Consultation on implementing action on social determinants of health to reduce health inequities: The contribution of collaborative work between sectors

WASAN ISLAND, ONTARIO, CANADA
20-24 SEPTEMBER 2010
MEETING REPORT
Consultation on implementing action on social determinants of health to reduce health inequities:

The contribution of collaborative work between sectors

WASAN ISLAND, ONTARIO, CANADA
20-24 SEPTEMBER 2010
MEETING REPORT
Contributors

This meeting report summarizes and synthesizes the discussions of participants at the World Health Organization (WHO) Consultation on Implementing Action on Social Determinants of Health to Reduce Health Inequities: The Contribution of Collaborative Work Between Sectors, held on Wasan Island, Ontario, Canada from 20-24 September, 2010. The report was written by the WHO Secretariat. All efforts have been made to verify the accuracy of its contents and any errors should be attributed to the WHO Secretariat.

The meeting was supported by funding received from the Breuninger Foundation, Germany. The support of the staff of the Breuninger Foundation is also gratefully acknowledged.

For more information: sdh@who.int.

© World Health Organization 2011

All rights reserved. Publications of the World Health Organization are available on the WHO web site (www.who.int) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press through the WHO web site (http://www.who.int/about/licensing/copyright_form/en/index.html).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers’ products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

This publication contains the report of the World Health Organization Consultation on Implementing Action on Social Determinants of Health to Reduce Health Inequities: The Contribution of Collaborative Work Between Sectors, and does not necessarily represent the views, decisions or policies of the World Health Organization.

Design: Inís Communication

Layout: www.paprika-annecy.com

WHO/ETH/11.1
# Contents

**Acronyms** ............................................. 1  
**Definitions** .......................................... 2  
**Overview of key contributions from the Consultation** .......................... 4  

1. **Introduction** ........................................... 6  
   1.1. Background and context ..................................... 6  
   1.2. Purpose of the meeting .................................... 6  
   1.3. Meeting approach ........................................ 7  
   1.4. Structure of this report ................................... 7  

2. **Barriers and challenges to intersectoral action on social determinants of health** .......................... 8  
   2.1. Structural barriers .......................................... 8  
   2.2. Cultural and language barriers ............................. 8  
   2.3. Process challenges ......................................... 8  
   2.4. Capacity and technical challenges .......................... 9  

3. **Strategies to overcome barriers and challenges to intersectoral action** .......................... 12  
   3.1. Managing political challenges ............................. 12  
   3.2. Managing trade-offs ....................................... 13  
   3.3. Improving leadership and accountability .................. 14  
   3.4. Addressing data challenges ................................ 15  
   3.5. Working in low-income contexts ........................... 16  
   3.6. Engaging with the private sector ........................... 16  
   3.7. Capacities required ....................................... 17  

4. **Tools and instruments for intersectoral action** .................................. 20  
   4.1. Institutional forms ......................................... 20  
   4.2. Legislative frameworks and regulation .................... 21  
   4.3. Budgeting and planning tools ............................... 22  

5. **Improving communication** .................................. 24  
   5.1. Making the case .......................................... 24  
   5.2. Choosing the right language ................................ 24  

6. **Next steps** .......................................... 26  

**Appendices** ............................................. 27
# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALMO</td>
<td>Arms length management organizations</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>GIS</td>
<td>Geographic information systems</td>
</tr>
<tr>
<td>HiAP</td>
<td>Health in All Policies</td>
</tr>
<tr>
<td>ISA</td>
<td>Intersectoral action</td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
</tr>
<tr>
<td>PRSP</td>
<td>Poverty reduction strategy paper</td>
</tr>
<tr>
<td>SDH</td>
<td>Social determinants of health</td>
</tr>
<tr>
<td>WHA</td>
<td>World Health Assembly</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Definitions

**Accra Agenda for Action (AAA):** An international agreement, adopted in 2008, that highlights the need for specific reforms in the aid sector to achieve improved aid effectiveness.

**Health Equity:** The absence of differences in health that are not only unnecessary and avoidable but are also considered unfair and unjust. Health equity does not imply that everyone should have identical health outcomes, but it does imply that all population groups should have equal opportunities for health and therefore that there should not be systematic differences in health status between groups.

**Health in All Policies (HiAP) Approach:** A policy strategy that establishes health as a shared goal across the whole of government and as a common indicator of development. This strategy highlights the important links between health and broader economic and social goals in modern societies. In addition, it positions improvements in population health and reductions in health inequities as complex, high-priority problems that demand an integrated policy response across sectors. This response needs to consider the impacts of policies on social determinants as well as the benefits of improvements in health for the goals of other sectors.

**Health Inequity:** Unfair and avoidable or remediable inequalities in health between populations within countries and between countries. These differences arise from social processes and are not natural or inevitable.

**Intersectoral Action (ISA):** Integrated work between different sectors towards a collective goal. In the context of health, ISA refers to actions affecting health outcomes undertaken by sectors outside the health sector, possibly — but not necessarily — in collaboration with the health sector.

**Social Determinants of Health:** The social determinants of health are the conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities. This term is also shorthand for the wider social, political, economic, environmental, and cultural forces that determine people’s living conditions.
Consultation on implementing action on social determinants of health to reduce health inequities: The contribution of collaborative work between sectors
Identifying solutions to barriers and challenges to intersectoral action on social determinants of health

Participants raised a wide range of barriers and challenges, some of which have been previously identified. However, this meeting enabled an in-depth and focused discussion on how each of these challenges could be managed. Participants emphasized that there was no “one-size-fits-all” approach to intersectoral action (ISA) and that, in order to be successful, fluency with a number of different methods was required. The detail provided by the participants gives a richer understanding of the range of options, methods, and solutions that exist.

How and when to use which tools and instruments

Participants suggested a number of different tools and instruments, many of which were along similar lines to those included in the Adelaide Statement on Health in All Policies. However, previous work on tools and instruments has concentrated mostly on the “what”, leaving insufficient information on “when” to use a particular type of tool and “how” to use it most successfully. Participants offered detailed guidance on when and how to use a selection of different tools, along with their main advantages and disadvantages. This information was accompanied by a number of illuminating case studies from participants’ own experiences, which are useful examples to help communicate these concepts.

What makes for success?

The input from participants has enabled a more detailed picture to be constructed of the components that contribute to a successful environment for ISA on social determinants of health (SDH). This detail will help to develop a more comprehensive “tool-kit” of the prerequisites, strategies, tools, and skills required to successfully go about ISA on SDH. The contributions from participants covered the full cycle of ISA. The importance of the quality of the planning process, more so than the plan itself, was emphasized as critical. Participants also contributed valuable information about undertaking ISA in low-income countries and engaging with the private sector.

Suggestions for the World Conference on Social Determinants of Health

The discussions from participants have been a useful resource for technical preparations for the World Conference on Social Determinants of Health. Participants also provided further suggestions specifically for the conference. They identified the need to consider who is the primary audience for the conference – if non-health leaders are an important target audience, WHO should think strategically about the process for selecting speakers (for example, including non-health leaders, or even influential people with limited background on SDH but who would be forced to consider the issue as a result of being invited to speak). High-level support for the conference would obviously be important, but there was also a need to consider engaging those who will actually be implementing any change after the conference (for example, through fringe meetings or pre-meetings). Finally, it was important to have a communications plan that covers from the present until six months after the conference and includes a process for ongoing engagement with non-health leaders.
Consultation on implementing action on social determinants of health to reduce health inequities: The contribution of collaborative work between sectors
1.1. Background and context

The World Health Organization (WHO) convened the Commission on Social Determinants of Health in 2005 to provide advice to Member States and the WHO Secretariat on how to reduce health inequities. Following consideration of the Commission’s final report1 by Member States, Resolution WHA 62.142 was passed at the World Health Assembly in May 2009. Among a range of actions, the resolution strongly called for a Health in All Policies (HiAP) approach and a renewed commitment to intersectoral action (ISA) to reduce health inequities, as well as the implementation of a social determinants of health (SDH) approach across public health programmes and improved capacity to measure health inequities and monitor the impact of policies on SDH. The resolution also requested the Director-General of WHO “to convene a global event before 2012 to discuss renewed plans for addressing the alarming trends of health inequities through addressing social determinants of health”. The Government of Brazil has kindly offered to host this WHO global conference – the World Conference on Social Determinants of Health – in Rio de Janeiro on 19-21 October 2011. The conference will bring together global leaders to discuss how to implement the recommendations of the Commission to reduce health inequities.


1.2. Purpose of the meeting

The WHO Consultation on Implementing Action on Social Determinants of Health to Reduce Health Inequities: The Contribution of Collaborative Work Between Sectors was held from 20–24 September 2010. It was hosted by the Breuninger Foundation on Wasan Island, Ontario, Canada to identify principles and strategies, including processes, tools, and structures, to inform the ongoing work of the WHO Secretariat in assisting countries in implementing collaborative work between sectors – or ‘intersectoral action’ – to reduce health inequities. The meeting brought together senior leaders from beyond the health sector. The participants’ backgrounds included finance, human resources, education, agriculture, social protection, labour, housing, central government, social development, and communications, as well as health. Participants were based in Australia, Bangladesh, Brazil, Canada, Malawi, Peru, and the United States of America, in addition to WHO participants.

The meeting provided a rare opportunity to explore, in an in-depth way, participants’ experiences and views on issues relating to ISA on SDH, in particular how to achieve ISA that results in a meaningful impact on health inequities, accommodating differing mandates, priorities, and policy goals between sectors. The meeting provided a forum for discussing why and how other sectors can be successfully engaged for joint action on health and health equity. This included frank exchange on the difficulties in working across sectors, including specific difficulties in working with the health sector. The meeting expressly sought not to focus on the typology of interventions (the “what”), which has been extensively addressed by other documents and meetings, but instead to explore in more depth “how” and “when” different approaches should be used to allow the greatest chances of success.

The discussions, synthesized in this meeting report, will be used to inform a range of ongoing work by the WHO Secretariat working with its Member States on ISA, and have fed into the technical preparation and discussion paper for the World Conference on Social Determinants of Health. It is also hoped that the meeting will serve as the beginning of a long-term, informal engagement with a group of experts from beyond the health sector who can continue to provide advice for WHO’s work in reducing health inequities.
1.3. Meeting approach

The meeting aimed to use an innovative approach for a WHO consultation. The WHO team set the scene for participants at the beginning with a brief formal presentation, outlining the context of WHO’s current work on intersectoral action and social determinants of health, and what WHO hoped to gain from the meeting. It was emphasized that the purpose of the meeting was not to reach consensus or produce a declaration or action plan, but rather to listen to and learn from the experiences of participants. In particular, WHO was hoping to hear about participants’ experiences of working with the health sector and with other sectors, any challenges and difficulties they had encountered, and their views on WHO’s approach to Health in All Policies. Moreover, it was hoped that this initial interaction would be the start of an ongoing process of engagement. In preparation for discussion at the meeting, participants were sent a mixture of common and individualized questions regarding ISA, which covered the main topics on the agenda throughout the week.

The rest of the meeting consisted of a mixture of focused discussions, in plenary and in small groups. Both the meeting format and the agenda were adapted frequently throughout the week, to optimize progress and respond to the discussions, but still managed to cover the major topic areas on the agenda.

1.4. Structure of this report

This meeting report seeks to capture the richness of the discussion at the meeting and describe the main themes raised by participants. It therefore reports the views of the participants and does not necessarily reflect the views, policies, or decisions of WHO. It is informed by the background materials, detailed notes taken throughout the duration of the meeting, and frequent progress meetings between the WHO Secretariat and meeting facilitator. Selected case studies discussed by participants during the meeting have been included as illustrative examples. This report attempts to structure the discussion in a logical progression, beginning with the main challenges and barriers to ISA on SDH and then moving to strategies, tools, and instruments to overcome these obstacles.
It is well recognized that intersectoral action on social determinants of health is not easy. Participants identified a range of barriers and challenges, some familiar and others that are less well known. These barriers, summarized in Table 1 below, provided the basis for further discussion about how to overcome them.

2.1. Structural barriers

Different sectors work within different organizational contexts. These differences can of themselves preclude collaboration or a lack of understanding of this diversity can undermine trust to work together. Inequalities in power and resources between different sectors can reduce incentives for collaborative work. This can be seen, for example, in low-income settings where donors and international organizations do not work collaboratively, making it difficult for governments to implement ISA at lower levels. It can also be seen in countries where health is seen as consuming disproportionate funding (partly driven by neglect of action on SDH), due to increasing expenditure on health care services, leading other sectors to feel disinclined to collaborate on health outcomes.

Lack of clarity and accountability are well-understood barriers to ISA. Participants further elaborated on this, identifying a lack of clarity about who has overall responsibility for ISA and who is accountable for achieving objectives in joint work as key challenges to be overcome. Corruption exerts particular strains on the capacity for ISA in many low-income settings, exacerbating this lack of clarity and further undermining the trust required for ISA.

2.2. Cultural and language barriers

The different cultures of specific sectors and their perceptions of each other present major challenges to ISA. Health is sometimes seen as a dominating sector, with an attitude of technical superiority when considering the contribution of other sectors to health and other shared outcomes. Differing values of sectors can also prove an obstacle – for example, the emphasis on “social” in considering SDH is value-laden and may even have negative or “soft” connotations for those working in some sectors, such as economy or finance. Mismatches in values can also occur in development work between recipients and donors.

Participants repeated the truism that different sectors have different understandings of the world and ways of describing it. This extends to prioritization of different forms of evidence. A key point is that the language of SDH and ISA is often perceived as abstract and conceptual. There is thus a need to inject real people and stories into evidence to engage decision-makers in other sectors as well as across the health sector itself.

2.3. Process challenges

Discussions on ISA often concentrate on so-called “win-win” situations, where there are mutual gains. However, such situations are rare and therefore most ISA involves reconciling conflicting interests. One of the biggest challenges for ISA lies in understanding how to manage situations that involve costs or trade-offs for another sector, while preserving an effective collaborative working relationship. In addition, ISA is often required to address long-term problems, such as acting on SDH to reduce health inequities, which can be difficult to champion given short-term drivers such as political cycles and donor project time frames.
It can also be difficult to identify the appropriate site for leadership and initiation of ISA. It is not always clear when this should be done by a central agency, compared to organizations closer to communities, and whether the health sector should aim to drive action or let others take the lead. Participants agreed that these issues are obviously highly context-specific. In ensuring leadership for ISA, there are also difficulties in setting up new agencies for this purpose, as opposed to changing existing systems, as demonstrated in Box 1.

**BOX 1: New structures are not always better**

In Peru, a major earthquake outside of Lima left thousands in need. Donors in Lima and internationally all wanted to contribute, but there was no mechanism to coordinate and distribute assistance. To solve this problem, a new agency was created – headed by a prominent businessman and with a board of directors, consisting of mayors, regional authorities, and representatives from a range of affected sectors (such as health and transport). This new agency was given responsibility for executing the reconstruction projects and was given permission to circumvent usual planning processes to “fast-track” work. Despite good intentions, the new agency was a failure. By creating a completely new bureaucracy, the new agency was not aligned to established processes for planning and working. The head of the agency was not from the affected region, but was from Lima. It subverted existing local leadership and opportunities for local participation.

### 2.4. Capacity and technical challenges

Data problems remain a major challenge for implementing effective ISA to reduce health inequities. This is a multi-faceted issue. There is often inadequate data on inequities and SDH. Furthermore, the data that is available is often difficult to use, especially for work between sectors. This is due to poor comparability and weak mechanisms for sharing any data that is available between sectors. Particularly in low-income settings, addressing these issues is difficult due to insufficient institutional capacity to meet demands for more and better data collection.
Table 1: Barriers and challenges to intersectoral action on social determinants of health (SDH)

<table>
<thead>
<tr>
<th>Structural barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Different sectors work within different organizational contexts</td>
</tr>
<tr>
<td>Managing collaboration between unequal partners, such as when sectors have different levels of resources and hence power</td>
</tr>
<tr>
<td>Lack of collaboration between donors and international organizations</td>
</tr>
<tr>
<td>Lack of clarity on who has overall responsibility for intersectoral action</td>
</tr>
<tr>
<td>Lack of clarity on who is accountable for achieving objectives in joint work</td>
</tr>
<tr>
<td>In some countries, health is seen as consuming disproportionate funding (partly driven by neglect of action on SDH), with the bulk of expenditure on downstream health care services</td>
</tr>
<tr>
<td>Corruption</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cultural and language barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mismatch between values of recipients and donors</td>
</tr>
<tr>
<td>“Social” can be value-laden and has negative or soft connotations in some contexts</td>
</tr>
<tr>
<td>Different sectors have different understandings of the world and ways of describing it</td>
</tr>
<tr>
<td>Different sectors use different forms of evidence</td>
</tr>
<tr>
<td>Health is sometimes seen as a dominating sector, with an attitude of superiority (public health is also “dominated” by the clinical services sector)</td>
</tr>
<tr>
<td>Language of SDH and intersectoral action is often abstract and conceptual</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing conflicting interests and trade-offs, especially in situations where there is no clear win-win</td>
</tr>
<tr>
<td>Addressing long-term problems and solutions in short-term political cycles</td>
</tr>
<tr>
<td>Mismatch between donor project time frames and long-term action on SDH</td>
</tr>
<tr>
<td>Identifying appropriate sites of leadership and initiation of action</td>
</tr>
<tr>
<td>• Central agency compared to peripheral agency</td>
</tr>
<tr>
<td>• Health sector compared to other sectors</td>
</tr>
<tr>
<td>• Changes to existing system compared to setting up new agencies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capacity and technical challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of data on inequities and SDH</td>
</tr>
<tr>
<td>Lack of comparability of data</td>
</tr>
<tr>
<td>Poor mechanisms for sharing data between sectors</td>
</tr>
<tr>
<td>Poor usability of data produced</td>
</tr>
<tr>
<td>Insufficient institutional capacity to meet demands for more data collection</td>
</tr>
</tbody>
</table>
Consultation on implementing action on social determinants of health to reduce health inequities: The contribution of collaborative work between sectors
Following the identification of barriers and challenges, participants suggested strategies to advance ISA to reduce health inequities by acting on social determinants of health. In addition to specific tools and mechanisms discussed further below, overarching strategic aspects were considered.

3.1. Managing political challenges

There is no “one-size-fits-all” approach to ISA and an awareness and flexibility to adapt in light of different and changing socio-political contexts is critical. Governments also cannot implement ISA alone, as increasing plurality of power in many contexts means that the role of government needs to shift more from command-and-control to stewardship and coordination, including in the process of building political support, as seen in Box 2. It is clear that the organizational partnerships therefore necessary for ISA to reduce health inequities start with connections between individuals. As always, it is imperative to ensure that the right people are engaged in the intersectoral process, including those who actually have the power to make decisions. But it is also important for collaborative work on ISA to include disadvantaged groups who have the greatest potential to benefit, linked to civil society groups and social movements who can press for action.

**BOX 2: Zero Hunger strategy in Brazil**

One of the initial statements made by an incoming President in Brazil was that “if all the people in Brazil are able to have three meals a day by the end of my leadership, then my ambitions will be fulfilled”. This instantly put the issue of hunger on the agenda at the highest level and started a multisectoral forum for discussion. Under the President’s leadership, an intersectoral approach was established to address all aspects contributing to food insecurity, including production, cost of food, family agriculture, and school meals. A big initiative such as this created the framework and space to bring together a range of actors to tackle the problem of hunger from a number of different perspectives, in a range of different ways and areas.

Bridging differing understandings of a problem between sectors requires identifying which sectors have vested interests in activities on a particular issue. Furthermore, achieving the overall goal of making the case for how a SDH approach can help other sectors achieve their objectives requires a sound understanding of the interests and objectives of other sectors in the first place. Employing a conceptual model showing the interplay between various social determinants, with all sectors represented, can be helpful in setting the scene as an invitation to other sectors — demonstrating that if all sectors are concerned about human development and well-being, then they all have roles to play and relationships to build.

Having identified the interests involved, resistance to taking the long-term approach necessary for ISA to reduce health inequities can be addressed in a number of ways. As with other policy-making, the consequences of not taking action can be presented with the relative cost-benefits of the proposed action compared to maintaining the current state. Encouraging senior bureaucrats to champion a cause can be useful, as they sometimes have long tenures and can maintain continuity in situations of political change or upheaval. Relationships with academic institutions and research centres can also assist with sustaining cooperation. Ideally, long-term ISA on SDH can be cemented by a whole-of-government strategic plan, with specific targets linked to individual sectors.
3.2. Managing trade-offs

Even with the above mechanisms in place, conflicts and trade-offs between short- and long-term goals, and between the interests of different sectors, are inevitable. Successfully implementing ISA to reduce inequities is likely to result in negative impacts or costs for some parties. To address this challenge, the following key questions must be kept in mind:

1. How can the negative consequences for the sector that “loses” be minimized?
2. How can sectors be facilitated to continue engagement after a loss?
3. If one sector benefits from an intervention, for example, through cost savings, can these benefits be shared in any way with the “losing” sector?

The first step in managing conflicts and trade-offs requires the clear identification of conflicting aims between sectors, partners, and stakeholders and also between time frames (for example, the possibility of identifying specific long-term gains for those who suffer short-term losses). The scale of impacts needs to be assessed to inform this, in terms of their significance and the time frame over which they occur, with respect to political cycles and how costs and benefits may be discounted over time.

**BOX 3: Managing conflicts in Germany**

The CEO of a major car manufacturing company notified a regional mayor in Germany that he was planning to change all of the transportation to one of his production plants from rail to road, all of which would run through a small town in the mayor’s district. If there was any problem advancing his plan, the CEO said he would relocate the entire factory to Portugal. The regional mayor knew there would be public outrage to the plan, so attempted to subvert the compulsory “public consultation requirement”. The change went ahead and public outrage in the town ensued. The change to road transport offered no benefit to the town (such as via taxation) and was a clear win-lose. The town sought technical advice from WHO regarding what the expected noise and air pollution would be. After seeking legal advice, the town was advised that a lawsuit against the regional authority for allowing the change to go ahead without proper consultation would likely be successful. They presented a package of demands to the regional authority (including re-opening the community centre, increasing the village’s budget allocation, and constructing barriers to reduce the noise pollution) to avoid the lawsuit.

This assessment is fundamental to ensuring transparency about who “wins” and who “loses” over time in a programme of ISA. This can be informed by a comparative analysis of alternatives (through both formal and informal calculations depending on what is required to make the decision) and an objective evaluation of the reasoning and data underpinning decisions. This is particularly important to ensure transparency in the case where a particular sector or actor seems to repeatedly benefit in ISA.

Following this assessment, priorities can be set, either through a systematic process or through the exertion of power by political actors. It is necessary to have an identified authority that can break deadlocks when they occur and this role generally needs to be undertaken by central agencies, such as the executive of government. Such agencies also have a key role in holding actors accountable for decisions made.

Once ISA is implemented, the management of the distribution of benefits and costs from the interventions is key to sustaining engagement by actors who “lose”. Sectors who “win” need to be willing to assist those who do not benefit or increase their chances of benefiting later. Losses are more likely to be sustainable in the short term if it is perceived that long-term benefit could accrue from the short-term gains to other sectors. Means for compensating sectors for losses can also be considered, to turn a “win-lose” situation into one where the sector that incurs costs has these mitigated to an extent, for example, through compensation settlements or adjustments (see Box 3 above). A particular challenge is that those who need to bear short-term losses often do not personally benefit from potential long-term gains that are beyond both political and budgetary cycles.
Trade-offs and negative impacts need to be identified at the strategy selection phase – it is more distressing to those involved if they are established later. But the approach also needs to be able to deal with unintended consequences, so there needs to be an ongoing monitoring and assessment process throughout the implementation phase. Staff and stakeholders may have been prepared for a certain type of loss, but if unforeseen further losses occur, this needs to be acknowledged and options explored to minimize harm, adapt, or alter course.

3.3. Improving leadership and accountability

Ensuring accountability remains challenging in the work of single sectors. For ISA, with the multiple parties involved, there is a need to implement new models for accountability. Central agencies again have an important role in assuming responsibility and holding the different actors to account. This is particularly so because they can be seen as neutral between different sectors. However, this requires ISA on SDH being adopted as a core responsibility of government, with a concrete plan for joint accountability with responsibilities clearly assigned and targets set. Performance against intersectoral targets can be aligned to budgets and incentives, as discussed further below.

**BOX 4: A health crisis with a housing solution**

In New Zealand, a group B meningococcal epidemic served as a crisis that triggered a successful intersectoral healthy housing initiative. Public health researchers demonstrated a link between household crowding and meningococcal infection. When executives of the national social housing agency were presented a GIS map, they could instantly see the map of density of crowding and disease correlated with the map of their housing. This led to a collaborative initiative between the health and housing sectors, which saw frontline public health nurses and housing officers knocking on doors together. For vulnerable families, this allowed simultaneous attention to multiple housing and health risks (crowding, insulation, repairs/renovations, treatment of unmet health needs, training and employment of unemployed youth to install insulation). The project was able to break down traditional vertical lines of organizational accountability and set up a separate structured programme, making use of small teams, with highly motivated (almost self-selected) employees, who were accountable to a shared project objective. This situation was made easier because it was a clear win-win for both sectors and the programme did not detract from core funding.

While governments have core motivations and responsibilities for ISA, they cannot undertake it alone. A number of entry points exist, shown in Table 2, which can be acted upon by a range of actors, including nongovernmental organizations (NGOs) and municipalities. Similarly, while central agencies retain a key role in leadership of ISA, the health sector needs to be nimble in identifying the best role for it to facilitate joint work to reduce health inequities (as shown in Box 4). It should not expect to always, or even often, lead ISA on SDH. Indeed, the health sector needs to react to opportunities for ISA that arise from outside the health sector, including crises and community demands. In these opportunities, its role is collaboration as for any other sector.

There is, however, also a role for the health sector in being proactive to catalyse ISA, identifying issues for collaborative work and taking the initiative in building relationships and identifying strategic allies in other sectors as potential partners. To further facilitate ISA in these scenarios, the health sector can develop a plan of outreach, make the initial contacts, and stage contact with other key sectors. It can also assemble the information to make the case, framing it in a way other sectors can understand and aiming to build ownership of the planned ISA in other sectors. Yet even in this case, the health sector should be wary of being seen as the sole driver of any proposed work.
### Table 2: Entry points for intersectoral action on social determinants of health

<table>
<thead>
<tr>
<th>Reactive entry points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public opinion and demand from communities</td>
</tr>
<tr>
<td>Downstream problems that can be opportunities for upstream policy change</td>
</tr>
<tr>
<td>Waiting for and taking advantage of a catalytic moment</td>
</tr>
<tr>
<td>Crises</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proactive entry points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building relationships, including incentivizing and facilitating relationship building</td>
</tr>
<tr>
<td>Identifying champions (political, bureaucratic, external advocates)</td>
</tr>
<tr>
<td>Having strategic allies in other sectors</td>
</tr>
<tr>
<td>The health sector building indebtedness or credit, by first helping others with their objectives</td>
</tr>
<tr>
<td>Aligning with existing efforts to improve policy coherence at national and international levels</td>
</tr>
<tr>
<td>Associating with strong causes in non-health sectors (such as food and nutrition, drugs and violence). Weaker sectors may also benefit and increase their influence by aligning themselves with the health sector, in contexts where it is relatively powerful</td>
</tr>
</tbody>
</table>

### 3.4. Addressing data challenges

Many of the data challenges identified above are difficult to resolve, particularly increasing the availability of data. This makes optimizing the use of whatever data does exist to inform ISA even more important. The sharing of data collected across different sectors is a clear avenue for improvement, ensuring that all sectors involved in ISA have equal access. Making data publicly available can assist with this. Systems are also required to ensure comparability of data collected by different sectors and to avoid the duplication of data. In a number of countries, international agencies have been a key influencer in insisting on better data collection.

When embarking on any new ISA project or research, all sectors require equal access to the data. All sectors making their data publicly available is a start, but this does not necessarily lead to data being shared between sectors or integrated. In many settings, communities and NGO stakeholders are often left to integrate the data themselves. It is also important to acknowledge that different sectors understand “evidence” differently and place a different balance of importance on quantitative versus qualitative sources of evidence.

In some situations, new data collection is required to assist intersectoral work on SDH, including the disaggregation of data to provide information on inequities. It is also important that adequate data is collected to be able to demonstrate outcomes of intersectoral work. But where new data collection is proposed, it must be ensured that the desired new data is worth any costs incurred and does not overwhelm institutional capacity to both collect and then act upon this new data.

Data also needs to be turned into usable information. Where there is greater transparency of public data, there is also a need to build the capacity and literacy of stakeholders to understand and use this data effectively, including being able to translate data into effective narratives for policy-makers.
3.5. Working in low-income contexts

Strengthening the capacity of governments in low-income contexts is a key priority to enable ISA on SDH. For ISA, it is essential to have a planning process that establishes a long-term vision for the country and a government that has sufficient capacity and will.

An agreed instrument that sets out national goals that all sectors can work towards is a good basis for ISA. This vision needs to reconcile social and economic development – especially in low-income contexts, economic growth is required to improve SDH. However, it is also important that economic development is linked to equity considerations.

Development assistance can also clearly be improved to support ISA to reduce health inequities. The Accra Agenda for Action provides a good framework to facilitate collaborative work, but is yet to be fully implemented. As has been previously recognized, Poverty Reduction Strategy Papers (PRSPs) can also provide a platform for ISA.

Governance capacity in recipient countries must be developed to coordinate ISA with donor funding. This requires building negotiation and management skills in governments and working with donors to mobilize sufficient will to execute planning processes that establish and pursue a long-term vision for countries. In some cases, decentralization of power and funding to regional and/or local levels can help to embed ISA. There is also increasing potential for South-South cooperation in showcasing initiatives and building capacity for integrated action on health inequities.

Civil society can also play a constructive role. Nongovernmental organizations can mediate between government sectors and donors as well as advocate for ISA on health inequities. Civil society can also contribute to monitoring activities that facilitate ISA, such as establishing a monitoring mechanism for Accra Agenda compliance.

3.6. Engaging with the private sector

The private sector plays an important role in improving or undermining social determinants of health. Unlike the common goal public agencies share in pursuing a public interest, the primary direction for the private sector is the generation of profit. This difference needs to inform work with the private sector. That said, the private sector is highly diverse and the same approach cannot be used with all the different actors the term encompasses, from multinational companies to small businesses. Groups championing work on SDH do not seem to have reached consensus on a common approach to working with the private sector.

It is important to recognize that it may not always be necessary to engage the private sector for ISA. The reasons for, and extent of, engagement warrant consideration in each situation. It may be helpful for WHO and/or other agencies advocating action on SDH to map out the extent of interactions between SDH and the private sector. When making the case to the private sector, it may be necessary to modify the framing of the arguments for addressing SDH so as to clearly describe the benefits for them in doing so in terms of achieving their own goals (see Box 5). Governments need to be aware of the full spectrum of instruments they have to influence private sector activity on SDH, such as regulation, taxation, incentives, public-private partnerships, and subsidies. Identifying and showcasing examples of good practice can provide good publicity for businesses involved. Many large multinational corporations have allocated budgets for corporate social responsibility, which may be able to be mobilized for intersectoral work on SDH.

**BOX 5: Rural development in Bangladesh**

In rural Bangladesh, employment opportunities are especially limited, meaning many women are destitute and unemployed. An NGO programme had been working to provide training and employment for these women in rural areas. However, the NGO programme was time-limited, so needed to find a way of ensuring an ongoing source of economic livelihood for these women once the programme ended. To solve this problem, the NGO negotiated with two large private sector companies who agreed to provide their products for these women to sell as agents “door-to-door” – for which the women would receive a commission. In addition to a source of income, the companies provided training to women. The initiative also enabled the companies to make profits from a previously untapped rural market.
3.7. Capacities required

An indication of the range of competencies, skills, and experience required for successful ISA on SDH is shown in Table 3. Capacity building is required in both institutions and for individuals. Capacity building in organizations is multi-generational and needs a learning culture embedded within organizations. Training can sometimes seem to be wasted when there is a rapid turnover of people, but this still contributes to long-term change. Institutions need to build core teams for the different stages of ISA, which assemble different disciplines and technical competencies and which have the confidence of key stakeholders. Institutions also require capacities for data collection and sharing, and to recognize and address disincentives.

**Table 3:** Capacities required for intersectoral action on social determinants of health

<table>
<thead>
<tr>
<th>Competencies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliable and tried methods</td>
<td></td>
</tr>
<tr>
<td>Evidence-based practice</td>
<td></td>
</tr>
<tr>
<td>Multi-disciplinary understandings</td>
<td></td>
</tr>
<tr>
<td>Authority/mandate</td>
<td></td>
</tr>
<tr>
<td>Community and place-based focus</td>
<td></td>
</tr>
<tr>
<td>Cultural competency</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skills</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical competence</td>
<td></td>
</tr>
<tr>
<td>Effective multi-faceted communication</td>
<td></td>
</tr>
<tr>
<td>Knowledge of intersectoral strategies</td>
<td></td>
</tr>
<tr>
<td>Negotiation</td>
<td></td>
</tr>
<tr>
<td>Consensus-building</td>
<td></td>
</tr>
<tr>
<td>Leadership</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Experience</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnerships</td>
<td></td>
</tr>
<tr>
<td>Coordinated service planning</td>
<td></td>
</tr>
<tr>
<td>Government and NGO service provider systems</td>
<td></td>
</tr>
<tr>
<td>Knowledge and methods</td>
<td></td>
</tr>
<tr>
<td>Practical delivery</td>
<td></td>
</tr>
</tbody>
</table>
For individuals, it takes a particular set of skills to work as a translator across sectors. This requires not just fluency in the language of different sectors, but also the ability to cope with failure and risk. Professionals require a high standard of communication skills to be able to argue the case for ISA on SDH. Media training could be used more proactively as a strategy to build capacities to advocate for ISA. In addition, as discussed above, capacity needs to be developed within communities and civil society in terms of bureaucratic and political literacy to effectively engage in participatory processes and demand increased action from governments.

Within sectors, there are sometimes more conservative or traditional sub-cultures that need to be more prepared to step outside their comfort zones and consider new methods of communication. There is also a need to be reflective and cognizant of not being rigidly constrained by the norms within sectors. It is helpful to be close to policy-makers and to understand their aims and constraints so as to be able to identify the best moment to raise an issue and make contact with them.

Practitioners need to be willing to use multiple processes of engagement. They need to try to understand the imperatives and realities for those in other sectors and be creative about opportunities to create shared ownership. Networking provides the opportunity to listen and to learn the language that is being used in other sectors. Humility is essential for successful work with other sectors. When trying to establish fora for cross-sectoral communication, follow-up is essential (“do it once, do it twice, do it again, and you create a tradition”). Networks need to be created with regular contact and updates on progress, agendas, and changes.

One of the best ways to build capacity (both of organizations and individuals) is by setting projects in place with intersectoral teams. Another way is to set systems and structures as pilots. Support for capacity building to learn by doing is especially important in low-income settings and in settings where there is illiteracy. There are additional challenges for capacity building in low-income settings that need to be overcome. There is, however, an inherent risk that the more training given to a public officer, the more likely they are to leave to the private sector or an international agency. International cooperation (including international agencies like WHO, and South-South cooperation) has a key role in building capacities not just at local and national level, but also capacities for regional and global intersectoral work.
Participants identified a number of different tools, mechanisms, and instruments for intersectoral action, including several reinforcing the broad groupings discussed in the Adelaide Statement on Health in All Policies.\(^3\) When considering tools and instruments, it is crucial to clarify when and how to apply them successfully and consider their main advantages and disadvantages, as opposed to merely describing them.

### 4.1. Institutional forms

The most obvious institutional forms for ISA involve bringing personnel from different sectors into common structures. As with all institutional settings, it is important that form follows function, meaning that the structure of institutions is designed around what they need to do. Institutional settings themselves are not sufficient and genuinely honest brokers are required. In addition, requirements and incentives to work together need to be embedded into institutional processes.

**Interagency committees and taskforces** can work well where there is a clear commitment and common interest and when they have a clear mandate to act. They are less useful when a detailed workplan is required or when there is no common consensus or budgetary tensions. They can be used at different phases of work and with different people, for example, undertaking problem definition with senior leaders, or during implementation with lower-level staff once political commitment has been secured.

**Horizontal ministries serving multiple ministers and sectors** seem an attractive mechanism for ISA but are inherently unwieldy, often becoming so large they can end up acting as separate agencies and perpetuating silos. They can be useful for specific intersectoral tasks where dedicated staff are required, as long as their existence is time-limited and staff then return to their former agencies to sustain the joint work. This model can involve less problems of territoriality, as a single ministry does not own the work. It can also be applied to achieve long-term goals.

**Presidential or Royal Commissions’** effectiveness can vary widely. They can be very influential or become simply places to park issues that are perceived as “too hard” as a delaying tactic, depending on political will. They offer similar advantages and disadvantages to the ministerial secretariat model above, except they are external. They are most often used at the problem identification stage.

**Boards of experts** can be used at all stages of policy-making and implementation, and can be overused. They are best used for stakeholder consultation as well as during the intervention phase. They tend to be elite, meet monthly, and have a mini-secretariat composed of public servants.

**Arms Length Management Organizations (ALMOs) and semi-independent government bodies** (such as human rights commissions and pharmaceutical decision bodies) are most useful for ISA for umpiring the space between or across sectors, but can also serve a think-tank function. These provide some degree of autonomy and independence from political time frames and can make politically difficult judgements about other government agencies, performing functions that politicians find difficult to do themselves. They are usually assigned management responsibilities over assets, service provision, or decision-making, but maintain direct link to a political authority.

---

They have independence from political input in day-to-day management but have strong political accountability. They are completely public sector organizations, funded from public money, with no tax concessions. For delivery of services, these agencies can fall into the middle ground of neither being government or private. They can be a neutral venue for joint activity and are also useful when people have lost confidence in government services or do not want political input into delivery on a regular basis. ALMOs work best when they have a foundation in law and a direct line of reporting to the political executive, but even so they remain liable to being shut down or overruled if they make politically unacceptable interventions.

**Regulated nongovernmental providers** are public bodies that sit between government, civil society, and the market, such as water authorities and research foundations. They are regulated due to a public interest in the services they offer and provide access to private equity and philanthropic funds. These providers can be useful for ISA due to being closer to the people they serve than government agencies and can be incubators for new ideas and concepts. They are often locality based, for example, urban development co-operations, and so therefore have more opportunities for joined-up action on the ground (“placed-based policy”). These providers can also be set up for long-term tasks beyond political cycles. However, they are not useful in situations where strong political control is essential. In order to ensure that equity, intersectoral aspects, and funding security are protected, there needs to be a regulatory environment which makes accountabilities clear and grants powers of intervention to the regulator. However, there is a fine balance here – the more that government has power to intervene, the more the courts will see the institution as government, and hence it will lose its advantages. Regulators can serve as a buffer between these agencies and politicians. Ensuring transparent and effective governance is essential – having elected boards open to the communities that these agencies serve can assist in this regard.

### 4.2. Legislative frameworks and regulation

Laws and regulations are not ends in themselves and need to be aligned to broader social processes to achieve change. However, they can lead public opinion or consolidate existing trends. For ISA, a primary function of regulatory approaches is to create incentives for transcending silos. Consideration should be given to regulations that mandate collaborative work as well as assessing how existing laws and regulations function as barriers to ISA.

**National constitutions** can be instrumental in setting the basis for ISA and common societal goals. They can also contribute to the setting of standards, along with other national and global agreements. **Regulating the alignment of budgets** can help to overcome compartmentalization of budgets, often a major barrier to ISA. A more interventional form of regulation for ISA involves regulating for cross-sectoral consultation. This does, however, run the risk that by naming sectors that must be consulted, those who are not named may be excluded, as often only the minimum mandated will be consulted. Blurred lines of accountability between sectors can act as a stimulus for joint development of guidelines (see Box 6).

**BOX 6: Adapting lines of accountability**

In Canada, there were increasing concerns within the education sector about the problems associated with poor nutrition in childhood. As well as rising levels of childhood obesity, some children were coming to school without eating breakfast properly, which was compromising their ability to learn. Of even more concern, these problems were disproportionately affecting indigenous children. There was rising public concern and broader political interest in acting on this issue. A collaborative initiative between the education and health ministries was established. The initiative led to a multi-pronged suite of activities including school nutrition and physical activity guidelines. Of key importance to its success, this new initiative was supported by structural changes to support joint working, which included joint lines of accountability for the project goals, affecting both ministries.
4.3. Budgeting and planning tools

It is well understood that the planning process for ISA is often more important than the final plan, with engagement of stakeholders and relationship-building essential throughout the process starting from problem definition. Openness to new process models can be helpful, with a willingness to test them in real time. Even when these experiments do not work out, they create new learning and may lead to culture change.

Prior to engagement, it is important to identify the prerequisites that need to be met. It is not always possible or sensible to engage on all issues. Sometimes the problem is not planning – a better plan will not always resolve issues. When intersectoral planning attempts fail, it is helpful to go back to the structural factors and change the approach to the issue, for example, changing the means of engagement, and with whom, as well as analysing whose interests are being met by “not engaging” or by the status quo.

Incentives through this process linked to the achievement of specific process and outcome indicators for ISA have proven useful, for example, the Index of Decentralized Management in the Bolsa Familia programme in Brazil. In this example, each municipality receives budget transfers that will increase or decrease based on the achievement of specific process and outcome indicators selected to reflect ISA. The peer pressure arising from comparison to the performance of other municipalities against the same joint working indicators has acted as an additional incentive for ISA. Decentralization, where funding and resources are devolved to sub-national authorities, has been an important reform to encourage ISA at local and regional levels in Peru and Brazil.

A range of budgeting tools can be useful to facilitate ISA. **Participatory budgeting** can increase joint work as communities rarely see their problems in the strict silos of government agencies. In this process, an elected (often local) authority leads a discussion on priorities with all sectors, and there can also be broader community involvement. Decentralization of budgeting also has the potential to increase ISA, as the number of silos may be fewer at local levels. Evaluation is also participatory. However, the effectiveness of this approach depends on the capacity of communities to participate fully and the capacity of authorities to implement action in response to what can sometimes be unrealistic expectations. As discussed above, “bureaucratic literacy” needs to be built for community members and civil society groups to fairly participate in this process. It can be difficult to ensure the legitimacy of those who claim to represent community groups. In successful examples, communities define their needs, interact with local authorities, and even implement activities.

In contrast to these “bottom-up” approaches, **outcome- or results-oriented budgeting** is a “top-down” mechanism by which central government can link funding to specific cross-sectoral national goals to encourage sectors to work together. It can be challenging, however, to reconcile this approach with more participatory approaches, as bottom-up mechanisms may not match top-down priorities.

This approach is similar to **performance based budgeting** used by donors. Here, future budgets and grants are reduced if the previous year’s allocation is not spent in order to incentivize recipients to spend their full amount of money on the agreed activities. An important limitation with this approach is that donors do not allow communities to define needs and components of the programmes to be funded by these activities. This can inhibit ISA as donors are often in search of concrete and measurable results and indicators, usually short-term in nature, which can hamper more complex intersectoral activities on SDH.

Other relevant mechanisms used in some countries include the release of budget commitments in advance to media and NGOs, to incentivize governments to fulfil their commitments through public pressure for accountability, and having representatives from central budgeting agencies assigned to sectoral budgeting priority-setting meetings, to ensure that the interests of all sectors are better represented when central budgeting discussions occur. Neither of these actions, however, necessarily leads to an increased focus on ISA or SDH and therefore a specific equity focus is required in employing these mechanisms.
Improving communication

5.1. Making the case

It is well known that policy-making is not a completely systematic or rational process. Stories with a human face can greatly influence policy-makers (see Box 7). Data should sensitively support narratives that engage people and act as a window to broader policy concerns. To be effective, people need to see themselves in issues and stories. Stories work best when they are interesting, evoke emotion, have some tension, are a little surprising, and involve some element that the audience can relate to. Sometimes a counter-intuitive message can be powerful. Bad news always gives an opportunity to tell a human story about an issue, but the health sector sometimes produces such a continuous stream that there can be a degree of immunity to bad news about health. Good news stories about health may be more unexpected and could come from other sectors.

Box 7: The power of a single story as a platform

In Malawi recently, a couple set their guard dogs on to their frail 72-year-old security guard. When the guard’s employers finally took him to hospital, they asked the doctor to perform an HIV test on the guard, on the premise of wanting to protect their dogs. The doctor complied with their request, without consent from the badly injured guard. This story created national public outrage, but also initiated public discussion about why a 72-year-old man was working as a security guard in the first place. This opened up a broader discussion about social protection for the elderly, medical ethics, and employment conditions.

The media are potentially a powerful ally in making the case for ISA on SDH and can act as a “legitimiser” of concerns. However, the media are also more like private sector customers than a partner with shared goals. The media do not necessarily want to be worked “with” or want to be seen as advocates. Thus stories have to align with journalistic priorities such as tension and interest. Communication can start by identifying the people who are the face of the story, working in the desired policy aspects from this basis.

Success with the media requires an ongoing strategy, to get multiple exposures in a number of ways over a long time. The full repertoire of new social media can be harnessed to capitalize on the power of the “non-media media” (such as civil society, NGOs, and advocacy groups). But it is also important to remember that these new technologies are a tool, not an end in themselves – an uninteresting message will remain so even in these media. Social media strategies often work best when coupled with traditional media campaigns.

5.2. Choosing the right language

The phrase “Health in All Policies” can be problematic. It can be seen as health-centric, with the health sector imposing its objectives on other sectors. Also, SDH are not clearly visible in the phrase. Terminology around determinants of human development or well-being in all policies may better allow other sectors to see how their own objectives could align with this approach.

Presenting health as a common goal can also be perceived as health-centric. Considering health instead as an “outcome” rather than an overarching goal can enable other sectors to see how their own outcomes relate to health outcomes, without establishing a hierarchy.
Consultation on implementing action on social determinants of health to reduce health inequities: The contribution of collaborative work between sectors
Next steps

The Wasan Island consultation has initiated a dialogue between WHO and a group of senior leaders from outside of the health sector. There is the potential for continued engagement by WHO in developing guidance for Member States on implementing intersectoral action on social determinants of health to reduce health inequities. This meeting report, and continued engagement with the group of participants, identifies key issues for further work by WHO on intersectoral action and has also fed into technical preparations for the World Conference on Social Determinants of Health, to be held in Rio de Janeiro on 19–21 October 2011.
Appendices

1. List of participants

Mr Daniel Albrecht Alba
Technical Officer
Ethics, Equity, Trade and Human Rights (ETH)
World Health Organization (WHO)
Switzerland

Mr Jorge E. Arrunátegui
Manager
Gerencia de Desarrollo de Capacidades y Rendimiento
Autoridad Nacional del Servicio Civil (SERVIR)
Peru

Mr Andy Burness
President
Burness Communications
United States of America

Dr Christine Burton
Associate Executive Director
RCS Programs & Partnership
Agriculture and Agri-Food
Canada

Dr Antonio Claret Campos Filho
Secondment of Brazilian Government
International Policy Centre for Inclusive Growth (IPC-IG)
Poverty Practice, Bureau for Development Policy
United Nations Development Programme (UNDP)
Brazil

Ms Eve Gaudet
Director
Provincial Literacy Planning & Performance
Ministry of Education
Canada

Dr Rüdiger Krech
Director
Ethics, Equity, Trade and Human Rights (ETH)
World Health Organization (WHO)
Switzerland

Mr Michael Lennon
CEO
Housing Choices Australia
Australia

Ms Margot Lettner
Wasabi Consulting
Canada

Dr Belinda Loring
Consultant Public Health Physician
Australia

Dr Alvaro Hideyoshi Matida
Centro de Relações Internacionais em Saúde Fundaçao Oswaldo Cruz (FIOCRUZ)
Brazil

Ms Anna Minj
BRAC Centre
Bangladesh

Ms Sandra Joy Pitcher
Deputy Chief Executive
Government of South Australia
Department of the Premier and Cabinet
Australia

Dr Kumanan Rasanathan
Technical Officer
Ethics, Equity, Trade and Human Rights (ETH)
World Health Organization (WHO)
Switzerland

Dr Eugenio Villar
Coordinator
Ethics, Equity, Trade and Human Rights (ETH)
World Health Organization (WHO)
Switzerland

Dr Susanne Weber-Mosdorff
Assistant Director-General (ADG)
World Health Organization (WHO)
Office at the European Union
Belgium

Ms Rachel Zibelu Banda
Chairperson
Industrial Relation Court
Malawi
2. List of questions sent to participants

1. What do you see as common values and goals, and potential areas of conflict, between your sector and the health sector, especially in terms of health equity?

2. What policy aspects of your work are enhanced by the health sector and/or health-related issues and impacts, and which aspects are challenged? What are the opportunities for joint work?

3. What are the key challenges and barriers (technical, political, and policy) you have encountered in working with other sectors, including health? How have you managed them?

4. What are the concrete “entry points” in your field for joint work with health and other sectors, such as local government interventions, specific population groups, common challenges or developmental targets and goals?

5. What institutional processes, mechanisms, structures and tools (e.g. budgetary, evaluation, planning) can facilitate collaborative work between sectors?

6. What capacities are required in your field to both promote and implement the idea of working intersectorally to achieve mutual goals? How can these be developed?

7. From your experience how could WHO and other international agencies best assist countries (governments and other actors) to implement intersectoral work?

8. What role does community participation and engagement play in successful intersectoral policymaking?

9. In work in your field, how have you successfully engaged the private sector to further your policy goals, and how have you managed conflicts with them?

10. How can the Accra Agenda for Action (Paris process on aid effectiveness), in calling for policy coherence and strengthening of government institutional capacities and ownership, facilitate intersectoral work for reducing health inequities?

11. How can low-income countries in your region address their particular economic, political and institutional challenges to implementing collaborative work between sectors that reduces health inequities?

12. What role can the media play in influencing policy debates towards collaborative work between sectors?

13. How can policymakers best navigate the media to their advantage in collaborative work between sectors?

14. Given there are more successful examples of collaborative work between sectors at local level, how can we best scale up successful, but isolated, intersectoral experiences to be effective at state/provincial, national, and global levels?
SOCIAL DETERMINANTS OF HEALTH

ACCESS TO POWER, MONEY AND RESOURCES AND THE CONDITIONS OF DAILY LIFE —
THE CIRCUMSTANCES IN WHICH PEOPLE ARE BORN, GROW, LIVE, WORK, AND AGE

[energy] [investment] [community/gov.] [water] [justice] [food]