance and support from central agencies or other project coordination bodies. This support has taken a variety of forms, including:

- Handbooks to improve understanding and skills related to intersectoral action;
- Training opportunities to meet the educational needs of all partners;
- Practice protocols that describe how to respond to complex issues from an intersectoral perspective;
- Speakers and advisors from other jurisdictions invited to share their experiences with intersectoral action.

In Iran, for example, the Healthy Cities/Healthy Villages program includes a comprehensive system of workshops which involved local teams and program staff in training about community development and intersectoral action.

4.5 Models and Frameworks Used to Organize Intersectoral Work

Due to the complexity of government roles and responsibilities, and the traditional silos often operating between government departments, all of those countries that have implemented 'whole-of-government' approaches developed a formal model to guide their intersectoral work. For instance, New Zealand employs a theoretical framework that encourages planners to consider action at four different levels (structural, intermediary pathways, health and disability services and impact) from which inequalities resulted. Norway uses an Intervention Map to identify entry points to comprehensive strategies to reduce health and social inequities. Both of these diverse models are available in Appendix D.

Such models have been useful because they:

- Guide the policy process in a strategic direction;
- Provide an entry point for action for health and other sectors, who may not have previously seen health inequities as something they could (or should) act upon;
- Allow government to get a better grasp on a very complex issue in more comprehensive ways.

These models have helped some countries with 'whole-of-government' approaches to clearly demonstrate how action to reduce inequities cannot be implemented by one sector acting alone.

Those initiatives that were strictly at the local or regional level tend to require a more flexible, organic structure that could respond to community needs and preferences with agility. The process in Belgium provides an excellent example. Given the patchwork approach to intersectoral action as described in the Belgian case study, it was acknowledged that pulling together a comprehensive, easy-to-follow policy framework would be very difficult. Intersectoral action for health inequities began in Belgium at local and regional levels, when staff working in different sectors simultaneously started to identify the need to reduce health inequities and began to plan initiatives to increase equity. For instance, the health sector began to build community health centres in deprived areas, the research sector began to study the relationships of poverty and health, local community groups began to speak out in support of people living in poverty and ethnic minorities, and politicians at the national and local levels started to fund projects for the improvement of housing and living conditions in some neighbourhoods. The result was "not a clearly established stepwise approach, but rather an incremental day-by-day pragmatic approach that inspired development, very often starting at the local level" (p. 6).

4.6 Structures to Organize Planning and Implementation

Beyond more theoretical models and frameworks, the case studies present a wide variety of concrete ways to organize intersectoral work, based in part on the ways in which government structures are organized and the ways in which health and health equity issues are framed. A common structure is one in which inter-ministerial committees were formed. Some case studies describe sharing leadership for these committees by rotating the chair position. In a few case studies, an elaborate system of committees and other structures to solidify intersectoral action is described. Developing a complex structure to support intersectoral action helps to lend credibility to the health issue and to a cooperative approach to addressing health inequities, but such an approach also has the potential to create confusion and add unnecessary bureaucracy.

To avoid this unnecessary complexity, the government of Norway explicitly chose not to develop a separate set of intersectoral committees for its National Strategy to Reduce Social Inequalities in Health. This decision was also assumed to enhance sustainability in the long-term. Instead, the Norwegian government based the policy process on existing government structures. The Strategy (begun in February 2007) is intended to be implemented through a reorientation of existing initiatives and budget allocations through the national budget, rather than through a separate action plan with special budget allocations. As described in the Norway report, "an exact funding pool for action to reduce social inequalities in health could have undermined the understanding of a need for reorientation of existing policies" (p. 16-17).

While it seems that, at both the local and national levels, bringing people from diverse sectors together to discuss issues and come up with common goals is a useful exercise, it does not appear to be sufficient to effectively foster intersectoral action. The role of intersectoral committees varied, with some playing a strictly advisory role and others having the authority to set policy. For example, in Ecuador the assembly has the ability to approve or reject taxes. Regardless of the role of intersectoral committees, analysis of the case studies suggests that it is important that a broad range of participants from all sectors be invited into the process. At the local level, the active participation of municipal government leaders seems especially important, as noted by the authors of the case study from India:

> "*[t]he importance of working with local government also emerges as a key lesson learned. Working with local government, advocating for sex workers' needs and rights and bringing community issues to the attention of local politicians, was nearly a daily task, not an effort that was undertaken only in times of crisis or under special circumstances. This frequent contact was helpful in creating a feeling of partnership between local political structures and the community and in fostering greater mutual trust. The efforts spent in nearly daily contact with the local political structures are a clear lesson for community action elsewhere" (p. 32).*

Beyond the use of committee meetings, many case studies described offering regular opportunities for diverse stakeholders to meet and share ideas. Conferences and community forums are two types of gatherings used by Belgium, Morocco, Ecuador and Brazil to help develop a shared vision among a variety of partners, including community members.

4.7 Monitoring Process and Outcomes of Intersectoral Work

Measuring the process and outcomes of the intersectoral initiatives presented in the 18 case studies proved challenging for many. Very few of the case studies presented systematic results, although a number could point to improvements that corresponded to the timing of program implementation. Often the case studies report on outputs of their intersectoral work, including the number and types of new policies and programs developed to address health inequities, increased awareness of the health and social needs of a particular population group, and increased

participation of community members in decision-making. In most cases it is premature to draw conclusions about the overall effectiveness of the use of intersectoral action for health and health equity because the work has been implemented quite recently and there has not been sufficient time for effects to accrue.

A number of case studies were able to document improvements in social determinants such as poverty levels and improvements in population health status. Frequently these were in national-level interventions where objective measures were already present on an ongoing basis. In these national programs it was difficult to ascribe these improvements to the described intersectoral activities, as the effects were continuations of longer-term trends in national populations.

In many of the locally-based case studies, where changes could be more directly attributed to intersectoral program effects, there are insufficient data to arrive at systematic conclusions. In Australia and India for example, the anecdotal descriptions of outcomes are very positive but a lack of baseline measures prevents a systematic appraisal of those initiatives' effects.

Some case studies, such as those from Iran and Chile, describe the systematic appraisals of intersectoral activities but at the same time highlight the need for better tools and instruments to monitor intersectoral collaboration, and its effects. The case study from Iran portrays a very comprehensive evaluation of their intersectoral initiatives, which included document reviews, process reviews and checklists, key informant interviews, focus groups, secondary data and a household social capital survey. In certain cases, such as those from Iran and Chile, where more comprehensive process and community-based outcome measures are used, results are generally positive, but across all of the case studies it is not possible to generalize.

In most cases, and particularly in those case studies in which the issue to be addressed by the initiative centred around health and health equity, the health sector frequently plays an important role in monitoring and evaluation of intersectoral initiatives by providing key technical expertise on data collection and analysis. For instance, the government of New Zealand is able to focus on explicitly reducing inequities in health partly due to the strength of their health information systems, which provide data used to both state the case for intersectoral action on inequities and then monitor the success of that action over time (for example, around improved housing, where respiratory cases admitted to hospitals was a useful indicator).

The setting of targets, in which clearly defined objectives are time-limited, is uncommon in the case studies reviewed. England has set a national health inequalities target on life expectancy and infant mortality, with the Department of Health taking lead responsibility for delivering on the target. That country's case study reported that "a strong focus on the health inequalities target backed by a national health inequalities strategy supported by Treasury has been a powerful way of engaging partners and promoting intersectoral collaboration" (p. 2). Given that so few of the case studies have used target setting, and thus far their experiences have been mixed, it is difficult to tell if setting targets is a useful exercise in planning, implementing and evaluating intersectoral work. Resolving this issue is an important next step in the continued development of intersectoral action for health equity.

4.8 Ensuring Sustainability of Intersectoral Efforts

As the "*Crossing Sectors"* literature review (PHAC, 2007) also found, intersectoral action tends to cost more and take longer to achieve results than other approaches, which makes it essential that all partners in the process make a long-term commitment. Yet sustaining intersectoral initiatives has been a challenge portrayed in many case studies, due to changes in government, emergency or public health crises shifting attention elsewhere, and/or staff turnover. In many cases, initiatives are still relatively new, and so long-term sustainability has yet to be tested. Those case studies

that do explicitly mention strategies for ensuring sustainability, and few do, refer to building trust and openness in working relationships and communications, and creating policies and practices to minimize staff turnover, so that those personal relationships so vital to successful and seamless intersectoral work can be relied on. It is possible to posit some general conclusions based on the experiences of countries such as Cuba, which has had a longer-standing commitment to intersectoral action. The experiences of specific initiatives such as the project for sex workers in India, which had been developed over a longer period of time, can also shed light on important factors for sustainability.

Learnings about how to develop sustainability include:

- The development of permanent intersectoral structures in government rather than short-term project-based initiatives. This is implicit in the 'whole-of-government' approach which establishes intersectoral collaboration as the standard approach to government. The creation of ongoing intersectoral action funding programs, although rare among the case studies, is viewed as an important means of ensuring sustainability through the creation of budgetary incentives.
- The creation of intersectoral funding programs for a citizen-led non-governmental organization was an important factor in the creation of an ongoing response to the needs of sex workers in North Kolkata, India.
- Other suggestions pertaining to sustainability included the implementation of training programs to increase the level of comfort among civil servants (as portrayed in the case study from Iran) and the creation of regular citizen forums or conferences to maintain public pressure and support for intersectoral action (as noted in the case studies from Brazil and Belgium). In Cuba, ongoing community health committees operate at the local level, and in Iran broadly-based village councils are primary collaborators at the local level.

5 The Role of the Health Sector

Through the design of services and programs which address the needs of socially disadvantaged and marginalized populations, health systems have a significant potential to influence health equity. Beyond the provision of services, however, the health sector also has the ability to have a powerful impact on broader socio-political environments, as the recent review C*hallenging Inequity Through Health Systems* (Gilson et al., 2007) has found. That report indicated that health systems can influence health equity by generating:

> "…*a sense of life security, well-being, social cohesion and confident expectation of care in times of illness; and they may be influential in building societal and political support for governments that promote health equity"* (p. viii)*.*

The report also acknowledged, however, the potential of health systems to perpetuate injustice and social stratification*.* One of the key ways the health sector can support health equity, Gilson and colleagues outline, is by providing leadership to develop processes and mechanisms that offer leverage for intersectoral action.

In many of the examples of intersectoral action described in the case studies, the health sector did take a leadership role in the coordination of the work. This is particularly the case in those case studies that identified their key objective as improving health or reducing health inequities. The leadership role of the health sector was, in some cases, justified by the fact that the health sector can provide the theoretical rationale and framework (e.g. the use of the population health model in Canada) that stresses the complex influences on health and health inequities*.*

Contrarily, the Chilean case study describes four separate intersectoral programs, and in none of

those programs was the health sector the initiator, and in only one has it taken a significant leadership role. In that one program, an initiative called Chile Crece Contigo that focuses on early child development, health was positioned as the lead sector because of its central role in the social protection model as it relates to the well-being of families and children. As well, in the Chile Crece Contigo program, members of the health system coordinate, support and monitor the work of primary health care centres, which serve as the entry points for expectant mothers and children. In this particular program, then, the health sector maintained a leadership role partly due to the fact that the organizers of the program saw improving health as one of its key objectives.

Some aspects of the culture of the health sector, however, might make it difficult for it to effectively build and maintain the types of collaborative relationships that are necessary for effective intersectoral work. The medical model of health, on which some of the culture of the health sector is based, can be competitive and prescriptive. The effect of this influence can lead to a sense that the health sector is taking over the process, working outside its mandate, and establishing a place of dominance within the public sector. As stated in the Norwegian case study:

> "*[t]he health sector may in some cases have to improve its role as team player with the other sectors in policy making … the health sector should integrate health objectives in equity policies in other sectors through health diplomacy, [rather than] enforce [its] own health targets on other sectors*" (p. 15-16).

In Canada, for example, the Quebec Public Health Act requires all ministries and agencies to consult the Ministry of Health and Social Services when they are formulating policies that could have an impact on health. One of the key challenges to implementing this legislation has been a feeling of resentment among government departments outside of health.

As well, the leadership role of the health sector may, at times, result in the issues being defined too narrowly and not adequately acknowledging the broader social, economic and historical contexts of the issue. This is the case with the Australian case study, which focuses on a particular health-related behaviour (petrol-sniffing) among Indigenous populations. While the Australian initiative did see some reduction in the rates of sniffing in the communities in which programs were implemented, much of the emphasis of the case study is on the behaviour itself, rather than the broader historical and cultural issues that continue to influence the health of Indigenous people.

To what extent the health sector can (or should) take the lead role in planning and implementation of intersectoral work for health equity depends in large part on the issue being addressed. The following three scenarios were evident in the case studies analyzed:

- When dealing with issues in which the health sector has the greatest degree of knowledge, experience and control over the strategies to improve health equity, it is reasonable for the health sector to take the lead role. This is the case in those initiatives that focus on improving access to the health care system or to other prevention-specific programs, including those associated with primary health care. In Malaysia, for example, local health care providers led a process of priority-setting which involved broader-based community involvement. The local providers sent the recommendations to the national health service.
- When the initiative focuses on issues where the health sector has knowledge about effective measures to improve health equity, but does not control the arena or means to implement the measures (e.g. health promoting schools programs), the health sector may take a lead role in promoting strategies, but ensure close cooperation and ownership of the initiative with other sectors. In Cuba the expansion of the mandate of primary health centres to clinics with a strong prevention and health promotion function is facilitated by local health committees. Those committees are intersectoral in nature and include members of the health sector as participants.

- When the initiative is attempting to directly address social determinants of health (e.g. education, poverty) beyond those directly related to the health system, the health sector might not lead the intersectoral work, but be a policy partner in its development and implementation. In these circumstances, the health sector on its own neither controls the means to implement strategies nor has the greatest knowledge in how activities should be framed. In the Malaysian example, a broad-based national strategy to address social and environmental determinants was led by the appropriate sectors – economic development, education and housing. In the Norway example, the whole-of-government approach was to promote the application of an intersectoral lens for health equity to the entire government budgeting process.

Within the health sector, it is useful for intersectoral initiatives to include training and educational opportunities for staff to learn about how to work better together with representatives from a wide variety of other sectors. Even in Cuba, a country with a long-standing commitment to intersectoral action, the need for better training among health professionals and administrators was identified in the case study as an important consideration.

A growing body of research and anecdotal evidence suggests the development of strong primary health care systems that integrate services and emphasize health promotion and illness prevention can help achieve health equity at the local level (Gilson et al., 2007). Beyond making health services more accessible to socially disadvantaged groups in the community, the evidence provided in some of the case studies demonstrates that the development of a strong primary health care system can act as a lever to begin the development of broader intersectoral initiatives at the community level. In Belgium, for instance, community planning processes are developed through community health centres. Such planning involves local community members and other stakeholders in gathering information about the health and quality of life of that neighbourhood, making a "community diagnosis" that outlines the issues and details steps to address issues and monitor outcomes.

Despite its role in the early stages of building intersectoral action for health, it is important for the health sector to continually re-evaluate its role and alter it as necessary. As the literature review *Crossing Sectors – Experiences in Intersectoral Action, Public Policy and Health* indicated:

> "*[t]he role of the health sector is no longer straightforward. It must be able to shift and adapt. It must know when to lead, when to follow, and what type of input to seek. It must also be vigilant in ensuring that the health aspects of complex files led by other sectors are identified and addressed. It must be sensitive to timing, able to distinguish among short-, medium-, and long-term gains, and prepared to make decisions on appropriate entry points and strategies*" (Public Health Agency of Canada, 2007, p. 33).

The Indian case study offers an excellent example of the potential for the role of the health sector to change over time. In that case study the Sonagachi HIV/AIDS Intervention Project (SHIP) was originally begun by the health sector and supported by the WHO Global Program on AIDS. Its initial goal was narrowly defined in strictly health terms: to decrease levels of sexually transmitted disease and increase condom use among a marginalized and vulnerable group of sex workers in the Sonagachi area. As the project leaders engaged in dialogue with sex workers themselves, the leaders quickly reached the conclusion that a much broader perspective on sex workers' health was needed that emphasized empowerment and quality of life, rather than strictly health-related behaviours. Gradually the leadership of the initiative transferred to the sex workers themselves and their supporting organizations. While the health sector initially played a significant role in India's intersectoral initiative, those health sector representatives initially working on the project recognized the need to step back and re-define the project as was indicated by its key stakeholders. When power was devolved to the sex workers they emphasized non-health care

interventions such as literacy training, occupational protections and financial security. As portrayed in the case study, this expanded focus does appear to be associated with important health outcomes, including lower rates of sexually transmitted disease and HIV than in other communities.

6 Innovative Practices

The following section describes some innovative ways in which challenges were overcome when planning and implementing intersectoral action, as presented in the case studies. These activities are not widespread in the case studies analyzed, but they are worth noting, and may require further study and follow-up.

- **New Zealand: Monitoring and reporting inequalities -** While many case studies refer to measuring and reporting health inequalities, New Zealand has done a particularly good job of steadfastly monitoring inequalities and reporting those inequalities in ways that best facilitate action. The New Zealand Deprivation Index evaluates census data using a nine point scale covering income, employment, access to communication and transport, education and property ownership to assign a "deprivation score" to small geographic units across the country. Use of this index has boosted intersectoral interest in inequities, facilitated discussion in academic and policy circles about the root causes of inequities and provided social agencies with evidence on which they could plan programs and policies to address health inequities in their region.
- **India: Use of participatory approaches to address the living conditions of a marginalized group -** The Sonagachi Project began mainly as a health education initiative with sex workers in the Indian city of Kolkata. The project has since evolved into an initiative that focuses on empowerment of sex workers, working to change the social context in which they live and work. Over time there has been complete devolution of the project to citizens (the sex workers and the organizations that support them), with ongoing financial and advisory support by sector partners. Using participatory methods, the project has assisted sex workers to create and register their own organization, the Durbar Mahila Samanwaya Committee (DMSC or Durbar) and their own financial co-operative. Durbar currently has an active membership of more than 2,000 sex workers, and an informal support base of more than 65,000. The organization is now self-sustaining in many of its activities. The planning model for the Sonagachi Project is highly values-based; responsiveness, egalitarianism and empowerment have permeated decision-making for the project from the beginning.
- **Belgium and Brazil: Establishment of cross-sector priorities through community consensus conferences involving service providers and citizens –** At both the municipal and neighbourhood levels, systematically bringing together representatives of various sectors and community members has stimulated cooperation among professional sectors (that were working on their own in the past) and residents. In some neighbourhoods in the city of Ghent, Belgium, for example, a Platform was created that provided a venue for 40 to 50 local people from a variety of sectors (social welfare, health, street workers, police, school services, etc.) to identify and better address issues such as poverty, traffic insecurity, and inadequate housing. These Platforms have now been running for over two decades. They are supported financially by local government.

  Brazil has 4,390 municipal health councils, 27 state health councils and a National Health Council. These councils were created by legislation that is designed, in part, to ensure public participation in the process of health sector planning. The composition of councils is 50% citizens, 25% health professionals and 25% managers (public and private). A series of National Health Conferences have also been held that are designed to exert an influence on Brazilian health care policy.
- **Iran: Training programs for service staff on the practice of intersectoral planning and action -** A significant amount of resources for Iran's Community Based Initiatives (CBI)

programs has been spent on training and capacity building. Since 2001, the CBI Secretariat has held approximately 50 workshops with more than 1500 participants in 25 districts across the country; participants were involved in workshops that were designed to enhance their skills in community development and intersectoral collaboration. Workshop participants have included members of district intersectoral teams, as well as community members. In some cases, participants have been supported to share their new learning by training others in subsequent workshops.

- **Chile: Evaluation and monitoring mechanisms -** Mechanisms using both quantitative and qualitative measures were put in place, in Chile, using a wide variety of indicators of 'success'. For instance, the objective of one of the initiatives described in the case study, Chile Solidario, was to reach families in extreme poverty and link them to the social network. The program has gone through an extensive evaluation process that looked at the design and application of mechanisms and instruments, the effectiveness of the management model used, and the overall impact of the program on families' capacities and social welfare conditions. Each of the four initiatives described in the case study from Chile has gone through this rigorous evaluation process, to understand and measure the processes and outcomes of intersectoral action.

7 Discussion: Summary of Key Findings and Questions that Remain

The analysis of the 18 case studies presented here offers another step in the efforts to learn about how intersectoral action for health and health equity has happened around the world. The learnings described here add a more practical component to the excellent review of the literature, *Crossing Sectors – Experiences in Intersectoral Action, Public Policy and Health* (PHAC, 2007), an earlier stage of this joint PHAC-WHO initiative. That review addressed the following questions:

- the types of problems addressed through intersectoral action;
- the conditions that shape horizontal and interjurisdictional collaboration;
- tools, mechanisms and approaches to support intersectoral action; and
- roles played by the health sector and other actors.

While some of the questions identified at the end of the "*Crossing Sectors"* literature review (PHAC, 2007) have still not been definitively answered (see Questions That Remain, section 7.1, below), the analysis of these 18 case studies has allowed us to learn more about how the impetus has been built for intersectoral action for health, and the challenges that have arisen from the many ways in which intersectoral action has been structured and organized. As well, the case studies have begun to shed more light on the most helpful role of the health sector, particularly as that role is adapted to the way in which health and social issues are framed.

The analysis presented here is consistent with one of the key conclusions of the literature review - that the broader socio-cultural, political and economic context for decision-making has a significant impact on how issues are framed and how intersectoral approaches are used to address those issues. The case studies analyzed present a wide variety of approaches to intersectoral action to improve health and reduce health inequities. Consistent with the results of the literature review, those approaches have, of course, depended on the nature of the health issue being addressed and the social, economic and political context in which the work took place. It is clear that there is not a 'one size fits all' model, and models change over time, as the health issues they are trying to address evolve and the intersectoral partnerships ebb and flow. While we have learned more about the concrete implementation of intersectoral action across the world, the evidence is still insufficient to support categorical conclusions about which model is best suited for which situation. Some general conclusions, however, are suggested below.

Successful intersectoral action requires the sharing of power. The creation of new entities,

committees, or other bodies to formalize and institutionalize power sharing is helpful. Given a commitment to address social determinants, the development of intersectoral strategies occurred with greater ease in government cultures that had a tradition of diverse sectors working cooperatively. In some countries, the sheer complexity of government worked against the development of successful strategies. Two of the best examples of this issue were Canada and Belgium. The overall strategies of both countries tended to be more of a patchwork, with significant regional variation. The Belgian case study acknowledges that its complex policy environment at the national level was a barrier to more comprehensive planning at those higher levels. The Canadian province of Quebec is one of only two provinces in which health and social services are located within the same government department. This integration on a structural level has helped to facilitate the development of the Quebec Public Health Law.

Intersectoral approaches can be initiated from the top-down (as seen with 'whole-of-government' approaches) or from the bottom-up. It is difficult to tell at this point if broad, whole-of-government approaches at the national level will be effective at reducing inequities in health. However, there is reason to speculate that whole-of-government approaches that originate at the national level are limited in their capacity to influence some key social determinants of health if such initiatives are not supported by comprehensive, ground-up processes that occur at local levels. Smaller scale, local initiatives in which community members share control over the process, or are otherwise able to meaningfully participate in that process, show significant potential for success.

The goals of the initiatives described in the case studies varied. How those goals were framed had a significant impact on the partners involved in the initiative and the types of strategies planned. Many case studies did not focus explicitly on the reduction of health inequities as a goal. More frequently, the goal was to improve health status in a marginalized group or geographical area with the implicit assumption that health inequities would be reduced as a result. Addressing the health needs of disadvantaged and marginalized groups lent itself to intersectoral action because the importance of addressing social determinants of health of those groups was most easily recognized. Disadvantaged groups were apt to articulate their needs in intersectoral terms and a variety of sectors were often already involved with them. Remote populations also lent themselves to intersectoral action because economies of scale do not support effective action by individual sectors.

In the case studies analyzed here, countries chose a wide variety of models to organize their work. These chosen models reflected countries' wide variety of notions of the term 'intersectoral action'. The most common model represented in the case studies was one in which multiple sectors agreed to participate in joint planning and decision-making, including the setting of priorities for the attainment of common or interrelated goals, and to which each sector then allocated resources. This general framework was followed in initiatives described in the English, Australian and Canadian case studies. This model sometimes included the requirement that local service providers agree to coordinate service delivery towards common objectives based on written agreements. The importance of written agreements and memorandums of understanding between community partners met with mixed success.

Another common model involved the convening of a multi-sector community-based group or forum to advise on local health priorities. The recommendations of these groups were then considered by health planners in the setting of system-wide priorities and financial allocations (e.g. Brazil, Cuba, Iran). Public participation, empowerment of marginalized groups at the local level, and a significant partnership role for non-government organizations are strong drivers, possibly because these groups are less likely to bring a sectoral-based perspective to the problem. Their participation consequently facilitates intersectoral collaboration.

Least frequently, case studies described action that involved the development of an intersectoral funding pool that supported action on social determinants through a third body. This was the case in case studies from India and El Salvador. The creation of intersectoral funding was relatively rare and, consequently, its impact could not be assessed. The lack of intersectoral funding mechanisms was cited as a barrier in many of the cases, however, based on the assumption that it would provide an important incentive to facilitate intersectoral action.

In the case studies analyzed, there was a relative dearth of systematic evaluations of intersectoral action. At the same time, almost all of the case studies reported positive outcomes that were thought to be attributable to intersectoral collaboration.

7.1 Questions That Remain

Analysis of the case studies illuminates a few key questions and/or issues needing further research and analysis. Those outstanding questions include:

- What are the best ways to provide relatively seamless integration of intersectoral approaches to tackling health inequities from national-to-regional-to-local levels? It is still unclear how consistent messaging, policies and programs can be implemented at all three levels at once (and, indeed, whether that is necessary).
- What is the impact of intersectoral action on health equity when the original goal has been framed as a reduction in health equity versus another goal that does not explicitly identify health? As we have seen, it is not necessary to frame the issue as a health issue to have an impact on health and health equity. It is still unclear, however, how best to frame objectives to ensure the development of the breadth and depth of partnerships needed to build effective intersectoral action.
- How can success of intersectoral action for health equity be defined and evaluated?) All cases indicated they were challenged by evaluating their efforts in a way that reflected the breadth of their work. While, again, there will be no ‘one size fits all’ approach to monitoring intersectoral work, it would be helpful to offer more guidance to countries in the approaches that might be tried.
- How can the health sector bolster its capacity to effectively collaborate in intersectoral work? The health sector needs support to understand both its potential and its limitations in work to eliminate health inequities. At the policy level, members of the health sector need help to better translate research on health inequalities into action, amongst other things. At the community level, health sector staff need support to understand how best to work with other sectors, and to facilitate community engagement, amongst other things.
- From other sectors’ perspectives, what is the best way to engage them in the process? Because most of these case studies were written from the perspective of the health sector, interviews with other partners involved in these initiatives would help to better understand the best way to build and sustain their involvement. Such interviews would also provide another way to view the strategies and outcomes of the initiative itself, which may or may not vary with that of what has been presented in the case study.
- Is there a benefit to setting targets that place a time-based objective on outcomes for intersectoral work? While setting clear and measurable objectives appears to be important to develop and maintain partnerships, it is unclear from the case studies whether the setting of targets is a useful practice.
- What components of intersectoral action for health and health equity are important to ensure sustainability of this approach? Given the length of time it often takes to have influence over complex determinants of health, long-term sustainability of intersectoral approaches is vital.

The questions above echo some of the remaining questions identified in the literature review, *Crossing Sectors – Experiences in Intersectoral Action, Public Policy and Health* (PHAC, 2007). That review also identified the need to know more about the broad range of roles played by sectors outside of health, including the media, the economic sectors and the public. As well, the literature review identified questions of sustainability and the need to learn the 'inside story' about those arguments that have been most persuasive in making the case for intersectoral action.

8 Conclusion

Health inequities develop from, and are maintained by, a complex set of factors that we are only just beginning to understand. The breadth of the 18 case studies, across many countries, cultures and levels of development, demonstrates the importance that is attached to intersectoral action. From the slums of India and remote villages of Brazil and Iran to the capitals of Norway, Canada, England and Australia, governments at all levels are struggling with the development of intersectoral action for health.

Throughout the case studies a significant influence on the success of intersectoral action for health were the social, economic, and cultural factors in the environment of that country or region, which provided a context for the work. The diversity of the contexts in these 18 countries has ensured that each country approached health equity differently. While the existence of a supportive environment in which to plan and implement policies and programs was helpful, efforts to address health inequities through intersectoral action experienced some success even in environments which were unstable and less supportive of this kind of work. While contextual factors often act as obstacles, they can also stimulate new and innovative opportunities.

These 18 case studies have helped to provide some clues about how best to tackle planning of intersectoral action, yet many important questions remain. While the need for intersectoral action is not new, a continued sharing of experiences is vital to improving the breadth and depth of our understanding of intersectoral approaches.

9 References

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10 Appendix A: TOR for the development of country case studies on intersectoral action for health (IAH), elaborated by WHO

I. Background

The link between social determinants of health and intersectoral action (IA) stems from earlier work at the Alma Ata Conference, the Ottawa Charter and Bangkok Charters. Recently, IA has been outlined as a key strategy in the conceptual framework[1] of the WHO Commission on Social Determinants of Health. The Commission Secretariat identifies the need to: identify successful examples of intersectoral action to benefit health and health equity in jurisdictions with different levels of resources and administrative capacity; and to characterize in detail the political and management mechanisms that have enabled effective intersectoral programmes to function in a sustainable manner.

Intersectoral action for health for this study is defined as:

> **"a recognised relationship between part or parts of different sectors to take action on issues to improve health and health equity"**

The IA case studies will examine the experiences of countries in implementing intersectoral action as part of a mix of strategies to improve health equity. To facilitate the description and analysis of IA experiences, a series of questions have been developed which are based on the learnings to date from the WHO Commission on Social Determinants of Health and a recent synthesis of documented country and regional experiences in IA developed by the Public Health Agency of Canada and the Health Systems Knowledge Network[2] to inform the work of the Commission.

These case studies are designed to explore issues related to intersectoral action: the context for action, approaches taken and their impact on health and health equity. The expected length of each policy case study is approximately 25 pages.

The case study should be written in a narrative style, telling a story of what happened. Specific descriptions of "opportunity moments" that moved the work forward, such as when a particular conversation topic or audience created a strong response, or when events opened up opportunities are especially valuable. Even though the case study should be evidence-based, it is not about presenting 'arguments' for 'persuasion'; it is about the methodology and process as well as about the story-line.

II. Aim of the proposed work

The purpose of the work is to identify specific mechanisms and models that are used in engaging and developing integrated policies for health, in particular IAH, in a variety of country contexts and to assess to what extent these different mechanisms and models are effective in contributing to health and health equity in different country contexts.

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[1] WHO Commission on the Social Determinants of Health 2006. *Towards a conceptual framework for analysis and action on the social determinants of health: Discussion paper for the Commission on SDH.* Draft (December 2006).

[2] Public Health Agency of Canada and the Health Systems Knowledge Network. Intersectoral action for health: A synthesis of country and regional experiences. Draft document (31 January 2007)

III. Main study questions

This project is intended to advance the following general questions through the development of individual case studies that will address a variety of country contexts, themes and approaches to intersectoral action:

What are some of the specific mechanisms used in working on policies and programs to advance intersectoral action to benefit health and health equity?
What role or roles does the health system/sector frequently take in these various models?
What are the common architectural arrangements of different models adopted?
What are the main strengths, weaknesses, threats (barriers to implement and sustain the action) and opportunities (facilitating factors) of the different models?

IV. Detailed structure for intersectoral action for health case studies

TITLE AND AUTHOR INFORMATION

A. Title of the case study
B. Author names, titles, institutional affiliation, phone and fax-numbers, postal and email address

SUMMARY (500 words)

SUBJECT/SCOPE

Brief description of the topic and focus of the case study, including the time period the case study covers.

METHODOLOGY

General design of the study/evaluation
Instruments and sources of information
Detailed methodology for collection of information

RESULTS

A. CONTEXT

A.1. What were the **contextual factors** at play?

a. Provide baseline **information** on the country, region and/or community of reference.

b. Identify **key characteristics of the policy environment** (see WHO Commission on the Social Determinants of Health 2005, pp. 18-19), including each of the issues below:

type of political leadership of key levels of government;
political systems and processes (e.g. government structure and processes);
macroeconomic policy;
policies affecting labour, land and housing distribution;
policies in education, social welfare, medical care, water and sanitation;
social value placed on health;

previous initiatives that focused on SDH approaches, intersectoral work, and/or efforts to reduce health inequities; and the impact of globalization in the country.

Which of these factors were most significant or had an impact on the work, and how?

A.2. What was the **nature of the public policy problem** that intersectoral action was designed to address? How was the issue framed, and what was the history of this discussion? For example, around issues of…

- o Health Equity
- o Education
- o Environment
- o Transportation
- o Economic development
- o Community development
- o Disease
- o Risk factor
- o Public security
- o Exclusion/indigenous people/gender
- o Specific population such as children, youth, seniors

A.3. What were the **origins of the policy or program?**

a. Outline the drivers to act, e.g.
   - o Lobbying and political pressure

   Economic conditions

   Negative information or new information, e.g. data from reports of commissions or task forces

   Strength of a given political tradition or a shift in power relations, such as a change in government

   Change in regional/international policies, accords or institutions

   Other

Particular use and dissemination of equity-oriented or social determinants data or information (e.g. what were the source and content of the evidence, how was it presented, and how was it distributed: broad public distribution via the media, targeted distribution to target audiences or power-brokers, etc.)

What did public debate focus on? What were the catalysts for public debate? What was the response to the public debate from government, NGOs, business, and communities? What were the points of conflict and opportunities seen in this debate?

What was the process of policy formulation or amendment? What evidence base was used? How was the policy announced, and was it timed?

Did the selected policy respond to a clear social need or a set of priorities widely accepted? Please comment.

A.4. What **policy or program objectives** were identified? Was there an **explicit** or **implicit** goal to reduce health inequalities? Please provide evidence for your assessment.

B. APPROACHES

B.1. What was the **nature of the intersectoral action**/program/policy (please note that this question is focused on the response to the problem identified in question A2), e.g.:
Place or settings-based – focused on a specific geographic community or setting, e.g. schools, workplaces
Targeted – population, disease or risk factor based
Incremental (staged or phased approach)

Broader policy framework
Other
What other strategies/approaches were included in the policy mix to address the issue?

B.2. Which of the following describes the **policy entry points (describe):**

Aimed to reduce societal stratification or to mitigate effects of stratification
Aimed to reduce exposure of disadvantaged people to health-damaging factors
Aimed to reduce vulnerabilities of disadvantaged groups
Aimed to reduce unequal consequences of illness in social, economic and health terms

B.3. What **mechanisms and tools** were used to support intersectoral action?

a. Describe the horizontal relations (e.g. which sectors were involved at the national and local level public and private) , which other public sectors.and vertical relations (e.g. which levels of government: national, regional, district or community etc.) For horizontal and vertical relation identified describe for each of the following, if applicable:
   1) Information, e.g. research, knowledge transfer, evaluation results, communications
   2) Institutional arrangements or mechanisms, e.g. particular platforms created/used for the initiative - a National Commission, a President's Task Force, etc.
   3) Financial mechanisms, including source of funding, budgeting structure, etc.
   4) Legislation and regulation
   5) Accountability frameworks or monitoring mechanisms
   6) Planning and priority setting

b. Personnel development, including skills mix required and training necessary. Were personnel with special skills recruited or brought into the process or should there have been, e.g. those with experience working across sectors, etc.? Did this mechanism help to overcome barriers? Please describe.

B.4. Describe the **architectural arrangements** of the intersectoral action/ program/policies.

a. Who were the principle **actors** responsible for influencing the policy decision, its implementation and evaluation, e.g. (please be specific in terms of their titles and positions):
   Government: politicians, bureaucrats, health sector personnel, non-health sector personnel, central agency personnel

Non-government: civil society organisations, private sector and philanthropic representatives, professional organisations
Media
Other

b. What **roles did each of these actors** play in the policy or programming development, implementation and evaluation stages? Respond to each of the issues below:
   1) Who were the main actors lobbying for or against the implementation of the IA? Please describe their actions.
   2) Who was responsible for implementation? How was this carried out?
   3) Who was in charge of monitoring and evaluating the IA? How was this carried out?
   4) How did each of the actors become involved?

   What was their interest in the initiative and its success?
   What were their expectations of the process or outcomes?
   Did previously existing alliances between actors have an influence?

c. Were there **participatory mechanisms emerging** from civil society and the government for the development of intersectoral action and programs? If so:
   1) Describe the mechanism.
   2) Who participates, and what are their incentives or motivations?
   3) Was there a strong participatory process? If so, in what ways and what was the impact?
   4) Which was the type of the participation of the civil society:
   - **Informing:** To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions),
   - **Consulting:** To obtain public feedback on analysis, alternatives and/or decisions)
   - **Involving:** To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered
   - **Collaborating**: To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution
   - **Empowering:** To place final decision-making in the hands of the public

d. What was the **role of the health system/sector** in the action in terms of leadership, coordination, priority, etc?

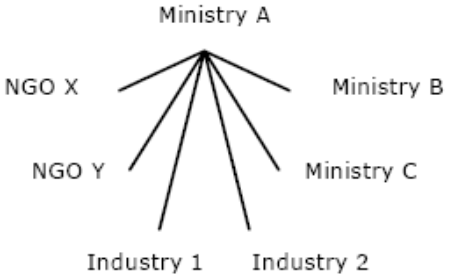
e. For the specific programming action or policy to be addressed, choose the best descriptor of the **level of integration** and explain:
   - Cooperation (for instance sharing information, consulting with others, or avoiding policy divergences and seeking consensus),
   - Coordination (for instance defining common limits by setting parameters for sectoral activities, or establishing commonly agreed or binding priorities)
   - Integration (for instance, establishing an overall inter-sectoral strategy such as an integrated policy for agriculture and nutrition that applies to both sectors).

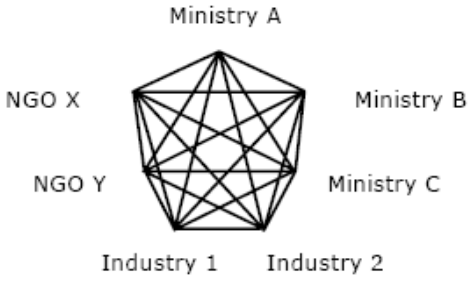
f. In relation to the question above, did the actions/program/policies aim at **horizontal cooperation/coordination/integration** (e.g. cutting across ministries or sectors) **or vertical cooperation/ coordination/ integration** (improving integration within a ministry or sector)?

g. What was **the model of the relationship** (according to the description below)? Please provide 2 maps using the types of models shown below.

   a. The first one should map the actors and the formal (official) relationships among them in the context of the intersectoral action.
   b. The second should map the actors and the informal relationship among them.

   For example, one sector may have been the primary coordinator of the activities, with the expectation that other sectors would contribute as they were able (example A in the models below), or the relationship may have been more of a network with everyone working towards a particular goal (example B in the models below), or there may have been another model. Identify the various actors, including the health sector, in the diagram.





h. Were there **budgeting and financing mechanisms** that promote intersectoral action, such as funding pools, etc.? If so:

   1. What were the financing mechanisms? E.g. National level distribution of money, or distribution by local level authorities?
   2. Which sector or entity proposed the mechanism?
   3. How was the mechanism set up?
   4. How is the mechanism accessed? What incentives are present to use it?
   5. Which sectors have taken advantaged of it, or not, and why?
   6. How did the mechanism influence planning and sectoral behaviours?
   7. What was the sense among sectors about the usefulness of the mechanism?

i. Were there platforms in existence that were intended to support intersectoral action, but were unused or underutilized? If so, please describe the platform and explain why it was not effectively used.

C. IMPACT

C.1. What were the **outcomes**?

a. **Policy outcomes**
   1) To what extent have the policy objectives been met?
   2) What has been the impact on health equity?
   3) Are there any indicators to assess the results obtained?
   4) Was the effectiveness of intersectoral action measured? If so, how?
   5) If objectives were not met, is there optimism that the policy objectives will be accomplished in the near future? What evidence backs this optimism or pessimism?
   6) To what extent can a short or long-term impact of this policy for health equity be determined or forecast?

b. **Process outcomes and institutional impacts**
   1) What were the actors' responses to the process and outcomes, given their expectations?
   2) How did the perspective of the health sector or other sectors change?
   3) Did health concerns become a stronger issue within the public, other sectors, or the government due to this initiative? What evidence is there of this?
   4) Did the initiative spur further changes in structures/institutions, overall resource patterns, public opinion, additional policy development?
   5) Were staff and key players de-briefed and the lessons transmitted?

C.2. What were the **lessons learned**? Was each of these a generalisable lesson or context-specific? For example, this discussion can focus on:

- What is the impact or role of data and evidence on SDH and/or health inequities in stimulating action?
- What elements of policy and strategy are important to develop from the outset, and why?
- What issues are better addressed as the process develops and new players emerge, and why?
- What would be the optimum timing for involving various key players?
- Which structures, mechanisms, platforms, and incentives work well or poorly, and why?
- How could implementation have been improved?
- How can specific barriers be overcome, including those related to funding/budgets, personnel and skills mix, etc. E.g. what kinds of arguments worked or did not work to persuade Ministries of Finance or other sectors regarding funding and budgeting issues? Did the initiative shift budgets?
- How can expectations be best managed?
- How has this initiative changed "business-as-usual"?
- Other

C.3. In your view, when and how would the approach, mechanisms and tools described above be **applicable to other policy environments**? (You may want to refer to contextual factors outlined in section A).

D. ADDITIONAL INSIGHTS

In addition to the above issues, authors are encouraged to respond to a number of issues that are rarely addressed in the literature, but would be extremely valuable for drawing out lessons. They include:

1. What arguments were most/least persuasive in making the case for intersectoral action?
2. What influence did "off-the-record" conversations and individuals' personal values and commitments have on the process and on the success of the initiative?
3. What was the ultimate event that provoked a policy response?
4. How was commitment sustained over time?
5. Which policy levers were most effective, efficient and equitable to advance health equity?
6. How can the health sector strengthen its capacity for intersectoral action?

Authors can find more detailed descriptions of key elements of these issues in the document "Intersectoral action for health: Synthesis of country and regional experiences."

SOURCES

Include citations in the text, and a reference list at the end of the case study (including weblinks whenever available) for key documents related to the case (policy documents, evaluation results).

11 Appendix B: Brief Summaries of Case studies

1. Australia

De Carvalho, D. (June 2007). *Intersectoral Action to Reduce Petrol Sniffing in Remote Communities of Central Australia.*

As a result of high-profile media coverage and strong local advocacy about petrol-sniffing among Indigenous youth, an intersectoral strategy was developed and implemented which included harm reduction, treatment and action on social determinants related to education and employment among aboriginal youth. This initiative was launched despite the lack of a national commitment to reducing health inequities but the intersectoral nature of the initiative was supported by the broad-based 'whole-of-government' framework that supported intersectoral responses as a base for public policy. Intersectoral bodies were established locally, regionally and nationally to support the initiative and substantial increases in sector-based resources occurred. The program represented a comprehensive multi-modal approach that included harm reduction (production of sniffless fuel), alternative activities for youth, rehabilitation and public education. Strong leadership was provided by the Indigenous community and there was an emphasis on increasing community capacity. Qualitative evaluations were positive but hampered by a lack of baseline data to monitor progress. Not all program components have been rolled out at time of the case-study because more time was needed to determine the most appropriate approach/model for specific interventions. The uncertainty was due to a lack of good evidence about the effectiveness of potential interventions.

2. Belgium

De Maeseneer, J., De Roo, L., Art, B., Willems, S., & Van de Geuchte, I. (2007). *Intersectoral Action for Health in Belgium: A Multi-Level Contribution to Equity.*

Intersectoral action for health and health equity developed gradually in Belgium, through an incremental approach, without the guidance of a global comprehensive policy framework. At the national level, strategies focused on improving universal access to health care services. At the regional level, the Local Social Policy brings together stakeholders from education, health, employment, environment and welfare to identify and address unique issues of health equity in cities and villages. At the level of the neighbourhood, a bottom-up approach has been used whereby representatives meet in local Platforms, which gather information, make a "community diagnosis", plan actions and monitor outcomes. Primary health care facilities play an important role through a Community Oriented Primary Care strategy. While the Local Social Policy and Platforms approaches have been shown to facilitate intersectoral action at the regional and local levels, no data is currently available to demonstrate outcomes of these initiatives to date.

3. Brazil

Dall'Agnol Modesto, A. A., Costa, A., & Bahia, L. (2007). *Health and Social Determinants in Brazil: A Study on the Influence of Public Participation on the Formulation of the Expanded Concept of Health and Liberating Practices.*

In the 1988 Brazilian Constitution, a concept of health was adopted that assured all people the right to health, based on two essential concepts: (1) an expanded concept of health, which overcomes the restrictive interpretation of health as a synonym of non-disease and regards health as central to the rights of a citizen; and (2) public participation, institutionalized as health councils and conferences, and encouragement of dialogue between directors of health services and systems on the one hand and parliamentarians, members of the Judiciary and civil society on the other. Throughout the sixteen years that the Unified Health System (Sistema Único de Saúde, SUS) has been in effect, health councils and conferences have become arenas of mediation, participation and intervention for different interests and different values. At present the field of health has inspired the development of public participation forums for policies in other public sectors in Brazil,

fully demonstrating the wisdom of including social control among SUS principles. The capacity to translate the principle of public participation into representative and flexible forums which include a variety of interests, approaches to health and sickness, and alternatives for formulating policies constitutes a major advance in the acquisition of the right to health in Brazil.

4. Canada

Chomik, T. A. (May 2007). *Lessons Learned from Canadian Experiences With Intersectoral Action to Address the Social Determinants of Health: Summary Report.*

The Canadian report describes eight separate case studies of intersectoral activity for health. They are: the Family Violence Initiative, National Homelessness Initiative's Supporting Communities Partnerships Initiative, Aboriginal Self-Government Agreements, Gender-Based Analysis, Manitoba Child Health, Quebec Public Health Law, Saskatchewan Human Services Integration Forum, and the Vancouver Agreement. Factors that motivated or facilitated intersectoral action included the nature and complexity of the issue, a history of working intersectorally, political will, central agency support, expectations for improved service efficiency and effectiveness, and an established information and knowledge base. Factors that served as barriers to intersectoral action included limited models with which to organize action, resource issues (e.g. insufficient time, personnel and money), multiple mandates, a lack of leadership, changes in government, and a public denial of the social issue.

5. Chile

Frenz, P. (August 2007). *Innovative Practices for Intersectoral Action on Health: A Case Study of Four Programs for Social Equity.*

The Chilean Case Study examines four programs whose ambitious social welfare goals demanded joint action across government sectors and the national, regional and local social intervention networks. In these initiatives the basis for intersectoral action was the recognition that disperse sectoral efforts were not reaching families or communities, producing little impact on social equity goals. One of the recommendations that crossed all the working groups was the importance of the family as the focus of intervention. Insights from the Chilean experience include: (1) economic growth is insufficient to successfully tackle problems of social exclusion and poverty, (2) the problems addressed by the four programs became priorities on the public agenda and the Presidential agenda as a result of public and political debate (3) the definition of the problem evolved from poverty reduction to social equity and policy approaches expanded from reducing gaps to addressing the social gradient. reflecting an evolving understanding of poverty and social inequity, its causes and solutions (4) ISA benefits from shared results and not just common objectives (5) how things are done determines what is done.

6. Colombia

Balladelli, P. P., Guzman, J. M., Korc, M., Moreno, P., & Rivera, G. (2007). *Health Equity and Ethnic Minorities in Emergency Situations: Experiments in Colombia on Intersectoral Action with a Differential Approach to Ethnic Communities.*

In Colombia, the impact of escalating armed conflict between the state and criminal forces on the vulnerability, exposure and health of some ethnic communities led to public debate on the need to improve living conditions for these communities. To this end, the Pan American Health Organization and World Health Organization have developed intersectoral programs and projects at different levels in the country. The Agenda of Cross-Institutional Cooperation and the Intersectoral Action Plan for Development of a Strategy on Healthy Environments has now been integrated into national public policy. The Plan links international organizations with national government organizations, and establishes formal relationships among regional and local authorities, government ministries, and community representatives. At the regional level, fierce clashes between government forces and guerrillas in two municipalities led to the evaluation and

strengthening of the community system for prevention and emergency care, particularly health care, for the local people.

7. Cuba

Serrate, P. C-F., Lausanne, R. C., Jean-Claude, M. M., Espinosa, C. S., & Gonzalez, T. C. (2007). *Study on Intersector Practices in Health in Cuba: Report to the Pan American Health Organization, Stage One.* AND Serrate, P. C-F., Lauzan, O. C., Jean-Claude, M. M., Espinosa, C. S., Hadda, J. H., & Gonzalez, T. C. (October 2007). *Study on the Practice of Intersector Action in Health in Cuba. Document Complementing the Report to the Pan American Health Organization.*

The development of the Cuban public health system has gone through three phases, with an evolving emphasis upon intersectoral collaboration. A focus on curative medicine and coverage extension in the sixties gave way to a greater emphasis on prevention, regulation and risk groups in the 1970's and 1980's with a growing use of intersectoral planning commissions and the development of polyclinics that provided holistic approaches to treatment. In the 1990's the focus expanded to embrace family and community health with an even greater focus on intersectoral action through the creation of local health councils and the enshrinement of IA as one of the central principles of public health delivery. Training programs were developed and implemented to strengthen intersectoral collaboration skills among public health professionals and decision-makers. A team from the National Health School (ENSAP) has carried out a systematic evaluation of intersectoral activities using a standardized questionnaire and methodology that addressed a number of key IA dimensions, including level of knowledge about intersectoral action among players in the health sector and other sectors, and presence of intersectoral action in the strategic objectives of municipalities and municipal health councils.

8. Ecuador

Vega, L. M. (August 2007). *Innovative Intersector Practices for Health and Equity: The Case of Cotacachi.*

Cotacachi, Ecuador established an intersectoral health council (CIS) in 1996 by decision of a civic assembly. The role of the CIS is to offer a space where policy agreements are reached, common goals are established, and the members announce their budgets and orient them towards the cantonal health plan. The CIS' mobilization capacity stems from the fact that since the mayor is the president, he is able to mobilize municipal logistics. Intersectoral action under this framework has resulted in no maternal or child deaths in the past three years and a reduction in illiteracy from 23% to 3.8% (6000 people were taught to read in 2 years and UNESCO declared them free from illiteracy in 2005). Key lessons from this process include (1) political will leading to true citizen participation and institutionalization of the participative process, (2) citizen organization and participation do not arise on their own, it is necessary to support and guide them and to link them to the real decision making power of local government, and (3) exercising leadership means sharing power.

9. England

Earwicker, R. (October 2007). *The English Experience in Promoting Intersectoral Collaboration in Tackling Health Inequalities.*

The election of a Labour Government in 1997 committed to promote social justice and fairness gave a major impetus to action on health inequalities. The government set up the Acheson inquiry that reported in 1998. This report provided evidence about a widening of health inequalities between different social groups and emphasised the need for action on a broad front across government. A national target was set which sought to narrow the gap in life-expectancy (by area) and infant mortality (by social class). A comprehensive national strategy was developed to support the targets, *Tackling Health Inequalities: A Programme for Action* which included indicators around smoking, housing quality, injuries, diet, immunization and poverty reduction. Intersectoral action

was identified as a critical requirement. Leadership was provided through Treasury. 18 departments and units were involved in developing the strategy. Local participation was facilitated by the development of a different tools and mechanisms. Local action was encouraged through Local Strategic Partnerships. Priorities and performance measures were incorporated into Local Area Agreements. The target has – as expected - proved challenging, with the gap continuing to widen, at least initially. More recently, there are signs that the gap has stopped widening and may even be narrowing, at least for infant mortality. Some progress has been made on narrowing the gap in the wider social determinants, including on child poverty, housing quality, educational attainment and child road accident casualty rates. Translating the national targets into local action has provided difficult. Recent target reviews have emphasised the need to sharpen local delivery, noting a lack of local leadership in some areas and gaps in the evidence base limited the effectiveness of local action.

10. El Salvador

Avalos, M. E. (August 2007). *Intersectoral Experience in the Empowerment of Adolescent Girls.*

The Interagency Program for the Empowerment of Adolescent Girls (IPEAG) was established through a group of United Nations agencies (UNDP, UNFPA, FAO, UNICEF and PAHO) to promote intersectoriality in addressing the needs of adolescent girls. The Ministry of Public Health and Social Assistance of El Salvador had a history of support for social participation and intersectoral action and supported the initiative through the Integrated Care Unit for Adolescent Health. In a patriarchal society like El Salvador young women were marginalized and were victims of systemic discrimination. Support for adolescent females was therefore identified as an important health equity issue. Health promotion strategies were supported through such nonconventional forms as a mural contest on the topic of birth control. Adolescents were responsible for the production of a variety of educational and audio-visual material on sexual and reproductive health. Specialized Integrated Care Units for Adolescent Health were established in 13 targeted communities which were staffed by multidisciplinary personnel who were trained in adolescent care. Eleven revenue generating enterprises, managed by adolescent girls, were created. A lack of baseline data limited the systemtic evalustion of the program although there is widespread acceptance that it has succeeded in empowering adolescent women in the affected communities. Although the program was national in scope, the case study emphasized the need for intensive and ongoing participation by local government.

11. India

Durbar Mahila Samanwaya Committee Theory and Action for Health Research Team (2007). *Meeting Community Needs for HIV Prevention and More: Intersectoral Action for Health in the Sonagachi Red-Light Area of Kolkata.*

In the early nineteen nineties, the All India Institute of Hygiene and Public Health (AIIHPH) initiated a conventional STI treatment and prevention program in a red light district in north Kolkata. The Sonagachi HIV/AIDS International Project (SHIP) was implemented through an intersectoral partnership of WHO, AIIHPH, the British Council, a number of Ministries and local NGOs. Sex workers in the area were poor and marginalized. The project quickly moved beyond traditional treatment and education modalities to focus upon the empowerment of the sex workers. Key interventions during the first five years included vaccination and treatment services for the sex workers' children, literacy classes for the women, political activism and advocacy, microcredit schemes and cultural programs. The sex workers created their own membership organization, the Durbar Mahila Samanwaya Committee that successfully negotiated for better treatment by madams, landlords and local authorities. In 1999 the DMSC took over management of SHIP and has since expanded to include forty red-light districts across West Bengal. It has an active membership of 2000 sex workers and has established a financial cooperative. The strong occupational health focus and the emphasis upon giving sex workers more control over their

bodies, living and working conditions has resulted in low rates of HIV infections and STI rates in Sonagachi, relative to the rest of the country.

12. Iran

Motevalian, S. A. (June 2007). *Intersectoral Action for Health in I. R. of Iran: Community Based Initiatives Experience.*

In 1991 the Healthy City concept was introduced in Iran and then expanded in 1996 with the establishment of the National Coordination Council for Health Cities Project (NCCHCP). The council included nine ministers and the heads of four relevant organizations. A series of Healthy City and Healthy Village initiatives were launched which focused on environment, water and sanitation, and healthy settings, although some local initiatives focused on issues such as addictions, health promotion, nutrition and injury prevention. Programs were launched and managed in close collaboration with local councils and were initiated by a comprehensive community needs assessment, based on household surveys, to guide local priority-setting. Intersectoral councils operated at the national, regional and local levels and local coordinators were often from the health sector. In 2006 the Supreme Health Council, headed by the President, was established to further the public health agenda within the Healthy City and Healthy Village initiatives. The process has achieved a number of positive outcomes in infrastructure and social capital. A particular emphasis was placed upon training participants in intersectoral action and community development although continuing needs for a stronger IA orientation among health professionals and administrators was noted as ongoing needs. The lack of an intersectoral funding base to support intersectoral action was also noted as a problem. The Iran case study utilized a particularly strong evaluation framework.

13. Malaysia

Jaafar, S. H., & Suhaili, M. R. H. (August 2007). *Malaysia: Primary Health Care Key to Intersectoral Action for Health and Equity.*

Based upon a strong governmental commitment to reduce inequities within Malaysian society there have been a series of initiatives that began in the 1970's with the New Economic Plan. A lengthy history of stable government and an ongoing commitment to equity provided the nation with an impressive platform for action. The impetus for the New Economic Plan had its roots in a serious riot which occurred in Kuala Lampur in 1969 and created a two-year long state of emergency. A intersectoral council of Ministers has been responsible for program planning and implementation. Through a series of five-year plans, a number of poverty reduction initiatives were undertaken which have resulted in substantial improvements in literacy, employment (especially among females), nutrition and sanitation. Overall poverty rates were reduced and a target for the eradication of hard-core poverty by 2010 is the target. A corresponding focus on the development of primary care and preventive services in rural areas was enacted throughout the same period. The development of the PHC system included a strong system of local intersectoral public participation in the setting of PHC priorities and the development of preventive measures. A substantial reduction in infant mortality, maternal mortality, communicable disease and child malnutrition occurred throughout the period.

14. Morocco

Naima, C. (September 2007). *At the Confluence of the National Initiative for Human Development and the Basic Development Needs Program: the Case of Larache Province, Essouaken/Imir Tlek and Doukkala/Boussafi Communes.*

The Basic Development Needs Program (BDNP) in Morocco constitutes an experiment in intersectoral action to promote equity in the areas of health and integrated local development and to address the social determinants of health. This program developed under a new King and government with an emphasis on increasing responsiveness to social issues and changing the

practices, behaviours and mind-sets that underlie the traditional system of governance that has been in place since Morocco first became independent. The goal has been to replace the 'top-down' governance model with a 'bottom-up' model (from the central to the regional to the provincial level) which emphasizes good governance, based on national/local, public/private and state/civil society partnership. The Ministry of Public Health shares some of these roles and is entirely responsible for others, all within a governance framework that is meant to be intersectoral. Other sectors are involved, but not in a fixed fashion; instead, they are identified on the basis of the priority needs established by the community, within the context of the community diagnosis and action plan. A lack of consensus on leadership is a remaining barrier to implementation, impeding progress on this initiative.

15. New Zealand

Matheson D., Rasanathan, K., Tobias, M. (August 8, 2007). *Health Inequalities: Unfair, Measurable and Remediable? The Case of New Zealand.*

Driven by a strong egalitarian public value system, New Zealand has incorporated a 'whole of government' approach to reducing inequalities in health, especially with regard to the ways in which ethnicity and socio-economic inequalities interact. Key policy documents released in 2000 and 2002 have embedded a health inequality focus into all levels of the work of the health sector and have provided a template (the Reducing Inequalities in Health Framework) for how action to reduce health inequalities could be achieved. New Zealand has done a particularly good job of steadfastly monitoring inequalities and reporting those inequalities in ways that best facilitate action. This has been achieved through a number of mechanisms, including a strong emphasis on ethnicity recording in the health sector, the routine matching of census with mortality records, and widespread use of a census-based small area deprivation measure, the New Zealand Deprivation Index. These approaches have boosted cross-sectoral interest in inequities, facilitated discussion in academic and policy circles about the root causes of inequities and provided social agencies with evidence on which they could plan programs and policies to address health inequities in their respective areas**.**

16. Norway

Torgersen, T. P., Giaever, O., & Stigen, O. T. (August, 2007). *Developing an Intersectoral National Strategy to Reduce Social Inequalities in Health: The Norwegian Case.*

In only a few years, Norway's policy environment has developed into a system of comprehensive, intersectoral policy to reduce social inequalities in health. The initial stages of Norway's work were outlined in an action plan which stressed the fact that social inequalities in health is a gradient challenge, implying that (1) there is a need for population strategies (not only high-risk groups) and (2) measures should be directed towards the whole causal chain, including the social determinants or structures. Building on this, an Intervention Map was developed which tries in a simple way to map out entry points for policies. These tools, backed by the political will of a new government, were utilized to set targets, plans, and policies for income redistribution, kindergarten coverage, work and the working environment, social inclusion, and health services.

17. Sri Lanka

Gunatilleke, G. (2007). *Intersectoral Action for Health – The Sri Lankan Case Study.*

Sri Lanka underwent a rapid health transition during the period 1950 -1975 that prolonged life and reduced mortality and fertility. The improvement in health occurred simultaneously with the improvement in other states of well-being. Each sector simultaneously pursued its goals to improve the conditions for which it was responsible. The intersectoral processes did not lead to clearly articulated programmes of intersectoral action for health in which the sectors other than health identified their contribution to health and consciously coordinated their activities to produce a desired health outcome. This failure is attributed to the existing structures of decision, the lack of

capacity to identify intersectoral links and become proactive on them and the prevailing administrative culture. The Sri Lankan case demonstrates processes that for the most part act independently of each other but act simultaneously to improve well-being as a whole with health as an integral component. These processes required (1) an overall social development strategy (2) a political process that evolves a high degree of national consensus for such a strategy (3) as far as possible equal weight and commitment to be given to each of the key indicators and (4) shared responsibility for the programme at the highest level of government.

18. Uganda

Mutambi, R., Hasunira, R., & Oringa, V. (August 2007). *Intersectoral Action on Health in a Conflict Situation – A Case Study of Kitgum District, Northern Uganda.*

In one region of Uganda, the Kitgum District, a 20-year war and violent tribal cattle raids have left most of the people in the area living under dehumanizing conditions in Internally Displaced Person (IDP) camps since 1996. The National IDP Policy, adopted in 2004, establishes intersectoral institutions at the national, district and sub-county levels. The District Disaster Management Committee (DDMC), made up of government departments in the district, humanitarian and development agencies, the private sector and other non-governmental organizations, is in charge of social service delivery and all other forms of support to IDPs in that area. This intersectoral framework of district-level committees and sub-committees has helped establish an integrated planning process for services and programs, introduced flexibility in resource allocation, has sped up the extension of social services to new settlements, and has enhanced the monitoring of progress on the efforts to protect and support IDPs. The health of the people in the district has improved since the introduction of these new committees; cases of acute malnutrition among children have decreased from 12% to 7%, and the stunting of children's growth has decreased from 31% to 23%.

Also submitted, but not included in analysis due to timing or nature of the submission:

India

Aggarwal, Surinder (2007). Tackling Social and Economic Determinants of Health through Women *Empowerment: The SEWA Case Study*

The Self Employed Women's Association (SEWA) works to achieve social and economic wellbeing of women through its twin goals of full employment and self reliance. SEWA facilities and services include, amongst other things: micro credit loans to its member, preventative and curative health care (including health education and awareness, immunization and micronutrient supplements, improved physical and financial access to health care from trained health workers, and the sale of low cost indigenous and western medicines), and loans to purchase a house or to improve an existing house. Tangible results of these services include women finding more regular employment, improving their marketable skills, increasing their savings, acquiring more assets, increasing the quality of their housing (including adding drinking water, toilets, electricity, etc), increasing the school enrolment of their children, and increasing their confidence and self esteem. SEWA has an organizational structure and working strategy based on networking and forging partnerships with other like-minded agencies. It networks with other organizations working in similar areas to advocate the cause of its members, and to lobby for favourable policies and legislation at national and international fora. It has adopted an intersectoral approach to produce synergy among its various wings to benefit the members of its services in an integrated manner.

European Union

Baer, W. (2007). *Strategies for Action to Tackle Health Inequalities in Europe: Intersectoral Examples from the European Union (2004 – 2007).*

The *Closing the Gap: Strategies for Action to Tackle Health Inequalities in Europe* project is a three-year EU-supported project, which wrapped up in June 2007. The project is coordinated by the German Federal Centre for Health Education (BZgA), together with EuroHealthNet – the European Association for National Institutes of Health Promotion. The goal of Closing the Gap was to develop a European knowledge base and infrastructure in order to implement and strengthen strategies and actions to reduce health inequalities. As a result of the project, a consortium of 21 national agencies working on the reduction of health inequalities has been developed. Good and promising practices in local policy measures and interventions have been compiled and are available on a public website.

12 Appendix C: Template Used for Analysis of Case studies

Case Study #:
Reviewer:
Case Study Title:

A Context:

1. What is the general political, social and economic context in which the intersectoral action occurred?

2. Key contextual factors of the work that have influenced its success:

B Purpose / Goals:

1. What are the goals of the intersectoral action for this case study?

2. How explicit was the desire to reduce health inequities? Were indicators or targets set, and, if so, how useful was this process?

C Project Initiation

1. What was the impetus for the work to begin?

2. How was the project initiated? Who took the lead role(s)? Initial responses to the work?

3. How was the case for intersectoral action built?

4. How did the work relate to social or cultural values (context) of that region/country/population group?

D Development of Partnerships:

1. How were partners chosen, and how were they motivated / persuaded to participate?

2. Key actors/sectors responsible for influencing the development and implementation of policy & programs: (? elected government officials, government staff, non-government organizations, local community members, private sector, etc). How important was the role (if any) of the non-government sector?

3. What is the history of these partners working together in the past?

4. Describe the structures (formal or informal) set up to ensure collaboration among key partners. How was integration within sectors or between sectors facilitated?

5. What role did the health sector play? (indicate key learning from this when possible)

E Impact and Outcomes

1. What level of integration was achieved (i.e. cooperation, coordination, or true integration)? How could you tell that integration was happening? Was true intersectoral action achieved (vs. multi-sectoral for instance)?

2. How were impacts and outcomes measured and reported? What mechanisms were used (if any) to ensure that an intersectoral process was used for measuring and reporting outcomes?

3. What were the impacts and outcomes of the work? (include both process & policy/program changes)

4. To what degree did the work achieve its objectives? To what degree did the work successfully deal with health inequities?

5. What mechanisms were put in place to ensure the work's sustainability? To what degree have these mechanisms been successful?

6. What were some key barriers to effective intersectoral action to reduce health inequities? How were they managed? To what degree were the barriers overcome?

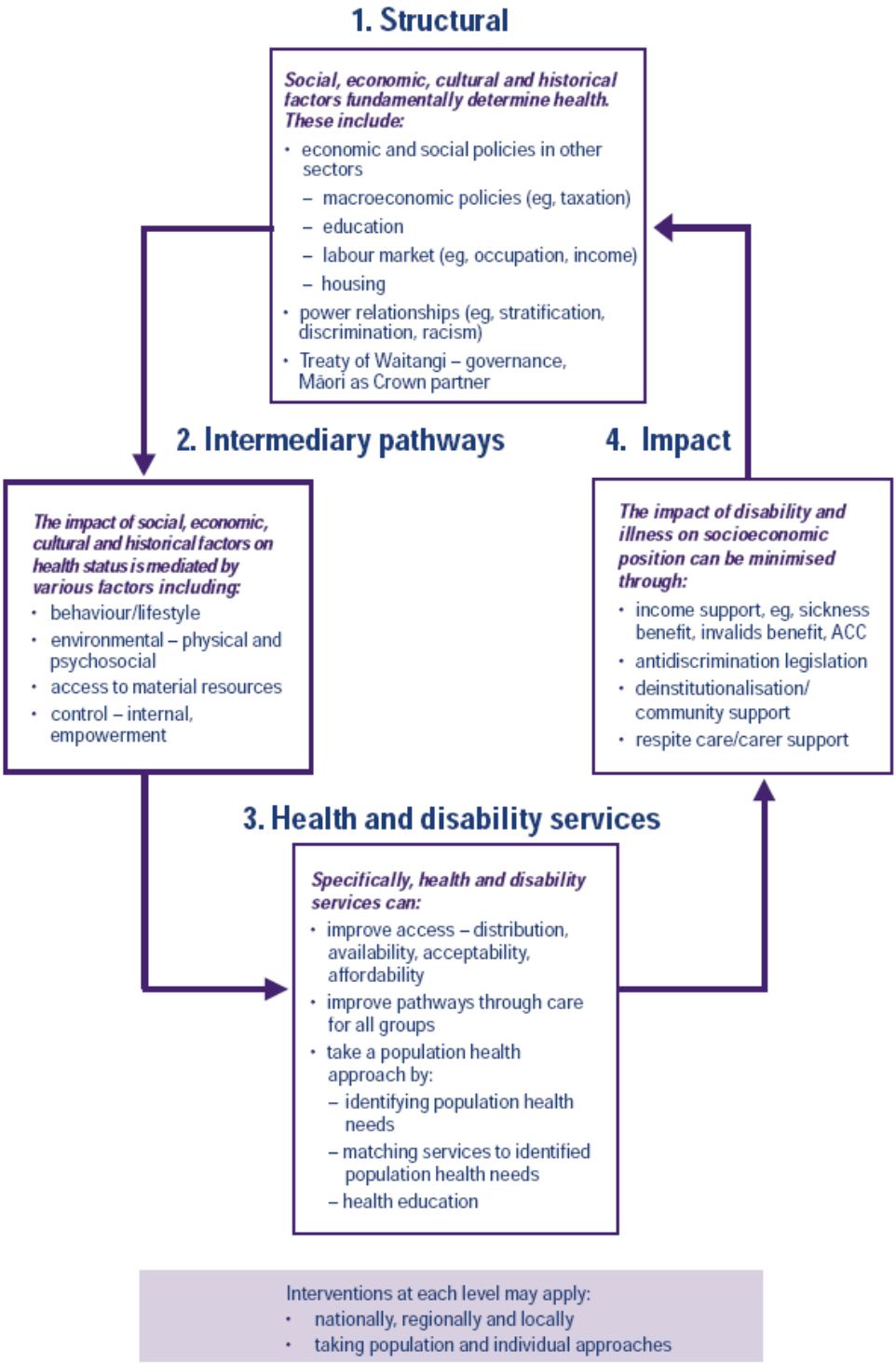
7. What were some key strengths of the work (especially given its social, economic and cultural contexts)?

8. Key learnings for the role of the health sector:

F **Summary comments** (key themes or areas learning that have not come up in any of the above questions):

13 Appendix D: Models Used by New Zealand and Norway as Frameworks for Intersectoral Action to Reduce Health Inequities

Reducing Inequalities in Health Framework (New Zealand)



(New Zealand, p. 8)

Intervention Map for Comprehensive Policies to Reduce Social Inequalities in Health (Norway)

	Social Reform Upstream	**Risk Reduction Midstream**	**Effect Reduction Downstream**
Universal measures	Public system for education, taxes, labour market policies, etc.	Working and living environment, broad lifestyle measures, etc.	Health systems
Selective measures	Means-tested social benefits, etc.	Targeted lifestyle measures, etc.	Targeted health systems

The Intervention Map gives strategic entry points for policies in the whole stream of causes combining universal and selective approaches. The point is to pay attention to all the six cells on the map as entry points for policy.

(Norway, p. 8).