Chapter 6: Coordinated, intersectoral action to improve public health

**SUMMARY POINTS**

- The factors that influence health outcomes are complex and extend well beyond the provision of health care services. Many also fall outside the authority of the health ministry. As a result, accountability for the progressive realization of the right to health must be shared across government as a whole. Coordinated, intersectoral action to improve health, including between ministries, between different levels of government, and with stakeholders outside government, is necessary in order to address complex and persistent health challenges.

- Legal and regulatory reform can support intersectoral action in health in a variety of ways, including by establishing new governance structures and processes for advancing shared goals, by establishing an accountability framework that sets out the responsibilities of participants, and by providing a clear mandate for intersectoral actions by relevant government agencies and authorities.

- The processes and structures that are used to formalize intersectoral and intergovernmental collaboration will vary between countries and will be influenced by existing institutions, traditions and constitutional arrangements, as well as the specific priorities that are being pursued. Governments may choose to invest in a number of structures and processes that vary in scale and focus in order to address different health priorities. Some intersectoral initiatives may be framed largely in terms of the health benefits they aim to achieve, while others may aim to achieve a number of related economic and social objectives.

- Securing high-level political commitment to an intersectoral initiative is vital, and may help to reduce resistance from ministries whose goals may conflict with public health.

- A successful partnership across sectoral boundaries requires the active participation and goodwill of all partners. The political commitment of partner ministries may be strengthened by formalizing the partnership in a declaration, memorandum of understanding or other framework document that sets out shared goals and the key responsibilities of each partner.

- Where different levels of government are involved, the unique legal status, legislative powers and comparative advantage of each level should be assessed.

- WHO has identified a number of practical steps that may assist health ministries as they seek to work with other ministries to realize the benefits of an intersectoral approach.

- Governance reforms have played an important role in many successful intersectoral initiatives, including in the areas of disease prevention, reducing health inequalities and improving food and nutritional security.

The factors that influence health outcomes are complex and extend well beyond the provision of health care services. The physical, economic, social and political environments in which people live have a profound impact on the health of individuals and populations. They affect life opportunities,
exposure to health risks, knowledge and access to information, preferences, choices and the capacity for self-protective behaviour, as well as access to – and the affordability of – health care services.

The wide range of factors influencing the health of the population creates profound challenges for governments and public health policy-makers. These include the need to work with a broader range of health stakeholders than has traditionally been the case, and to develop new structures for collaborating across portfolio boundaries. The need for a coordinated, intersectoral approach to health policy-making has been called many things, including an “all-of-government” approach, “health in all policies”, and “joined-up government”. This chapter discusses how legal and regulatory reforms can help to create an enabling environment for intersectoral action on health. For example, regulation can:

- provide a clear mandate for engaging with other sectors and stakeholders, both within and beyond government;
- establish new governance structures and processes for advancing shared social goals (including health); and
- establish a framework for accountability that sets out the responsibilities of all participants for achieving shared goals, and requires the evaluation of progress.

### 6.1 The purpose and scale of intersectoral reforms to improve public health

The structures and processes that are used to formalize intersectoral and intergovernmental collaboration will vary between countries and will be influenced by existing institutions, traditions and constitutional arrangements, as well as the specific priorities that are being pursued. Policies tend to evolve incrementally, rather than through a dramatic process of re-invention. For this reason, there may be benefits to building on existing structures and processes, while shaping and adapting them in new directions.²

There is no single blueprint for intersectoral action in health. Governments may choose to invest in a number of structures and processes that vary in scale and focus in order to address different goals and priorities. Some intersectoral initiatives may be framed largely in terms of the health benefits they aim to achieve, such as obesity prevention or active living. More ambitious, cross-sectoral partnerships may aim to achieve a number of economic and social objectives, including improvements in health and well-being. Examples of broader, intersectoral partnerships include:

- initiatives to reduce road traffic injuries;
- initiatives to improve the safety and security of the food supply;
- initiatives to improve child health, well-being and educational attainment; and
• integrated approaches to improving the quality of the local environment encompassing, for example, improved housing, infrastructure, social services, crime prevention and environmental remediation.3

Intersectoral structures may also provide a solution when governments have already passed multiple pieces of legislation that overlap and share common goals, but which are administered across a number of ministries. For example, the Republic of Korea has passed 25 Acts, administered by six ministries, which seek to improve the physical health and nutrition of children, and to reduce obesity. While the overlapping tasks mandated under these Acts could be merged within a single ministry, another alternative is to create an intersectoral committee to facilitate collaboration among ministries.4

Intersectoral initiatives may generate benefits that extend well beyond health. Public health leaders should consider how best to present the case for intersectoral action, remembering that collaboration with other sectors and ministries may be easier to achieve when initiatives are framed in terms of language, concepts, goals and values that are familiar or appropriate to that sector. For example, an integrated approach to reducing rates of violence in disadvantaged urban communities is relevant to the goals and values of policing and the justice sector. In addition, however, intersectoral action on the underlying social determinants of violence could include policies and programmes to respond to drug and alcohol problems, mental illness, poverty and unemployment. Laws, policies and programmes to create safer and healthier communities, in turn, will contribute to broader, societal goals; for example, reducing reliance on government welfare payments, creating a more socially cohesive environment that attracts local businesses, attracts tourism and reduces the pressure on over-burdened health systems and health care workers.5

Public health leaders can help to overcome inertia and to generate political support for intersectoral action by highlighting the health benefits that could result from coordinated action. For example, the threats to health and health equity are not the only grounds for action on climate change. Nevertheless, mitigating the impacts of climate change on health is an important argument supporting an all-of-government approach to improving environmental sustainability and reducing greenhouse gas emissions.6

**Intersectoral action in health: the evolution of an idea**

This subsection briefly reviews highlights in the evolution of intersectoral action in health, and identifies some priority areas where intersectoral governance structures could be used to advance the right to health.

In the Alma Ata Declaration (1978),7 intersectoral action was recognized as a key to improving primary health care, through coordinated action across a range of sectors, including agriculture, animal husbandry, food, industry, education, public works and communications. In 1986, the Ottawa Charter for Health Promotion recognized that intersectoral action is fundamental to reducing inequalities in health status within the population.8 The Charter emphasized health promotion both as a concept and strategy for re-orienting health systems in order to improve health equity and to achieve greater control by individuals and communities over the determinants affecting their health.
The Charter emphasized that health promotion includes building healthy public policy. This means putting health “on the agenda of policy-makers in all sectors and at all levels, directing them to be aware of the health consequences of their actions and to accept their responsibilities for health” (see Box 6.1). Like the Alma Ata Declaration, the Ottawa Charter emphasized the importance of community and individual self-reliance, and drew attention to health impact assessment as a strategy for making healthier public policies.

**Box 6.1: Intersectoral action in the Ottawa Charter for Health Promotion**

The prerequisites... for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organizations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health...

Health promotion goes beyond health care. It puts health on the agenda of policy-makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services and cleaner, more enjoyable environments.

In 2008, the WHO Commission on Social Determinants of Health emphasized that disparities in health between rich and poor countries, and between rich and poor people within the same country, are fundamentally linked to disparities in power and income, goods and services. These factors are reflected, in turn, in disparities in living and working conditions, in the quality of the surrounding natural environment, and in access to health care, education, leisure and other opportunities for a flourishing life (Box 6.2). The Commission called for a new approach to development that involves the participation of all levels of government, civil society, business and local communities. It also emphasized the importance of political leadership:

Policies and programmes must embrace all the key sectors of society, not just the health sector. That said, the minister of health and the supporting ministry are critical to global change. They can champion a social determinants of health approach at the highest level of society, they can demonstrate effectiveness through good practice, and they can support other ministries in creating policies that promote health equity.

**Box 6.2: Conclusions of the WHO Commission on the Social Determinants of Health**

“The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances...
of people’s lives – their access to health care, schools and education, their conditions of work and leisure, their homes, communities, towns or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequalities between and within countries.”

In 2010, the Adelaide Statement on Health in All Policies pointed out that the interdependence of public policy requires not only an integrated response across government departments, but partnerships with the business sector and civil society. The Statement identified important attributes that are reflected in successful approaches to intersectoral action in health, as well as examples of regulatory tools and processes that governments can consider when designing an intersectoral response (Box 6.3).

**Box 6.3: Adelaide Statement on Health in All Policies**

“Health in All Policies works best when:
- a clear mandate makes joined-up government an imperative;
- systematic processes take account of interactions across sectors;
- mediation occurs across interests;
- accountability, transparency and participatory processes are present;
- engagement occurs with stakeholders outside of government;
- practical cross-sector initiatives build partnerships and trust.

Tools and instruments that have [been] shown to be useful at different stages of the policy cycle include:
- inter-ministerial and inter-departmental committees;
- cross-sector action teams;
- integrated budgets and accounting;
- cross-cutting information and evaluation systems;
- joined-up workforce development;
- community consultations and Citizens’ Juries;
- partnership platforms;
- Health Lens Analysis;
- impact assessments;
- legislative frameworks.”

In 2011, the World Conference on Social Determinants of Health in Rio de Janeiro considered how intersectoral action and structures could reduce health inequalities by tackling the social determinants of health. Participants discussed strategies for institutionalizing intersectoral action
and emphasized the need to integrate intersectoral governance at all levels, from the level of United Nations agencies to local communities. At all levels, effective intersectoral engagement and action requires “a long-lasting sustainable process rather than a single event or programme”.  

At the international level, partnerships for multisectoral action have been recognized as an essential strategy for improving global health, in order to reduce fragmentation, conserve resources and maximize impact and influence at the country level. For example, a key feature of the global response to chronic, noncommunicable diseases is the emphasis on partnerships between governments, WHO and other United Nations agencies, development assistance agencies, civil society organizations and, where appropriate, the private sector. This has been formalized in the United Nations Task Force on noncommunicable diseases, which is led by WHO and coordinates the activities of United Nations organizations and intergovernmental organizations in implementing the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. A separate global coordination mechanism established by WHO facilitates engagement and partnerships between a broader group of stakeholders including WHO Member States, United Nations funds, programmes and agencies, civil society groups and the private sector, while protecting against conflicts of interest.

The Rio conference on social determinants of health highlighted the importance of ensuring the participation of civil society in intersectoral structures, and of civil society’s role in keeping governments accountable. Evaluation and accountability require both good information and “permanent structures and forums (such as intersectoral committees) that [facilitate] comparison of data”.

6.2 Practical steps for initiating intersectoral action

Intersectoral action can be initiated at a variety of levels, depending on its scope and purpose. In many cases, political leaders at national, regional, city or local level, in consultation with public health leaders will have a vision or a preliminary plan of what could be achieved through an intersectoral partnership. In some cases, a parliamentary interest group (such as a cross-party parliamentary diabetes support group) may provide the initial impetus, support and advice. Securing high-level political commitment to an intersectoral initiative is vital: it gives legitimacy to the open-ended process of negotiating a partnership with relevant sectors, and can help to reduce opposition from ministries whose goals may conflict with public health. Where different levels of government are involved, the unique legal status, legislative powers and comparative advantage of each level should be considered.

A successful partnership across sectoral boundaries requires the active participation and goodwill of all partners. The political commitment of government to intersectoral action on health may be strengthened by formalizing the partnership in a declaration, memorandum of understanding or other framework document. Such a commitment may even be formalized in the national constitution. For example, Thailand’s Constitution (2007) provides that if a public programme might have a serious impact on natural resources or the environment, a participatory health and environmental impact assessment must be carried out before the programme can begin (Box 6.4).
Article 67 states, in part:

Any project or activity which may seriously affect the quality of the environment, natural resources and biological diversity shall not be permitted, unless its impacts on the quality of the environment and on the health of the people in the communities have been studied and evaluated, and consultation with the public and interested parties has been organized, and opinions of an independent organization, consisting of representatives from private environmental and health organizations and from higher education institutions providing studies in the field of the environment, natural resources or health, have been obtained prior to the operation of such a project or activity.

Civil society organizations, professional associations, academia and the private sector are important partners for achieving shared health goals. In Brazil, governments and civil society organizations signed a Declaration for the Prevention and Control of Noncommunicable Diseases, which commits the parties to implementing the WHO Framework Convention on Tobacco Control, the WHO Global Strategy on Diet, Physical Activity and Health and other strategies. Signatories committed to placing these policies on the work agendas of national, state and local governments, ensuring integrated action between sectors, access to resources and broad community participation. The Declaration constitutes an important statement of intent which supports the implementation of a coordinated, intersectoral approach to noncommunicable diseases encompassing surveillance, prevention and treatment.

Although helpful, declarations and statements of intent are not a substitute for action by governments. Governments must ensure that they take the concrete steps that are required to deliver on their promises, by enforcing public health laws, reforming and improving them and honouring human rights obligations. Governments should ensure that partnerships with the private sector, where appropriate, do not undermine their capacity to use legal and regulatory powers effectively to protect public health. For example, the Guidelines for the implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control recommend that: “The tobacco industry should not be a partner in any initiative linked to setting or implementing public health policies, given that its interests are in direct conflict with the goals of public health”.

Despite the importance of high-level political support, health ministries, rather than other ministers or heads of government, will often be the leaders of intersectoral initiatives for health, with practical responsibility for moving them forward. WHO has identified a number of practical steps that may assist health ministries as they seek to realize the benefits of an intersectoral approach. For example, health ministries should:

- Build understanding among health sector personnel of the need for an intersectoral approach to implement health priorities or to advance shared societal goals;
- Strengthen the capacity of health sector personnel to interact with and develop alliances with other Ministries;
- Use health impact assessment as a tool to identify how health department priorities will have an impact on the goals and interests of other ministries and their constituencies.

Box 6.4: Constitution of the Kingdom of Thailand (2007), Article 67
• Identify areas where interests are aligned, but be aware of areas where disagreements and rivalries could also arise. Create alliances where possible without undermining health goals;

• Identify existing structures and processes for cross-ministerial, intersectoral action and cooperation. Are these appropriate? Review existing laws and mandates for intersectoral action. Are they adequate? Identify new potential mechanisms for intersectoral cooperation. Seek high-level political support for these to be formalized and used;

• Be responsive to initiatives led by other sectors that provide opportunities for improving health and achieving health goals. For example, initiatives to improve food security, led by the agricultural sector, may also provide opportunities for improving diets, diversifying away from tobacco cultivation and supporting the cultivation of healthier oils;

• Explain the health impact of policies administered by other ministries, and the health benefits of a collaborative approach to policy development. Share relevant health data with other ministries;

• Choose the best method of collaboration for implementing each initiative, remembering that the most appropriate implementation strategies may vary according to the priority in question.

• Develop a strategy for engaging other sectors and ministries, and a common framework that assists all sectors and partners to understand the issues and the required actions;

• Support community participation in the development and implementation of health initiatives through public consultation, preparation of discussion papers, web-based tools and mass media;

• Look for ways to ensure political accountability through reporting requirements and access to information. Reporting mechanisms mandated by international agreements provide opportunities for reporting on government commitments and progress made in intersectoral activities;

• Monitor and evaluate the progress of intersectoral efforts to advance priority health goals, and identify and promote good practices.

6.3 Case studies of governance reforms supporting intersectoral action on health

This section presents three case studies of intersectoral structures and processes designed to advance health in three important areas: firstly, health promotion and disease prevention; secondly, reducing health inequalities through action on the social determinants of health; and thirdly, reducing hunger and improving nutritional security. The discussion highlights key features of the governance structures adopted in each case.

(a) Disease prevention and health promotion

Effective disease prevention strategies require action to be taken outside the health sector in order to promote healthy living, to improve access to information, to reduce risk factors for disease, and to improve the quality of the environments in which people live. National leadership can take a variety of forms.
In Mexico, a National Council for the Prevention and Control of Chronic, Noncommunicable Diseases was established by presidential decree. The National Council acts as the permanent coordinating body for national action on noncommunicable diseases and their risk factors, linking Secretariat of Health officials with their counterparts in the finance, agriculture, education and trade ministries. The Council coordinates activities both among federal government agencies, and between the federal government and the states under the National Health Council.

A similar model operates in the United States of America. In 2009, Congress passed legislation calling on President Barack Obama to establish an intersectoral National Prevention, Health Promotion and Public Health Council. The Council now comprises the heads of 20 federal government agencies, and is supported by an Advisory Group of experts appointed by the President (Box 6.5). Legislation required the Council to develop a national prevention and health promotion strategy, setting out specific goals for improving health through federally funded prevention and health promotion programmes. The Council is also required to publish an annual report setting out corrective actions that federal agencies can take to achieve national goals for reductions in tobacco use, harmful use of alcohol, physical inactivity and poor diet.

**Box 6.5: The National Prevention, Health Promotion and Public Health Council (United States)**

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<th>The Council: The National Prevention Council, established by executive order of President Obama, 10 June 2010, comprises:</th>
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<td>• The Surgeon-General (Chair)</td>
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<td>• Secretary, Department of Health and Human Services</td>
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<td>• Secretary, Department of Agriculture</td>
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<td>• Secretary, Department of Education</td>
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<td>• Chairperson, Federal Trade Commission</td>
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<td>• Secretary, Department of Transportation</td>
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<td>• Secretary, Department of Labour</td>
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<td>• Secretary, Department of Homeland Security</td>
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<td>• Administrator, Environmental Protection Agency</td>
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<td>• Director, Office of National Drug Control Policy</td>
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<td>• Director, Domestic Policy Council</td>
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<td>• Assistant Secretary, Indian Affairs, Department of the Interior</td>
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<td>• Attorney-General, Department of Justice</td>
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<td>• Acting Chief Executive Officer, Corporation for National and Community Service</td>
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<td>• Secretary, Department of Defence</td>
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<td>• Secretary, Department of Veterans Affairs</td>
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The Advisory Group: The Council is supported by an Advisory Group on Prevention, Health Promotion and Integrative Public Health. Members of the Advisory Council include a diverse group of licensed health professionals with expertise in:

- worksite health promotion;
- community services, including community health centres;
- preventive medicine;
- health coaching;
- public health education;
- geriatrics; and
- rehabilitation medicine.

Key duties of the Council include:

- providing coordination and leadership among federal agencies on disease prevention, health promotion practices, and integrative health care;
- developing a national strategy for disease prevention and health promotion that includes the most effective and achievable strategies for reducing preventable illness and disability in the United States. This strategy must set out specific goals for improvements in health, together with specific, measurable actions and timelines for implementing the strategy;
- providing recommendations to the President and to Congress on changes in federal policy required in order to achieve national goals for reducing tobacco use, reducing sedentary behaviour, and improving nutrition;
- reporting annually on corrective actions recommended to federal agencies to meet the goals and actions taken by relevant agencies. This annual status report must contain a list of national priorities for improving lifestyles, covering: smoking cessation, proper nutrition, appropriate exercise, mental health, behavioural health, substance abuse and domestic violence. It must contain “specific, science-based initiatives” to achieve national goals for nutrition, exercise and smoking cessation and for preventing the five leading disease killers in the United States.

Four features of this model for intersectoral action deserve emphasis. As a national council comprising the heads of federal executive agencies, the Council has a clear mandate for shaping and implementing new programmes and policies. In order to discharge these responsibilities, the Council is served by an Advisory Group of experts in preventive health. Although the legislative mandate is
imposed directly on heads of government agencies, the presence of the Advisory Group ensures that the policy-shaping process is less vulnerable to entrenched departmental cultures and goals, which may run contrary to public health objectives.

Secondly, the authorizing legislation by Congress seeks to ensure accountability for the implementation of the national prevention strategy by ensuring that it contains specific indicators for measuring progress, and by requiring preparation of an annual status report which enables Congress and the President, to monitor progress.

Thirdly, in addition to encouraging collective action by federal agencies, the National Strategy envisages that the National Prevention Council and the Advisory Group will engage with a broad range of partners to ensure implementation of the national prevention strategy. These include state and local governments, businesses, community organizations and faith-based organizations.

Fourthly, the authorizing legislation illustrates how rising health care costs are a driver for government investment in intersectoral initiatives for preventive health. In this case, the legislation established a Prevention and Public Health Fund to provide sustained funding for preventive health programmes, reaching US$ 2 billion per year by 2015, in order to reduce the rate of growth in health care costs.

(b) Promoting health equity and reducing health inequalities

The WHO Commission on Social Determinants of Health found that health inequalities arise from the “societal conditions in which people are born, grow, live, work and age”. These social determinants include “early years’ experiences, education, economic status, employment and decent work, housing and environment and effective systems of preventing and treating ill-health”. It follows that reducing health inequalities within the population requires an intersectoral approach that addresses areas of sustained disadvantage in social and economic living conditions. The priority areas for government action to promote health equity vary between countries, but often include policies to address the following kinds of problems:

- inadequate income;
- unemployment;
- substandard housing;
- fuel poverty;
- lack of sanitation and lack of access to clean water;
- low levels of education;
- hunger;
- lack of access to fresh fruit and vegetables and to nutrients required for a healthy diet at reasonably affordable prices;
- high rates of risk factors including smoking, binge drinking and substance abuse;
- poor access to health care services, including prenatal and mental health services;
- high rates of crime and violence;
• high rates of teenage pregnancy;
• high rates of suicide and self-harm;
• lack of access to safe public areas for recreation and physical activity;
• lack of public transport;
• dangerous and contaminated physical environments;
• social isolation and lack of social supports.

Making progress on a complex set of issues like these calls for an integrated response that coordinates the work of all relevant ministries, coordinates actions by different levels of government, and provides opportunities for partnerships between government, community groups, businesses and other stakeholders.

In England, the foundation for government action to reduce health inequalities was an independent scientific review that documented the widening gap between the health outcomes of different social groups and made policy recommendations covering a range of sectors. By the 1990s, the mortality rate of working age men in England was almost three times as high for those in the lowest socioeconomic quintile (unskilled workers) as it was for the highest quintile (professionals). A subsequent joint review by the Department of Health and the Treasury identified a set of priority interventions for public spending. This review provided the basis for the government’s national strategy for tackling health inequalities.

In 2001, the government adopted a national health inequalities target: to reduce inequalities in health outcomes by 10%, as measured by infant mortality and life expectancy at birth. Additional targets were added in 2004, including a target to reduce (by 10%) the gap between the most deprived 20% of local area authorities and the population as a whole. The government used indicators for health and for deprivation in different local government areas to measure the gap and progress towards the target.

The national health inequalities strategy was adopted in 2003. It grouped policies and services under four themes: supporting families, mothers and children; engaging communities and individuals; preventing illness and providing effective treatment through the National Health Service (NHS); and addressing the underlying, long-term determinants of health (Box 6.6).

Box 6.6: A programme for action for reducing health inequalities in England

In 2003, the Department of Health in England outlined a strategy for tackling health inequalities. The strategy focused on four themes:

• supporting families, mothers and children: in order to provide children with the best possible start in life, and to break the intergenerational cycle of poor health;
• engaging communities and individuals: the strategy recognized the need for the government to respond to local problems and “pools of deprivation” through specific and targeted interventions. These would operate alongside the delivery of mainstream services to local communities and socially excluded groups;
• preventing illness and providing effective treatment and care through the NHS. The strategy included policies to reduce tobacco use, to tackle cancer and coronary heart disease, and to improve primary care through the government-funded NHS;
• addressing the underlying determinants of health. The strategy included long-term activities undertaken by the government, at national and local levels, to address the underlying social determinants of health; for example: by reducing poverty and improving employment opportunities and living conditions for disadvantaged groups.

One important feature of the government’s strategy was the recognition that government services needed to be tailored to local circumstances in order to meet local needs. The strategy envisaged that this would occur through “local strategic partnerships” between local government authorities, primary care trusts (which commission the provision of health services from health care providers on behalf of the NHS), as well as communities, businesses and the voluntary sector. Under the government’s strategy, local government authorities were required to negotiate Local Public Service Agreements with the central government, to include performance targets covering a range of sectors, as well as the national health inequality targets. Local governments were invited to use the local strategic partnership process to review local challenges together with other stakeholders and to agree on additional outcome-focused targets for local performance, with a reward grant paid to those authorities that met their target.38 The entire strategy was supported by a set of health and social indicators for measuring local area performance, national performance and the difference between national performance and performance in deprived local areas.

(c) Improving food and nutritional security in Brazil

Institutions, laws and governance reforms have played an important part in Brazil’s efforts to reduce hunger and improve food security. Brazil is the world’s seventh largest economy and a large agricultural producer and food exporter. Nevertheless, a significant segment of the population lives in conditions of hunger and food insecurity, due to lack of income to purchase adequate food, exacerbated by variations in food production between geographical regions.

Despite these problems, Brazil has achieved significant reductions in poverty, hunger and food insecurity over the past decade. In 2003, using the methodology developed to track poverty and food insecurity across all regions in Brazil, there were 50 million people, including nearly 11 million families, living below the poverty line (now frequently defined as US$ 1.25 per day).39 By 2009, over 20 million people (nearly 4 million families), had been removed from poverty.40

When Luiz Inácio Lula da Silva became the President of Brazil in 2003, he made hunger and food insecurity a priority of his Presidency, stating in his first speech that “If at the end of my mandate every Brazilian can eat three times a day, I will have fulfilled my life’s mission”.41 President da Silva immediately launched Fome Zero (Zero Hunger), a national programme that combined emergency activities to increase income and access to food with longer-term structural activities to reduce poverty and increase the supply of food at affordable prices.42 This section highlights the key governance reforms involved in the implementation of Fome Zero, together with a brief description of the programme’s leading policies.
Intersectoral governance reforms

Fome Zero was supported by a number of governance reforms that made it possible for civil society to originate and participate in policy proposals, and which also facilitated coordination between different federal ministries and different levels of government. Together, these reforms created the National System for Food and Nutritional Security (SISAN), which was formalized in the Federal Law on Food and Nutrition Security (2006).\(^43\) SISAN comprised:

- the National Conference on Food and Nutritional Security;
- the National Council of Food and Nutritional Security;
- the Inter-ministerial Chamber for Food and Nutritional Security;
- agencies and entities implementing policies and programmes for food and nutritional security at federal, state and municipal levels; and
- private institutions that respected the goals of SISAN and wished to participate in it.

“Food and nutritional security” was defined in 2004, during Brazil’s Second National Conference on Food and Nutrition Security, and this definition was subsequently included in federal law (Box 6.7). The concept draws attention to a number of underlying variables including: sufficient quantity of food; the quality of food, including its safety and nutritional balance; regularity of access to food; as well as choice and dignity: freedom to choose food that is culturally appropriate without compromising other needs.\(^44\)

As reflected in Article 4 of the Federal Law, the achievement of food and nutritional security rests on intersectoral policies and programmes addressing a range of underlying factors which affect the capacity of low-income families to participate in the domestic food market, both as food producers and consumers. Effective policies on food and nutritional security must seek to:

- expand access to food through support for traditional and family farming;
- ensure biodiversity and the sustainable use of resources;
- promote good health and nutrition, especially among vulnerable social groups;
- ensure the safety and quality of food;
- improve access to information; and
- implement participatory public policies to improve food production, commercialization and consumption.

Box 6.7: Food and nutritional security in Brazil: a multifaceted concept

Organic Law of Food Security and Nutrition, Brazil\(^45\)

**Article 3.** Food and nutritional security consists of the realization of the human right to regular and permanent access to good-quality food, in sufficient quantity, without compromising the fulfilment of other basic needs, having as its basis healthy nutritional habits that respect cultural diversity and that are environmentally, culturally, economically and socially sustainable.
Article 4 Food and nutritional security comprises:

I. Expansion of access to food through its production, particularly via family and traditional farming, food processing, industrialization and commercialization, including international agreements; better food supply and distribution, including of water; job creation and redistribution of wealth;

II. The conservation of biodiversity and the sustainable use of resources;

III. The promotion of health, food, and nutrition for the population, including specific population groups and those more socially vulnerable;

IV. The guarantee of the biological, sanitary, nutritional and technological qualities of the food, as well as its good use, which stimulates healthy food practices and lifestyles that respect the ethnic and racial diversity of the population;

V. The production of knowledge and the access to information; and

VI. The implementation of public policies and sustainable and participatory strategies of food production, commercialization and consumption, respecting the diverse cultural characteristics of the country.

At the federal level, three governance reforms played a critical role in shared efforts to achieve these goals. Firstly, Fome Zero was initially administered by a new, Extraordinary Ministry for Food Security and the Fight against Hunger, which subsequently became the Ministry for Social Development and the Fight against Hunger. The functions of this Ministry included “formulating and coordinating the implementation of the National Food and Nutrition Security Policy for the purpose of ensuring the human right to food”, and creating links between policies and programmes administered by federal, state and municipal governments, as well as those of civil society. The creation of a ministry devoted to the coordination of hunger and food security initiatives reflected the high level of political commitment to hunger prevention within the da Silva administration, and maintained the relative political priority of Fome Zero among other programmes competing for attention and resources.

Secondly, President da Silva re-established the National Council of Food and Nutritional Security (CONSEA), a unique body which is attached to the Presidency and ensures the participation of civil society in national policy-making on food security. One third (currently 19) of the delegates to CONSEA are ministers and secretaries from portfolios related to food and nutritional security. The remaining two thirds of delegates come from civil society and represent nongovernmental organizations, social movements and professional and religious organizations.

CONSEA is required to convene the National Conference on Food and Nutrition Security every four years. The national conferences are a unique aspect of participatory democracy in Brazil, proposing and prioritizing policies and guidelines that form the foundation of the National System for Food and Nutrition Security (SISAN). The national conference is preceded by state conferences convened by the 27 state CONSEAs, which debate issues of food security relevant to their geographical constituencies, nominate delegates to the national conference, and submit proposals which are included in the base document for the national conference. A similar process occurs at the municipal level. For example, the Fourth National Conference on Food and Nutrition Security, held in 2011, was
attended by 1626 delegates representing the 26 states, and carried forward the work of over 75,000 people from 3000 municipalities. 48

Thirdly, CONSEA’s legal role includes considering and framing resolutions and guidelines adopted by the national conference into specific proposals that take account of the politics and institutions of government. 49 These proposals, which include budgetary requirements for their implementation, are submitted to the Inter-ministerial Chamber for Food and Nutritional Security (CAISAN), a purely governmental body that comprises over a dozen Ministers and Secretaries who participate in CONSEA. CAISAN is charged, in turn, with transforming the proposals received from CONSEA into government programmes (with supporting directives, goals, budgets and resources), and with implementing and monitoring them. 50 CAISAN is chaired by the General Secretary of CONSEA and its Executive Secretariat is maintained by the Ministry for Social Development and the Fight against Hunger.

**Fome Zero: leading policies**

Fome Zero was a political programme that began with the government of President da Silva but developed over time. The first set of policies aimed to increase access to food by boosting the purchasing power of the unemployed and those on low wages. The largest initiative here was the family grants programme, Bolsa Família, which consolidated a range of income assistance payments. In 2010, these payments reached over 12.7 million families living in poverty and extreme poverty (nearly 50 million people). 51 The conditions for receipt of the Bolsa Família – that children are vaccinated, receive regular health checks and attend school – are monitored by municipal and state secretariats within the Ministries of Education and of Health, which communicates the data to the Ministry for Social Development and the Fight against Hunger. Since 2006, municipalities have received economic incentives to improve their monitoring of these conditions and for maintaining up-to-date data on municipal enrollees.

A second set of policies aimed to increase access to food by strengthening family farming, which (unlike Brazil’s export-oriented agribusiness sector) accounts for production of most of the domestic food supply. 52 Family farmers represent the majority of the rural population, but many live in conditions of food insecurity. The Family Farming Food Acquisition Programme, funded jointly by the Ministry for Social Development and the Fight against Hunger and the Ministry of Agrarian Development, involves direct procurement of food from family farmers, traditional peoples and groups resettled under agrarian reform programmes. Under one set of initiatives, the National Food Supply Company purchased products from farmers at market prices, and used these to re-establish public food security stocks. Under another set of initiatives, based on agreements with states, cities and local family farmers’ associations, products purchased from farmers’ associations are donated to municipal food security programmes, including subsidized restaurants and school meal programmes which, by law, must purchase 30% of food from family farmers. 53 A further set of initiatives aimed to boost milk production and distribution in semi-arid regions.

Other programmes supporting food production included agrarian reforms to resettle displaced groups, regularization of land tenure, expansion of credit to family farmers, harvest insurance, the
building of rainwater cisterns to encourage self-sufficiency and independence from water utilities, and technical assistance.

A third set of policies aimed to directly increase access to food. Under President da Silva’s administration, the school meals programme was expanded to include all students in kindergarten, elementary and high school. Other initiatives included the federally-funded workers’ food programme for low-income workers, as well as the Network of Public Utilities for Food Security and Nutrition (RedSAN), administered by the Ministry for Social Development and the Fight Against Hunger. RedSAN activities include subsidizing restaurants and food banks and distributing emergency food baskets, which include products produced by family farmers.

Strengthening the National System for Food and Nutrition Security

Brazil’s National System for Food and Nutrition Security (see Figure 6.1) is both intersectoral and decentralized. Since Brazil has a highly decentralized political system, the federal government relies for implementation on governance relationships with over 5500 municipalities. The National System for Food and Nutrition Security has been strengthened through the establishment, by presidential decree, of the National Food and Nutritional Security Policy, together with a National Food and Nutritional Security Plan which reflects that policy (Box 6.8). This law clarifies the roles and obligations of the bodies that make up the National System for Food and Nutrition Security. This includes the establishment and resourcing of CONSEAs at the state and municipal levels to ensure comprehensive engagement with civil society at all levels. It also includes the establishment of CAISANs at state and municipal levels to coordinate the actions of state and municipal agencies in food security at each level (Figure 6.1).

Box 6.8: Key goals of Brazil’s National Food and Nutritional Security Policy

Brazil’s National Food and Nutritional Security Plan is based on the following goals and principles:

- The promotion of universal access to adequate and healthy food, especially for those living in conditions of food and nutritional insecurity;
- Sustainable, decentralized systems for food production, extraction, processing and distribution;
- Permanent processes for education, research and training in relation to food and nutritional security and the human right to adequate food;
- The coordination of actions to secure food and nutritional security for quilombolas and other traditional communities, and indigenous peoples;
- Integrating activities on food and nutritional security with activities undertaken at all levels of health care;
- Ensuring universal access to a sufficient quantity of water, with priority for those living in conditions of water insecurity, and for family food production, fisheries and aquaculture;
- Support to initiatives to promote food sovereignty, food and nutritional security, and the
human right to adequate food in the international arena;
- Monitoring of the realization of the human right to adequate food.

The articulation of policies and programmes for food security between the federal, state and municipal levels of government occurs through tripartite forums, convened by CAISAN, which provide the link between the intersectoral coordinating agencies of each level of government. These structures are intended to facilitate the administration of programmes which, like the Bolsa Família, depend upon a range of actions being taken by government agencies at every level. The presidential decree specifies the criteria to be met by states and municipalities, and non-profit organizations that wish to become members of SISAN, as well as the financing responsibilities of each level of government. In 2010, Brazil’s efforts to improve food and nutritional security were further strengthened through a constitutional amendment recognizing the right to food. Brazil’s model for addressing hunger has become an important model for other countries that wish to ensure community participation while integrating government actions across sectors and between different levels of government.
Figure 6.1: Brazil’s national food and nutrition security system and policy⁵⁸
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