1. Introduction

This report provides an overview of Crossing Sectors: Dialogue on Intersectoral Action held June 10-11, 2007 in Vancouver, British Columbia, Canada. The dialogue was co-hosted by the Public Health Agency of Canada and the World Health Organisation (WHO) in support of the WHO Global Commission on Social Determinants of Health (SDH). It was held in conjunction with the 19th World Conference on Health Promotion and Health Education.

The Dialogue began with a welcome and remarks from the Dialogue Co-chairs:
- Mr. Jim Ball, Director General, Strategic Initiatives and Innovations Directorate, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada, and
- Dr. Jeanette Vega, Director (ad interim), Department of Equity, Poverty and Social Determinants of Health, and Head of the Secretariat to the WHO Commission on the Social Determinants of Health (SDH).

The co-chairs provided an overview of the context for the dialogue (see section 3 below) and its purposes: 1) to share experience in intersectoral action for health and to consider implications for future cross-sectoral approaches, and 2) to inform recommendations to the WHO Commission on Social Determinants of Health.

Specific objectives were identified, including:
- to share highlights from participants’ intersectoral action case studies
- to discuss collective learnings and identify issues related to advancing effective intersectoral approaches
- to consider the implications for providing practical supports, models, and tools to support intersectoral action, and
- to discuss next steps, including the development of a report to the WHO Commission on Social Determinants of Health.

The expected dialogue outcomes were outlined, and included the creation of:
- an informal network of individuals and organisations involved in intersectoral approaches to address social determinants of health
- feedback to case study authors to shape final cases
- knowledge to inform the analysis and report on intersectoral action to the WHO Commission on Social Determinants of Health
• a foundation for further action and collaboration to support intersectoral approaches.

Please refer to Annex A for the dialogue agenda.

Dialogue participants included case study authors from 17 countries and the European Union, as well as other representatives from: the Public Health Agency of Canada, the World Health Organisation, two of the WHO’s regional offices (the Pan American Health Organisation and the Eastern Mediterranean Regional Office), and the WHO Commission on Social Determinants of Health.

Annex B provides a full listing of dialogue participants, with contact information.

2. Introductory Remarks

The Honourable Monique Begin, former Canadian Minister of Health and current Canadian Commissioner to the WHO Commission on Social Determinants of Health provided introductory remarks. Key messages included the following:

• The need for intersectoral action is not new – working across sectors is recognised as a difficult issue among political, bureaucratic and non-government actors.
• The significance of shared values to reduce health and social inequities is a foundation to the work of the Commission, its interim statement and intersectoral approaches to address social determinants of health.
• Intersectoral action is a key implementation issue related to the work of the Commission. Its practical focus is critical to tie together the knowledge that has been synthesised within the Knowledge Networks, Country and Civil Society Streams of Work.
• There is a need to demonstrate to the Commission the evidence and stories that intersectoral approaches work to reduce health inequities.
• Recommendations to the Commission must be succinct, crisp and action oriented.
• The stories related to intersectoral action must be told in a variety of ways – quantitative and qualitative, brief, high-level approaches supported by more detailed, technical documents.

3. Project Overview

Ms. Gerry Gallagher, Public Health Agency of Canada, provided an overview of the Intersectoral Action for Health Project, the project phases, the role of dialogue participants and the approach to the two-day dialogue. The main phases of the project are summarized below.

• Phase 1 – Synthesis and Analysis of Documented Experiences (October 2006 to March 2007). The final literature review, Crossing Sectors: Experiences in Intersectoral Action, Public Policy and Health is available at www.phac-aspc.gc.ca/publications_e.html. This review of documented
experiences of intersectoral action was developed to inform the final report of the Health Systems Knowledge Network to the WHO Commission on Social Determinants of Health. It was developed by the Public Health Agency of Canada in collaboration with the Health Systems Knowledge Network and EQUINET.

• **Phase 2 – Case Study Development** (February to July 2007). Twenty-three cases are drawn from all six WHO regions, high, medium and low-income nations and a range of socio-political contexts. The draft case studies and powerpoint presentations were completed in advance of the June 10-11 dialogue, and are currently under final revision.

• **Phase 3 – June 10-11 Dialogue on Intersectoral Action and June 13 Symposium.** The approach for the two-day dialogue was primarily an interview style format, where case study authors were interviewed by other case study authors and responded to questions by the interviewer and other participants. The second day focused on learnings related to the experiences and implications for future intersectoral work and the report to the WHO Commission on Social Determinants of Health.

On June 13, a symposium panel was held as part of the 19th World Conference on Health Promotion and Education. Three panelists discussed their experiences in intersectoral action: Dr. Amit Sengupta, Peoples Health Movement (India), Ms. Ardath Paxton-Mann, Economic Diversification Canada and Dr. Kimmo Leppo, Ministry of Social Affairs and Health, Finland. The panel was moderated by Mr. Jim Ball of the Public Health Agency of Canada.

• **Phase 4 – Case study finalisation, analysis and development of intersectoral action report to the WHO Commission on Social Determinants of Health (June to October 2007).** This phase will build on the work of the previous phases. The report is expected to highlight key learnings and outline key considerations, which can be used by various regions and countries when developing intersectoral approaches to tackle health inequalities, and which will inform the final report of the WHO Commission on Social Determinants of Health.

4. **Sharing experiences in intersectoral action**

The balance of June 10 and the opening session of the June 11 dialogue focused on interviews of case study authors, by a fellow case study author. These cases are drawn from low medium and high income settings from six geographical regions, and from a range of socio-political contexts. The interviews were grouped under the following five themes: Broad Policy Frameworks; Multi-Level Interventions; Primary Care/Community-based Interventions; Empowerment; and Post-Conflict/Emergency Response. The original listing of
the cases, with their presenters, is outlined below – note that certain cases were reassigned to other groups subsequent to the submission of the cases.

Case studies will be made available on the Canadian and WHO websites later in the year after finalization and completion of a report to the WHO Commission on Social Determinants of Health.

Broad Policy Frameworks:
- Norway, National strategy to reduce social inequalities in health, Dr. Tone Poulsso Torgessen
- Chile, Integrated action for social equity: Chile Barrio, Chile Solidario, Chile Emprende, Chile Crece Contigo, Dr. Patricia Frenz
- Sweden, Intersectoral action for health – (how) can it happen?, Dr. Bosse Pettersson
- New Zealand, The New Zealand Experience, Dr. Don Matheson
- United Kingdom, The United Kingdom Experience, Dr. Fiona Adshead (verbal presentation)
- European Union, Strategies for Action to Tackle Health Inequalities in Europe – Intersectoral examples from the European Union (2004-2007), Mr. Walter Baer

Multi-Level Interventions
- Canada: Canadian Experiences with Intersectoral Action to Address Determinants of Health, Ms. Mana Herel and Dr. Treena Chomik
- Sri Lanka: Intersectoral Action for Health: The Sri Lankan Case Study, Mr. Godfrey Gunnatillake [reassigned to Broad Policy]
- Belgium – Intersectoral action for health in Belgium: a multi-level contribution to equity, Dr. Jan De Maeseneer (Regrets) [reassigned to Primary Health Care]

Primary Health Care/Community-based Interventions
- Malaysia, Primary Health Care: Key to Intersectoral Action for Health and Equity, Dr. Safurah Hj Jaafar
- Iran, Intersectoral Action for Health in I.R. of Iran: Community-Based Initiatives Experience, Dr. Abbas Motevalian
- Cuba, The Cuban Experience, Dr. Pastor Castell Florit-Flores (via teleconference- June 11)
- Ecuador, La intersecorialidad y el desarrollo local municipio de Cotacachi, Dr. Luz Marina Vega

Empowerment
- India – Intersectoral action for health: The case of Sonagachi, Dr. Kevin O’Reilly (via teleconference)
- Brazil - ** (Regrets)
Indigenous
- Australia – Intersectoral Action to Reduce Petrol Sniffing in Remote Communities of Central Australia, Mr. David de Carvalho
- Columbia - Intersectoral Action in Colombia: Emergency, Health Equity & Ethnic Minorities, Mr. Gabriel Rivera [reassigned to Emergency]

Emergency/Post-Conflict Response
- Uganda – Intersectoral Action on Health in a Conflict Situation - Dr. Rosette Mutambi (Regrets)

In addition to the case studies noted above, Morocco has submitted a case study entitled Etude de cas – Au confluent de l’Initiative nationale de développement humain et du programme des besoins essentiels de développement: le case su site de la province de Lrache, communes d’Essouaken/Imir Tiek et de Doukkala/Boussafi. The case was submitted by Dr. Chikhaoui Naïma. Other cases that had been discussed but that were pending at the time of the meeting were from Sudan [malaria], Viet Nam [malaria], and a second case study in India [for the Self-Employed Women’s Association (SEWA)].

5. Lessons learned/Key messages

Following the interviews, the co-chairs facilitated a dialogue among participants to consider the lessons learned from the experiences. Highlights of lessons learned and key messages include the following:

Context
- Context matters in the design and application of intersectoral approaches. The choice of approach needs to align with the policy problem and the broader socio-political context, decision making environment and machinery.

Approaches
- Intersectoral approaches are being used as strategies in: broad policy frameworks by Ministries of Health to address health inequalities [example of New Zealand], and in local development and well-being initiatives, where health departments play a lesser role [example of Canada - Vancouver Agreement].

- Primary Health Care, understood to mean that the “fundamental population health needs are cared for”, has people as its starting point. When the health needs of people are considered holistically, in relation to a broad definition of health and in relation to other needs, the health
system’s and state’s responses to these needs to automatically evoke intersectoral solutions.

- Leadership from the health sector is better explored and understood than leadership from other sectors [example of Chile]. However, leadership from other sectors, and the health sectors role in this context, is not less important. When IAH is led by the health sector, the vision the health sector has of health (e.g. disease. focus, risk factor focus, or SD focus) will affect the type of IAH the health sector supports.

- Cross, or multi, sectoral action for health may be as important a strategy as IAH when tackling socially determined health inequities [example of Sri Lanka, where at a global level, several sectors acted complementarily on a higher goal of social equity]

- The shape of the government (e.g. federal, centralized) has an important effect on the mechanisms used for IAH and the implications for coordination between the different levels of government [example of Belgium and Canada].

- While many of the policy interventions are context specific, some of the process models may be transferable across different socio-political contexts, e.g. 10 step process outlined by Sweden, policy development phases outlined by Norway.

Impact
- More qualitative than quantitative evidence exists that intersectoral approaches have been effective to reduce health inequalities. Concrete gains in health status and in reducing health inequalities were noted in at least 10 of the cases.

Broad Implications
- The definition of intersectoral action has evolved in the past 10 years. In 1997, the term was defined as “A recognised relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issues to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable that could be achieved by the health sector acting alone.”

- Intersectoral action may now be seen as a subset of multisectoral or “cross sectoral” action -- work by multiple sectors toward broader social and or economic goals, but not necessarily working together (example of Sri Lanka). Further research on integrated policy making, as advanced in

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the environmental spheres, suggest further work on classifications and definitions is needed.

- The question of how a society protects itself against the negative impacts of its various activities should be asked. The health sector then needs to be clear on what policy work to reduce social health inequities is necessary, as well as when specific intersectoral action is necessary.

- The health sector itself needs to break its own hegemony over health. If IAH does not happen spontaneously, the health sector needs to trigger it. The capacity within the health sector to play the role of health diplomat requires information, evidence, negotiation, flexibility and leadership. Health diplomacy require skills in reframing health policy challenges and policy/program options into technical and political vocabularies and conceptual frameworks used by other sectors, central agencies and decision makers, e.g. Masters degree programs in Public Health and Health Policy intersectoral modules and assignments.

- The distinction between generalizability and transferability is key. Given the current research, through this project we must emphasize the transferability of lessons to different contexts.

- Intersectoral action can happen more easily at the local level –increased attention must be paid to budgetary tools and incentives to enable intersectoral action to happen at higher levels of government.

- A key challenge for the field is how you can find the triggers for IAH to change the reality where extreme poverty, malnutrition are the case.


Impact assessments are important tools – evidence of the impact of public policy on health and health inequalities is required.

6. Practical Supports for Future Intersectoral Action

There is a need and perceived value in:

- sharing experiences between countries, regional and global actors, the WHO Commission, decision makers at global, regional, national, sub-national and local levels. This sharing should be expanded to include
learnings from other sectors, e.g. OECD work re: education and health, the environment.

- getting the CSDH to champion IAH or “cross-sectoral” work on IAH as a strategy to address the social determinants of health. Without IAH it will be difficult to implement CSDH recommendations.

- compiling and assessing existing processes and tools – e.g. planning models, feasibility tools for intersectoral action; tools to assess context and potential approaches for use within that context. Where needed, value was seen in adapting tools, or developing new ones.

- WHO developing norms related to definitions (e.g. including an understanding of whether IAH is instrumental or has some implicit value (e.g. empowerment); taxonomies of what works in which contexts, in order to assist with transferability; and guidelines for IAH.

- using problem based learning approaches, e.g. intersectoral actors to address complex policy problems. This could be achieved by collaborating with OECD (for developed nations) and UN (for developing nations). Training models/guidelines and case collaborations are possible avenues worth exploration. N.B. Could develop guidelines for schools of public health and health policy.

- developing/training a cadre of health diplomats - global, regional, national, sub-national and community levels. For example a health policy leaders program, focusing on intersectoral, intrasectoral and multisectoral spheres of action (could adapt models from UN agencies and country specific diplomatic core). Possible streams: policy leadership, management leadership, program leadership, accountability leadership. Potential partners include: schools of public health, management, policy studies, health professions (medicine, nursing, allied health professions, epidemiology, social policy, community planners, etc.)

- assessing organisational (and governance) models of health institutions at the global, regional, national, sub-national and local levels re: decision making, influence of levers outside health sector and capacity for intersectoral action.

### 7. Next Steps

Nicole Valentine provided an overview of timeframes related to the WHO Commission. The interim statement of the Commission is planned for July 2007 and the final report for May 2008. The intersectoral action report is needed in the fall 2007 to allow time to influence the final report of the WHO Commission. Next steps for the project were agreed as follows:
• **By July 15, 2007:** Case study authors to refine the case studies based on questions/feedback from the interviewers and 2 external reviewers – 1 within the country and 1 outside the country.

• **July-August 2007:** Project team to further analyse cases, develop options and outline and draft intersectoral action report for the Commission.

• **September 2007:** Project team to distribute draft report to case study participants for comments.

• **October 2007:** Project team to finalise draft report and present to the WHO Commission on Social Determinants of Health

Slight amendments to this timeframe have subsequently been made by the Project Team. This involves the September and October items as follows:

• **October 2007:** Project team to distribute draft report to case study participants for comments and to present recommendations to the WHO Commission on Social Determinants of Health.

• **December, 2007:** Project team to finalise report.

8. **Dialogue Wrap-Up**

The dialogue concluded with a round table of reflections from dialogue participants. Participants commented on the value of the in-person discussion and sharing of experiences related to intersectoral action. The expected dialogue outcomes as noted on page 1 were viewed as being met. Participants noted that the implementation of what has been learned requires action in parallel to the development of the report to the Commission and beyond.