

Strategizing national health in the 21st century: a handbook  
Chapter 12

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# Intersectoral planning for health and health equity

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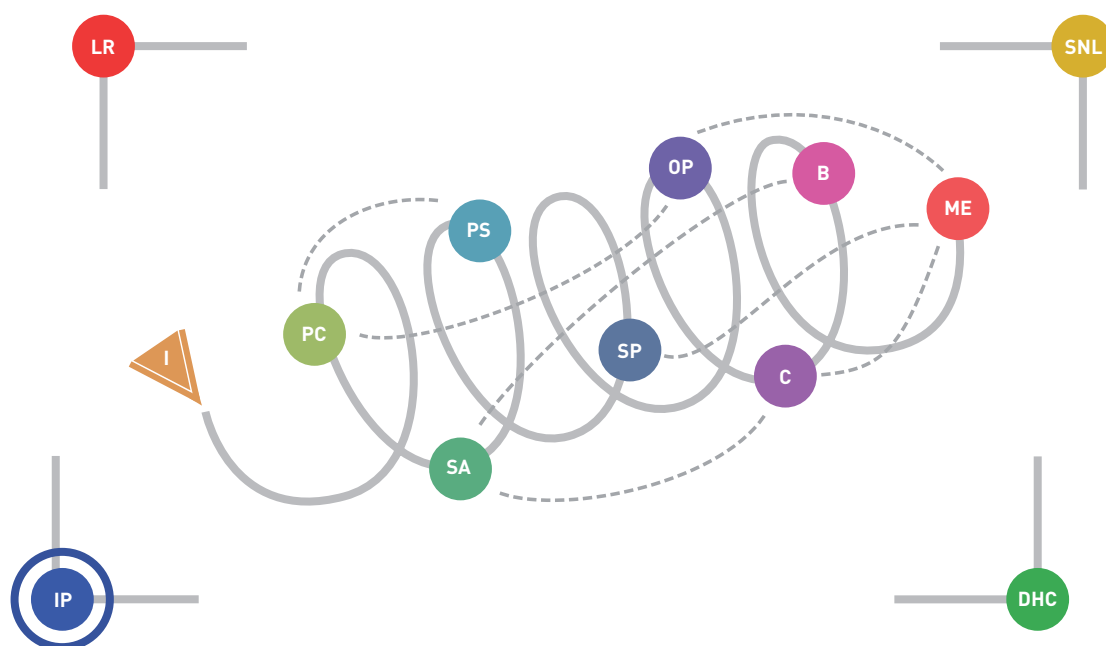
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<b>DHC</b>	CHAPTER 13 Strategizing in distressed health contexts

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# Overview

**This chapter outlines the need and practical action for including intersectoral planning for health and health equity within the overall process of strategizing for health.**









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# Summary

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## **What** is intersectoral planning for health and health equity?

Health equity is acknowledged as a critical component of the post-2015 sustainable development agenda, and is an essential element of any country's path towards universal health coverage (UHC). Intersectoral planning implies that governments and other stakeholders proactively address the determinants for health inequities by identifying and promoting intersectoral action as an integral and vital component of the national health planning process.

## **Why** do we need intersectoral planning?

Intersectoral planning addresses determinants of health, alongside clinical services, in order to achieve greater sustainability of results through:

- ▶ determining and confronting risk factors of ill health in a concerted effort;
- ▶ increasing the level and equity in distribution of health within populations;
- ▶ supporting achievement of the SDGs.

## **When** should we engage other sectors?

One should engage from the beginning of the national health planning process.

- ▶ However, intersectoral planning is not a linear process and thus several entry points exist.
- ▶ These different entry points find their correspondence in the approved SDGs.
- ▶ Intersectoral planning for health should be viewed as a multi-directional, continuous and constantly evolving process.

## **Who** should be involved: roles and responsibilities ?

The health sector, and in particular the ministry of health, should lead and understand the different interests and roles of many other sectors.

- ▶ Partnerships with or sponsorships by levels of government that have responsibility across sectors (e.g. ministry of planning, prime minister's or president's office, etc.) should be sought.
- ▶ All sectors should be linked to the 17 SDGs.
- ▶ While all sectors can do something to improve the health situation, the mechanisms the different sectors have and their potential strength in influencing the top risk factors and the most important social determinants vary.

## **How** should we plan for and implement intersectoral action?

Each country is different and needs to prepare and present its own case for intersectoral action on health inequities. It is important to:

- ▶ keep the target audience of non-health people in mind;
- ▶ find a common ground and build a common understanding between the health sector and all other relevant sectors;
- ▶ make good use of the situation analysis phase of the national health planning cycle;
- ▶ engage in policy dialogue and negotiation;
- ▶ link groups of indicators, including on social determinants, across dimensions of inequity and levels of results chains, as well as across different sectors.





## 12.1 What is intersectoral planning for health and health equity?

### 12.1.1 Health equity and social determinants of health – how do they relate to national health planning?

*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.*<sup>1</sup>

The above definition of health from the WHO Constitution indicates that some people might be deprived of their right to enjoy the highest attainable standard of health due to race, religion, political belief, economic or social condition, and that this is unjust. This definition inherently encompasses the concept of health equity by implying that the gold standard for health should be the same standard for all population groups, regardless of characteristics which are often the basis for discrimination or vulnerability – i.e. race, religion, political belief, economic or social condition. Indeed, despite major improvements in life expectancy and health outcomes globally, health inequities, i.e. differences in health status between more advantaged population groups and more disadvantaged population groups, therefore remain a significant – and in many cases growing – challenge. Indeed, even today, 70 years later, there are huge differences in health status across the world. For example, in Japan, life expectancy for women is 87 years but in Sierra Leone it is only 46 years. In Angola, out of 1000 children, 167 die before their fifth birthday; in Luxembourg it is only two.<sup>2</sup>

These health inequities – whether in relation to communicable diseases or noncommunicable diseases (NCDs), injuries, or resulting from new emerging risks like climate change – are rooted in the social determinants of health. The social determinants of health (SDHs) are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. The social and economic conditions, their effects on people's lives and the resulting differences in life expectancy and health status are also health inequities, because they are avoidable, unjust and unfair.<sup>3</sup>

Health equity and SDH are acknowledged as critical components of the post-2015 sustainable development agenda, and are an essential element of any country's path towards universal health coverage (UHC). Intersectoral planning implies that governments and other stakeholders proactively address social determinants and health inequities by identifying and promoting intersectoral action as an integral and vital component of the national health planning process. In other words, reducing health inequities is pivotal to achieving the goal of UHC, one of the distinct strategic directions of many national health policies, strategies and plans (NHPSPs). Without intersectoral action as a fully integrated component – and indeed, mindset – embedded

**Health inequities are rooted in the social determinants of health.**







in the national health planning process, health inequities will likely persist, and as a result, the health of any nation's population will suffer.

In this regard, this chapter's objective is to describe the need and practical action for including intersectoral planning for health and health equity within the overall national health planning process. It discusses why and how to integrate other sectors into national health planning processes, with the objective of ensuring better health and health equity.

## Box 12.1

### Basic concepts<sup>4</sup>

#### What are health inequities or inequalities?

Health inequities are avoidable and unfair inequalities in health between groups of people within countries and between countries. These inequities arise from inequalities within and between societies. Social and economic conditions and their effects on people's lives determine their risk of illness and the actions taken to prevent them becoming ill or treating illness when it occurs.

#### What is meant by social gradient?

Within countries, the evidence shows that in general, the lower an individual's socioeconomic position, the worse is her or his health. There is a social gradient in health that runs from top to bottom of the socioeconomic spectrum. This is a global phenomenon, seen in low, middle and high income countries. The social gradient in health means that health inequities affect everyone.

#### What are the social “determinants” of health?

The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems shaping the conditions of life. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

#### Intersectoral Action for Health:

“Coordination of health-related activities of the different sectors in order to achieve the highest attainable standard of health for every human being” according to the Alma Ata Declaration.



## 12.1.2 The Sustainable Development Goals (SDGs) – a marked accent on intersectorality

Since 1978 a number of different concepts, theories and frameworks have been designed and promoted to “achieve the highest attainable standard of health for every human being” through working across sectors. Examples include: Health for All,<sup>5</sup> Health Promotion,<sup>6</sup> Whole of government and whole of society,<sup>7</sup> Health in All Policies,<sup>8</sup> Human rights-based approaches,<sup>9</sup> Gender-based approaches,<sup>10</sup> and Social determinants approaches<sup>11</sup> to health. Each one of them has its own strengths and theoretical and ideological underpinning. However, all share a concern for health and health equity and require action by sectors other than health for their implementation – but, they also share the challenges of implementation.

Most major public health programmes have at one point or another considered intersectoral action in their global or regional strategies and some have produced multisectoral action frameworks. Just to mention a few: The global action plan for the prevention and control of noncommunicable diseases (2013–2020)<sup>12</sup> has multisectoral action as one of its overarching principles and has an appendix linking 21 different sectors to the main risk factors for NCDs. The UNAIDS 2016–2021 strategy On the fast-track to end AIDS has a whole section about HIV and the SDGs, calling for joint action and shared progress.<sup>13</sup> In 2013, the Roll Back Malaria partnership/United Nations Development Programme (UNDP) published a Multisectoral action framework for malaria;<sup>14</sup> and in 2014, the Reproductive, Maternal, Newborn and Child Health Programme published *A multisectoral policy compendium for RMNCH*.<sup>15</sup>

However, these examples all relate to individual public health programmes. Unfortunately, the past decades of global guidance on overarching national health planning have much less frequently included intersectoral action compared to programme-specific strategies (see Box 12.2). Only a very few countries have systematically and comprehensively integrated other sectors into their national health planning processes, e.g. Australia, Finland and New Zealand. This is quite remarkable as the collective work done by 16 public health programmes as part of the Commission on Social Determinants of Health found that most social determinants of health inequity are shared among the various public health conditions regardless of whether they are classified as communicable, maternal and neonatal, and nutritional disorders; noncommunicable diseases; or injuries.<sup>16</sup>

One explanation could be the perpetuation of the sectoral silo-thinking and fragmentation observed 30 years ago that include both health and other sectors (see Box 12.1). Managers and staff may want to stay within their familiar comfort zones. This might be due to budget allocation principles and accountability frameworks within governments that may not support multi-stakeholders and intersectoral collaboration. The single-sector focus of the Millennium Development Goals (MDGs) and donor financing mechanisms may also have contributed. However, the results are loss of opportunities for sustainably improving population health, and in the end higher health care costs and lower social and economic productivity in societies.

## Box 12.2

### Why is intersectoral planning missing in the planning process?<sup>17</sup>

“Recognizing the multisectoral character of health development, the Alma Ata Declaration called for the coordination of health-related activities of the different sectors....”

“There are several reasons why health strategies have not advanced far in this direction. Despite the new strategy for health, health planning has remained a more or less self-contained exercise within the health sector, carried out principally by health professionals, in relative isolation from other development processes. This isolation is reinforced by the tendency of most sectors to perceive health as comprising mainly medical services and their output. This pushes the health strategy back to a curative approach. In this context, other development sectors tend to regard intersectoral collaboration for health as a diversion of time and resources from their own sectoral priorities.”

The Sustainable Development Goals (SDGs)<sup>18</sup> take a holistic multisectoral approach to development, compared to the selective single-sector approach of the MDGs. The SDGs differ from the MDGs in a number of ways. They are for all countries and are not just development assistance goals; they are concerned with equity, i.e. with specifying the need to disaggregate data and monitor achievement for different population groups, rather than just with average achievements; and they realize sustainable development can only be achieved by addressing all the goals at the same time – rather than selectively. By necessity, the achievements of the SDGs will require intersectoral action at global level, in each country, and within each country at sub-national levels. One extremely important way intersectoral action can take place at national level is through an intersectoral approach in the national health planning process, i.e. intersectoral planning, the subject of this chapter. The SDGs are thus a concern for all, whether national or local health planners or the international community.

**By necessity, the achievements of the SDGs will require intersectoral action at global level, in each country, and within each country at sub-national levels.**

### 12.1.3 Intersectoral planning made explicit: good examples from New Zealand and Norway

**Some countries have already successfully integrated health equity and intersectoral action into their national health planning processes and documents and can be viewed as examples for health-specific strategies whose broad goals entail collaboration with other sectors.**

There are examples of countries that to some extent have integrated health equity and intersectoral action into their national health planning processes and documents (see Boxes 12.5 and 12.7). Here, the New Zealand Health Strategy 2000 as well as the Norwegian Public Health Act of 2012 are highlighted, as they exemplify a health-specific strategy whose broad goals and specific objectives entail collaboration with or action by sectors other than health.

New Zealand is a country with three large ethnic population groups – Maori, Pacific and European – and a history of strong social welfare policy. A change of government in 1999 meant a shift in emphasis from a sole focus on economic growth as a measure of progress to achievement in social progress given equal weight. Comprehensive analyses were done as part of the strategic planning process for the Health Strategy 2000, e.g. on life expectancy by ethnicity and deprivation and on the distribution of risk factors such as tobacco smoking. The analyses showed huge inequities and the importance of tackling their root causes, i.e. the social determinants.<sup>19</sup>

The New Zealand Health Strategy 2000 thus set out the main aim to reduce the inequities between the three population groups and included tackling the broader determinant of health and reorienting health services. Some of the Strategy's 10 broad goals and 61 specific objectives require explicit intersectoral action. Other goals and objectives – such as improved access to health services, improved participation in health system decision-making and workforce by Maori and Pacific populations – were more directly within the remit of the health sector and its own institutions.

The roll-out of the Strategy was accompanied by an integration of social determinants of health and health inequity indicators into the social reports produced by the Ministry of Social Development. These social reports could follow medium- and long-term impact of policy initiatives and action, and thus have a potential to inform evaluation and design of public policy. However, one challenge highlighted by a study of the effectiveness of this approach was that government agencies concerned with economic development made negligible use of the reports. The study recommended anchoring the reports in the national legislation.<sup>20</sup>

By contrast, Norway's approach to a common framework for intersectoral monitoring was based on their Public Health Act of 2012,<sup>21</sup> which provided for a broad cross-government responsibility for health and health equity. It required much intersectoral work, between the launch of their Strategy to Reduce Social Inequalities in Health in 2007 and the development of the Public Health Act in 2012, to gain acceptance of this broader concept of health in the policy sphere.<sup>22</sup> The Public Health Act now forms the basis for reporting both on the status of public health and on the intersectoral public health policy work.



### 12.1.4 Intersectoral planning as the focus of this chapter

This chapter focuses on overarching national health and development planning rather than on health service and individual public health programme planning. Therefore, health inequities arising from differential access to and benefit from health services are, for example, only touched on very briefly. The chapter seeks to take a pragmatic rather than dogmatic approach. It realizes that there is no hard and fast blueprint for intersectoral action and health equity that will guarantee success. However, there are strong rationales and there are examples to be drawn on and inspired by.

**There is no hard and fast blueprint for intersectoral action that guarantees success; this chapter, however, offers strong rationales for certain planning practices that can be used in different contexts.**



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## 12.2 Why do we need intersectoral planning?

Endemic malaria has disappeared from most of North America and northern Europe with general social and economic development, including better housing, land drainage, less-crowded housing, closed windows and a reduced tendency for people to live close to their livestock, and not as a result of direct vector or chemo-prophylactic control. However, while the time immediately after the First World War saw malaria epidemics spreading across Europe, these epidemics subsided or responded easily to control interventions, suggesting that strong health systems (i.e. for delivery of medications) and the improvement in overall socioeconomic conditions rather than changing the vector ecology were responsible for alleviating the problem. Transient resurgence of malaria in connection with war, population movements and associated disruptions has been seen in several places – including: Armenia, Azerbaijan, Italy, Spain, and Tajikistan – with a rapid return to the earlier situation once the societies recover. In contrast, when malaria control does not take into account broader development issues and is based solely on direct vector control and chemotherapy through local or global campaigns, resurgence with added virulence is often observed once the campaign measures are relaxed.<sup>23</sup>

Another such example comes from the history of tuberculosis (TB) in Europe. TB death rates in Europe increased in the 17th and 18th centuries with industrialization and urbanization, when a rise in population density led to crowded living

conditions and poor nutrition, contributing to the progression of the disease. With the subsequent economic growth, social reform, a gradual decline in the level of poverty and improved living conditions, the TB incidence had already declined about eight- to tenfold by the 1940s when chemotherapy first became available. Some have suggested that the decline until the end of the 1940s was almost exclusively due to improved nutritional status and living conditions. Others have argued that public health interventions such as isolation of infectious individuals and the pasteurization of milk to prevent bovine tuberculosis have also contributed to the decline. However, it seems clear that, on the one hand, the highest TB rates have been recorded in places where rapid urbanization was coupled with very poor living conditions for the disadvantaged. On the other hand, the most rapid declines in TB incidence and deaths have been recorded where economic growth was coupled with social and health sector reform and important medical advances.<sup>24</sup>

Both examples further suggest that there are strong links between general development and health development. They show that socioeconomic development and health systems development are mutually reinforcing and increase the chances for sustainable achievements. In other words, addressing the determinants of health (which intrinsically involves collaboration between sectors) concomitantly to addressing clinical services leads to sustainable results.

**Socioeconomic development and health systems development are mutually reinforcing; addressing determinants of health alongside clinical services leads to greater sustainability of results.**

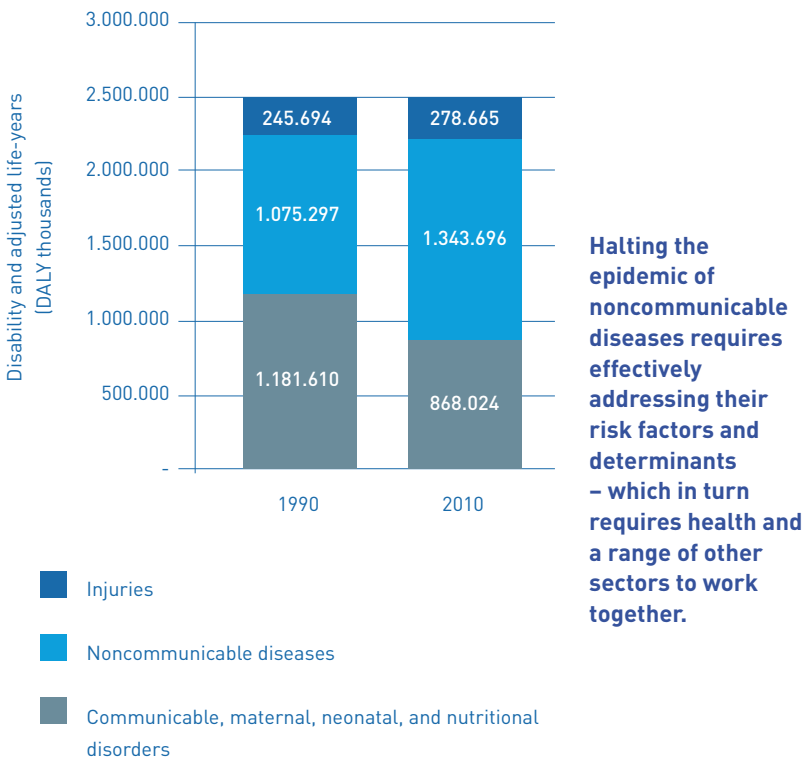
### 12.2.1 Burden of disease

There has been a remarkable reduction in the global burden of communicable diseases, maternal and neonatal conditions, and nutritional disorders from 1.18 billion disability-adjusted life-years (DALYs) in 1990 to 0.87 billion in 2010, i.e. a reduction of 26.6% (Fig. 12.1).<sup>25</sup> This success may be explained by a combination of factors. These include general poverty reduction; improved access to education, in particular for girls; improved access to clean water and sanitation; and improved access to selected health services. All these factors were specifically emphasized in the Millennium Development Goals and the action spheres of different sectors.

However, Fig. 12.1. also shows that the overall global burden of disease remained constant at about 2.5 billion DALYs over the two decades, i.e. the gains in communicable, maternal, neonatal and nutritional disorders were outweighed by increases in noncommunicable diseases (NCDs) and injuries. The NCDs increased by 25.3%, i.e. from 1.08 billion DALYs in 1990 to 1.34 billion in 2010; and injuries increased by 0.03 billion in the same period. Some of this increase might be explained by people living longer (life-expectancy at birth in 1990 was 64 years and in 2013 it was 71 years<sup>26</sup>). However, changes in lifestyles and exposures may also have contributed to the increase.

If nothing is done to halt the epidemic of NCDs, it is very likely that the overall global burden of disease in 2030 will be higher than it was in

**Fig. 12.1 The Global Burden of Disease (1990–2010)**



1990. Halting the epidemic of noncommunicable diseases requires effectively addressing their risk factors and determinants. This can only be done through the health sector and a range of other sectors working together in a concerted effort, i.e. through comprehensive intersectoral NHPSP.



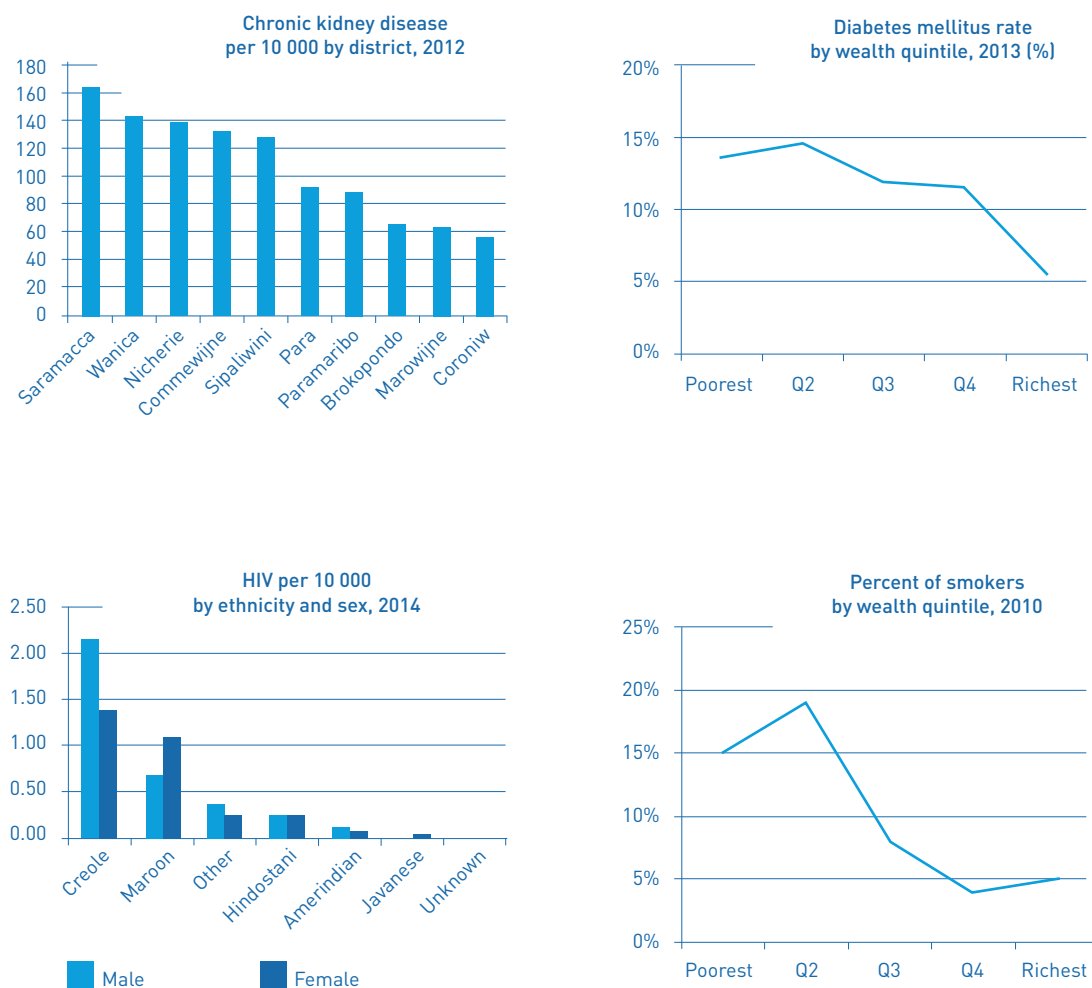


## 12.2.2 Social determinants

The overall global burden of disease numbers (Fig. 12.1) mask considerable differences across countries. Within countries, a disaggregation of national averages, e.g. by geographical location, wealth, ethnicity and sex, will almost always reveal considerable health inequities, as is the case in Suriname (Fig. 12.2).

Chronic kidney disease in Suriname is more than 2.5 times more prevalent in Saramacca district compared to Coronie district and diabetes II is about three times more prevalent among the poorest wealth quintiles compared to the richest. The HIV prevalence is much higher among the Creole and Maroon ethnic groups

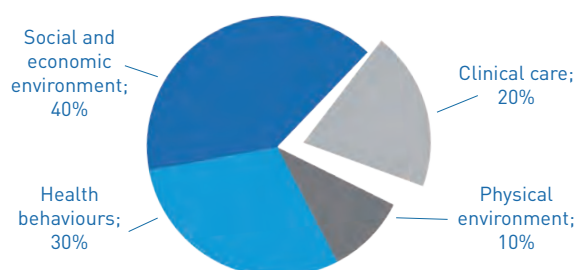
**Fig. 12.2 Examples of health inequities in Suriname<sup>27</sup>**



compared to other ethnic groups. However, it is interesting to note that the prevalence among Creole women is lower than among males, while for Maroons it is the other way round. Finally, smoking prevalence among the two poorest wealth quintiles was found to be three to four times higher than in the richest quintile. While the poorer wealth quintiles were found always to have higher disease and risk factor prevalence than the richer quintiles, the districts and ethnic groups that had the highest prevalence varied across diseases, conditions and risk factors. This raises the important question of what shapes the population health profile in a given society.

The effect that clinical care has on the health of populations is far smaller than commonly thought. A study across communities in the United States of America showed that access to and quality of clinical care explained only 20% of premature deaths in communities. Other factors together accounted for the other 80%, i.e. social and economic factors 40%; health behaviours 30%; and the physical environment 10% (Fig. 12.3).<sup>28</sup> However, both the health behaviours and the physical environment are in turn also shaped by social and economic factors. This means that about 80% of a population's health may be shaped by the circumstances in which people are born, grow, live, work and age, in other words, the social determinants of health.

**Fig. 12.3 Factors affecting populations' health in the USA**



Equitable access to cost-effective quality clinical care should remain a fundamental right for all. However, effectively and sustainably improving the level and distribution of populations' health will require action across multiple sectors to address key risk factors related to exposures and behaviours, such as dietary risks; child and maternal malnutrition; tobacco use; air pollution; alcohol and drug use; unsafe water, sanitation and handwashing; unsafe sex; occupational risks; low physical activity; sexual abuse and violence; and other environmental risks of the global burden of disease.<sup>29</sup> It will further require action on those social determinants that create differential exposure and vulnerability across population groups and that are often grounded in societal context and in social, political and economic position.<sup>30</sup> The SDGs call for comprehensive action on these determinants and risk factors, by emphasizing equity across all goals and through the specific goal dedicated to equity (SDG 10), which underlines the dire need for data disaggregation (by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts).<sup>31</sup>

Likewise, national health policies, strategies and plans thus need to be based on a thorough analysis of disaggregated data, and should put a distinct emphasis on and ensuring that the factors shaping population health are addressed. Ignoring these factors will mean that overall health status can only be marginally improved, at best. Addressing the social determinants of health means intersectoral action, and this approach must be embedded in the national health planning process.

**80% of a population's health may be shaped by the circumstances in which people are born, grow, live, work and age, in other words, the social determinants of health.**

### Box 12.3

#### Early child development in Viet Nam – why improved intersectoral planning is sorely needed

Maternal education has long been considered an important determinant for maternal and child health status in many countries, including Viet Nam.<sup>32</sup> In Viet Nam's rural areas only 22.8% of mothers of children aged 0–8 years have completed secondary education, compared to 53.9% in urban areas. Health care seeking behaviour as well as utilization rates in Viet Nam are causally linked to educational levels.<sup>33</sup> Some suggest that this is due to limited knowledge of certain key childhood symptoms and the resulting health-seeking delays and a higher risk of adverse outcomes.

In the poorest Vietnamese income quintile, secondary school completion rate is 8.1%; it is 73.7% among the richest. Among the majority ethnic group of Viet Nam (Kinh population), the completion rate is 34.4%, but only 13.6% for ethnic minorities. 58.9% of children in the poorest quintile aged 36–59 months enjoy early childhood education, while for the richest it is 90.6%.<sup>34</sup> What a

child experiences before eight years of age sets a critical foundation for her or his entire life, and there is a strong association between child survival and child development. The physical, social, emotional and language domains strongly influence basic learning, school success, economic participation, social citizenship, and health.<sup>35</sup>

These inequalities are part of a vicious circle of intergenerational inequity that can only be broken by appropriate action. This action must inherently be intersectoral in nature because it is at the intersections between education, local government, social welfare and health. Intersectoral action must be carefully planned for and embedded into NHPSPs. When intersectoral action is one-off and effectively isolated, it is unsustainable. Ensuring that intersectorality is an integral component of NHPSPs assures the longer-term collaboration necessary to bring about the kind of change needed in Viet Nam.





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## 12.3 When should we engage other sectors?

**Especially the situation analysis phase is an immense opportunity to ensure that the right questions regarding equity and the determinants of health are raised, and that those key issues are adequately assessed.**

The short answer to the question above is “from the beginning”. However, intersectoral planning, as part of the national health planning process, is not a linear process and thus several entry points exist, e.g. see Box 12.4. The situation analysis phase in particular is an immense opportunity to ensure that the right questions regarding equity and the determinants of health are raised, and that those key issues are adequately assessed. Actions may be undertaken all along the planning cycle; however, without the principal matters coming to the forefront during the situation analysis phase, these actions will not be slated in.

Box 12.4 summarizes eight entry-points for addressing health inequity and intersectoral collaboration in national health planning. For some of them, the health sector is both the leader and the implementer; for others, the health sector emphasis is on providing leadership; while for others again, the health sector may act primarily as a catalyst. These different entry points for tackling health inequalities find their correspondence in the approved SDGs, where health goes beyond Goal 3 (see Annex 12.1). Nearly all SDGs play a key role for health. Each entry point is briefly described with reference to three key SDGs in brackets. Please note that several of the analyses mentioned as entry points can be carried out during the situation analysis stage of the health policy and planning cycle.

Only the strongest links with other SDGs are indicated in Box 12.4 – there are, of course, many more links of varying strengths (see Annex 12.1). Often the strength of a link between an entry point and an SDG will depend on national and local contexts. The many pieces of the analysis and action may in the end appear in different

sectors’ strategies and work plans. However, all the important ones should be mentioned in the NHPSP with reference to the sector and sectoral plan where the responsibility lies. All need to come together in a monitoring and accountability framework of the NHPSP as well as for the SDGs overall. In the following sections the specifics of the analysis, planning and monitoring will be elaborated.

### Box 12.4

#### **Eight potential entry points for reaching and sustaining greater health equity<sup>36</sup>**

- 1. Analysis of evidence on inequities and their causes.** Examine health data disaggregated as relevant to the country; review studies (including qualitative studies) conducted in subpopulations; explore the causes of inequity that require intersectoral action; and review reports by human rights bodies (SDG 5, SDG 10, and SDG 17).
- 2. Analysis of and action on laws, policies, standards, protocols and guidelines.** Consider how equity, human rights, gender and social determinants are affected by the existing policy, legal, normative, programmatic and monitoring and evaluation frameworks, and how these issues could be addressed (SDG 5, SDG 10, and SDG 16).

**3. Analysis of and action on the causes of differentials** (social determinants at play) to identify the most relevant, including those that influence:

- ▶ differential exposure to the physical environment, e.g. adverse workplaces and community settings, poor infrastructures, unhealthy and harmful consumables, etc. (SDG 6, SDG 8, and SDG 11);
- ▶ differential exposure to the social environment, e.g. social norms that can undermine health, gender expectations and repression, ethnic and racial discrimination, unregulated marketing, etc. (SDG 5, SDG 10, and SDG 16);
- ▶ differential community and individual vulnerability, e.g. poverty and unemployment, family and community dysfunction, poor knowledge, low levels of health literacy and care-seeking, alcohol abuse, food insecurity and malnutrition, etc. (SDG 1, SDG 2, and SDG 4);
- ▶ differential access to health products and services, e.g. skewed availability, financial barriers, products and services with poor acceptability, etc. (SDG 1, SDG 10, and SDG 16);
- ▶ differential benefit from health services, e.g. poor quality health services, discriminatory treatment and care, biased referral systems, services insensitive to needs, limited patient-provider interaction, poor adherence to advice and recommended treatments, etc. (SDG 5, SDG 10, and SDG 16); and
- ▶ differential consequences of illness and disability, e.g. loss of income, impoverishment/catastrophic health expenditure, stigmatization or other forms of discrimination (SDG 1, SDG 10, and SDG 16).

**4. Analysis and allocation of resources.**

It is not just a matter of the absolute level of resources – but also how they are distributed within societies and put to use. Skewed distribution of attention, resources and efforts in countries might prioritize outputs that increase rather than decrease inequity (SDG 1, SDG 10, and SDG 16).

**5. Analysis, strategies and actions to specifically address gender issues.** Gender-responsiveness should be promoted in all processes and in organizations and services (SDG 4, SDG 5, and SDG 16).

**6. Analysis and provision of means for civil society and individuals to participate in decision-making.** The right to health is best protected when individuals and concerned populations, including those marginalized or otherwise disadvantaged, are actively involved in decision-making on policy, health planning, and their individual health (SDG 4, SDG 10, and SDG 16).

**7. Transparency, accountability and keeping sectoral managers and services to task** are essential for reducing health inequities, together with safe mechanisms for reporting and addressing complaints whenever rights to health are threatened or violated, individually or collectively (SDG 5, SDG 10, and SDG 16).

**8. Ensuring gender balance and equity in organizational processes** through ensuring sex parity, appropriate gender representation, and inclusion of concerned population groups among staff, management and board members (SDG 5, SDG 10, and SDG 16).



## 12.4 Who should be involved: roles and responsibilities

Different sectors, and often also different health programmes, may have different planning cycles. Furthermore, in some countries, there may be an overall national development plan, again with its own cycle. The health sector's proactive coordination with all of them is paramount.

Intersectoral planning for health should be viewed as a multi-directional, continuous and constantly evolving process. It will be important to keep track of the different planning and monitoring cycles because they provide windows of opportunity to get health into the relevant sectors' plans and monitoring frameworks. From the perspective of the health sector, intersectoral planning means being engaged with other sectors on a regular basis, and being on the alert for crucial windows of opportunity where health needs to be part of the dialogue.

Opportunities that should not be missed for leading the engagement of other sectors are the preparation of the national development plan and the national health plan. This implies bringing in other sectors throughout the health planning process and bringing health into the other sectors' planning processes from the situation analysis, and priority-setting phases, for example.

A key role of the health sector and in particular the ministry of health is to lead and understand the different interests and roles of many other sectors actually or potentially influencing the risk factors and social determinants of health, and to facilitate the process (see e.g. the case of Estonia in Box 12.5). This requires technical capacity and knowledge as well as leadership considerably beyond the clinical aspects of health.<sup>37</sup> If this is not adequately available, consultants may be used and the capacity built during the process. The ministry of health will not be able to carry the responsibility alone. Partnerships with or sponsorships by levels of government that have responsibility across sectors (e.g. ministry of planning, prime minister's or president's office, etc.) will have to be sought. However, the health sector has to take the initiative for leading the process, and keeping it in motion and on track. Special attention should be given to ensuring it is based on facts and consensus, and to prevent it from being sidetracked by political agendas or particular interest groups.

## Box 12.5

### The National Health Plan 2009–2020, Estonia<sup>38</sup> links with a large number of strategies and development plans across different sectors

#### Ministry of Social Affairs

- ▶ Primary healthcare development plan (in preparation)
- ▶ Estonian Hospital Master Plan 2002
- ▶ Nursing Care Network Development Plan 2004–2015
- ▶ Strategy to Guarantee the Rights of the Child
- ▶ Development Plan for Prevention of Family Violence (in preparation)
- ▶ National Cancer Strategy 2007–2015
- ▶ National HIV and AIDS Strategy 2006–2015
- ▶ National Drug Addiction Prevention Strategy until 2012
- ▶ National Tuberculosis Control Strategy 2008–2012
- ▶ National Strategy for Prevention of Cardiovascular Diseases 2005–2020
- ▶ Development Plan for Infertility Treatment 2007–2010

#### State Chancellery

- ▶ Estonia's European Union Policy 2007–2011
- ▶ Government Programme 2007–2011
- ▶ Ministry of Finance
- ▶ National Strategy Reference Framework 2007–2013

#### Office of the Minister Urve Palo

- ▶ Estonian Integration Programme 2008–2013

#### Ministry of Environment

- ▶ Estonian National Strategy on Sustainable Development 'Sustainable Estonia 21'
- ▶ Estonian Environmental Strategy until 2030
- ▶ National Radiation Safety Development Plan 2008–2017

#### Ministry of Culture

- ▶ Strategic Development Sports for All Programme 2006–2010

#### Ministry of the Interior

- ▶ Development Plan for Civic Initiative Support 2007–2010
- ▶ Regional Development Strategy of Estonia 2005–2015
- ▶ National Spatial Plan 'Estonia 2010'
- ▶ Internal Security Development Plan 2009–2013 (in preparation)

#### Ministry of Education and Research

- ▶ Youth Work Strategy 2006–2013
- ▶ General Education System Development Plan 2007–2013
- ▶ Bullying Prevention Programme 'Safe School' (in preparation)

#### Ministry of Agriculture

- ▶ Estonian Rural Development Strategy 2007–2013
- ▶ Development Plan for the Government Area of the Ministry of Agriculture 2009–2012

#### Ministry of Justice

- ▶ Development Plan for Reduction of Juvenile Delinquency 2007–2009
- ▶ Development Plan for Combatting Trafficking in Human Beings 2006–2009

#### Ministry of Economic Affairs and Communication

- ▶ Estonian Housing Development Plan 2008–2013
- ▶ Transport Development Plan 2006–2013
- ▶ Estonian National Traffic Safety Programme 2003–2015
- ▶ Estonian Information Society Strategy and Implementation Plan

To make a positive impact on a risk factor or social determinant of health, it is important first to map and understand who else shares a common interest in health and who is opposed to changes

A first indication of which sectors to involve can be made based on Box 12.4 and the Annex that links the eight entry points to the 17 SDGs. While all sectors can do something to improve the health situation, the mechanisms the different sectors have and their potential strength in influencing the top risk factors and the most important social determinants vary. Furthermore, the interest of the different sectors to act may also vary. The interests may be categorized into:

**Shared** – this is the case where a sector shares the primary interest of health to make a positive change to a risk factor or a social determinant. For example, the education sector would likely share the interest to contribute making a dent on “clustering of disadvantages”. This is because higher enrolment, lower drop-out and higher completion rates would be among the education sector’s success criteria.

**Different** – in this case, the sector’s interest will be different from health’s interest without necessarily being opposed. For example, the primary interest of “urban planning and transport” might be to get the motorized road traffic flowing rather than providing easy, safe and preferred access to physical activity, including walking and cycling.

**Opposed** – there are, however, also cases where the interests of the other sector is directly opposed to the interest of health. For example, parts of trade and industry and others may be opposed to reducing marketing and access to tobacco and alcohol products, with a claim that it will directly affect their bottom line.

It is important to map who shares the primary interest of health in making a positive impact on a risk factor or a social determinant, who has a different interest and who is directly opposed to making changes. The reason is, of course, that it can have a major effect on the process and whether a particular component of the plan will be successfully implemented.

When interests are shared, the other sector would not need incentive or much negotiation to be convinced for action. However, when the interests are different, the sector in question might need some push and explanation of the health benefits to include relevant action. The primary focus should be on where there are potentially strong influences on the risk factor or the social determinant.

Special attention must be given to situations where a sector has opposing interests but exercises a potentially strong influence on a particular risk factor or social determinant. For the same risk factor or determinant, there might be other sectors with potentially very strong or medium-strong influence that share the interest with health or have different but not opposing interests. Forces can be joined with these, e.g. to change legislation and regulations or to strengthen enforcement of the same.

Table 12.1 briefly describes the roles and responsibilities of the ministry of health and other sectors and actors during three phases of planning and managing intersectoral action: analysis, negotiate and plan, and monitor and hold accountable. Details of these phases are provided in section 5.



**Table 12.1 Roles and responsibilities**

PHASE	MINISTRY OF HEALTH	OTHER SECTORS AND ACTORS
<b>Analyse</b> (see subsection 5.1)	<ul style="list-style-type: none"> <li>▶ <b>Manage the process of knowledge gathering</b> – commission or take direct charge of getting all available knowledge together in a format conducive to decision-making</li> <li>▶ <b>Lead analysis and consensus building</b> – involve the key stakeholders, experts and opinion leaders to have a common understanding of the causes of the burden of disease and the health inequity situation in the country</li> <li>▶ <b>Inform and publicize</b> – to generate and nurture an evidence-based public debate and demand for action;</li> <li>▶ <b>Identify knowledge gaps</b> – to encourage and direct future data collection and research</li> </ul>	<ul style="list-style-type: none"> <li>▶ <b>Prime minister's office, national planning, etc.:</b> sponsor, bring inter-sectoral action for health and health equity on cabinet agenda and into national development analysis</li> <li>▶ <b>Researchers, bureau of statistics, information units of sectors, and civil society organizations:</b> provide data and participate in analysis</li> <li>▶ <b>Politicians, opinion-makers, and media:</b> participate in consensus and dissemination process</li> </ul>
<b>Negotiate and plan</b> (see subsection 5.2)	<ul style="list-style-type: none"> <li>▶ <b>Set priorities for policy planning, design and implementation</b> – this may include bringing together all the parties and stakeholders in a consensus process</li> <li>▶ <b>Identify and handle possible conflicts of interest and controversies</b> – this may include brokering and negotiating, proposing compromises, or mobilizing pressure for political or legislative decision</li> <li>▶ <b>Train trainers</b> – to integrate health and health equity concerns into ongoing training programmes for different sectors and cadres</li> <li>▶ <b>Move the political process</b> – bringing together the power of knowledge and evidence, the social power of civil society and the state power through accountable political leadership; and moving health higher on the political agenda</li> <li>▶ <b>Appropriately link the national health plan with the plans of the relevant sectors</b> – to negotiate inclusion of relevant action into the plans of other sectors in formats that can be monitored across sectors</li> </ul>	<ul style="list-style-type: none"> <li>▶ <b>Prime minister's office, national planning, etc.:</b> sponsor, keep inter-sectoral action for health equity on cabinet agenda, and demand progress</li> <li>▶ <b>Sectors, including civil society organizations:</b> participate in process, commit to action and results within their domains, and include in their own plans</li> </ul>
<b>Monitor and hold accountable</b> (see subsection 5.3)	<ul style="list-style-type: none"> <li>▶ Keep track of <b>activities in other sectors</b> that have bearing on health, including the policies and policy-results</li> <li>▶ <b>Improve own data sources</b> with respect to completeness and possibility for disaggregation</li> <li>▶ <b>Encourage, guide and support other data sources</b> to produce relevant disaggregated data, linking health with social determinants and risk factors</li> <li>▶ <b>Analyse, disseminate and present information</b> in formats that are conducive to informing managerial action and political and public debates</li> </ul>	<ul style="list-style-type: none"> <li>▶ <b>Prime minister's office, national planning, etc.:</b> sponsor, keep sectors accountable for commitments and report to cabinet</li> <li>▶ <b>Sectors, including civil society organizations:</b> report on committed actions and results, participate in reviewing progress, and commit to continued action and results within their domains</li> <li>▶ <b>Politicians, opinion-makers, and media:</b> participate in evaluation, consensus and dissemination process</li> </ul>

A question that sometimes comes up in connection with intersectoral planning is who pays for it. In the case of shared interest, it should obviously be the individual sector from its normal budget allocations. However, when the interests are different (non-opposing) it might impact on budgets, as sectors might have to do certain things additionally or differently in order to have a positive effect on health and health equity. This could mean that there has to be internal reallocation of budgets or that additional budget allocation will be required. However, as sectors will not be asked to do activities that do not fall

within their mandates, implementation should be covered from within the sectoral budget – even if the ministry of finance will have to allocate additional resources, which could be generated, e.g. from public health taxes. Sectors that have opposing interests might be “brought to pay” in form of public health taxes, e.g. on tobacco, alcohol, unhealthy food, etc.<sup>39</sup> One activity that might be relevant to cover from the health sector budget would be capacity-building programmes for integrating health considerations into other key sectors’ ongoing training programmes.



## 12.5 How should we plan for and implement intersectoral action?

Each country is different and needs to prepare and present its own case for intersectoral action on health inequities, based on its own data and analyses of the risk factors and social determinants that are causing the situation, in order to mobilize political attention and intersectoral commitment. When presenting the case, it is important to keep the target audience of non-health people in mind. They need to be able first to understand the message, second to see how the message is relevant to them, and third to be convinced why they should engage. There is the need to find a common ground and to build a common understanding between the health sector and all other relevant sectors.

A wide range of options and tools<sup>40</sup> exists for presenting data in tables and graphs in different formats (see, e.g. Fig. 12.2). It is important to link groups of indicators, including on social determinants, across dimensions of inequity and levels of results chains, as well as across different sectors. Tabular and graphic presentations frequently fall short; or might not be wholly understood by target audiences. It might therefore be useful to supplement tabular and graphic presentations by “telling the story”,

e.g. in short narratives specifically formulated with the relevant target audience in mind. In the Viet Nam case (Box 12.3), at least three sectors contribute directly to breaking the vicious circle of intergenerational inequity, i.e. education, local governments, and social welfare – while the underlying unfair distribution of resources is on the shoulders of finance, politicians and civil society. Other sectors, including the economic sectors, can recognize an interest in the results of action and indicator improvement – i.e. increased social and economic participation and reduced demand for health care.

A parallel more comprehensive and more technical option is to pull all relevant information on each major disease in the country – prevalence, distribution across locations and population groups, and possible causes of the pattern – and present it in master sheets, one for each disease.<sup>41</sup> This option has the advantage of highlighting the causes of the diseases as well as identifying key knowledge and action gaps. Such an analysis is a good opportunity for engaging the scientific community as well as civil society organizations in preparing the case (see also subsection 12.5.1).

**Planning and implementing intersectoral action is unique for each country; planning must be based on its own data, analyses of the risk factors, and social determinants causing health inequities.**



## 12.5.1 A good starting point: the situation analysis phase of the national health planning cycle

As explained earlier (Box 12.4), there are several analyses which can potentially be undertaken during the situation analysis phase of the planning cycle, with the view of integrating intersectoral planning for health and health equity into the overall national health planning process. Some countries may analyse data from existing monitoring systems containing good information on intersectoral factors influencing health equity (e.g. see Finland's compass system<sup>1</sup>). Others may start from broader survey analyses of the overall health situation and associated intersectoral priorities.<sup>42</sup>

Complementary to these analytical approaches, a concrete starting point could be the total burden of disease and its risk factors in the country, broken down by diseases and conditions and, where possible, disaggregated by the relevant dimensions of inequity in the country. This should be part and parcel of the situation analysis phase in the national health policy and planning cycle. The Global Burden of Disease Project produces updated profiles for each country.<sup>43</sup> The profiles provide ranking of the 25 largest contributors to premature death and DALYs, comparison between 1990 and 2010, and benchmarking with other countries of comparable levels of economic development.<sup>44</sup> Starting from the burden of disease profile, in particular the DALY components, will help to focus, prioritize, and overcome differences of interests. It can give

appropriate weight to diseases and conditions that reduce social, mental and physical well-being without necessarily causing premature death. It will also help avoid falling into the trap of being led or misled by the availability of data or gaps in the same. The profiles also provide an overview of burden of disease driven by the 15 leading risk factors. This includes both those that are attributes, e.g. high blood pressure, high body-mass index, iron deficiency, etc. as well as those that are exposures, e.g. dietary risks, smoking, household air pollution, etc. Risk factors provide links to the social determinants and are the crux of the ill-health equation that cannot be addressed without true intersectoral action.

During the situation analysis (and at times, subsequent phases) of the health planning cycle, it will usually be sufficient to look at the largest 10–15 contributors to the burden of disease plus maybe one or two other diseases known to be focused in particular subpopulations or locations. The reason is that the same social determinants and risk factors are driving several diseases and their inequitable distribution.<sup>45</sup>

The burden of disease country profiles do not disaggregate the data as suggested for the SDGs by income, gender, age, race, ethnicity, migratory status, disability, geographical location and other characteristics relevant in national contexts.<sup>46</sup> To find such disaggregated data for the top diseases, conditions, and risk factors, one

<sup>1</sup> Finland has an intersectoral monitoring system that analyses population need and health and social service responses and is also used for national reporting, but less emphasis is placed on this data at the national level (<http://www.hyvinvointikompassi.fi/en/web/hyvinvointikompassi/>, accessed 26 May 2016).

will have to look for locally-available information from records, surveys, and studies; and data analysed in preparation for the national plan will need further scrutiny with respect to equity, risk factors, and social determinants in mind. More often, though, complete information will not be available. One of the results of a situation analysis phase can be to bring attention to the lack of information, and to stimulate dialogue on how to fill the gap in data generation.

However, even with data gaps, the inequity picture will generally come together like a mosaic, with the pattern showing up even if some of the pieces are missing. Once the pattern is beginning to show, it is time to start asking questions about what it means. Why do some districts have much higher prevalence of chronic kidney disease compared to others? Why do people in the lower income quintiles have higher prevalence of diabetes than those in the richer quintiles? Why do some ethnic groups have higher prevalence of HIV than others? Why do poor people smoke more than the richer? (see Fig. 12.2). And in those frequent cases where very little information is available, this should lead to an inclusion of inequality-monitoring mechanisms as a key discussion point during national health planning processes.

One challenge is that the disaggregated prevalence data – if they exist – are often scattered without any single source having the full over-

view. Another challenge is that the answers to the why-questions, i.e. the social determinants causing the observed inequities, are often country- and context-specific and come out only in planning processes that put effort into understanding root causes of bottlenecks. In order to overcome such challenges, planners could, for example, take an iterative Delphi method type approach as part of the situation analysis.<sup>47</sup> Other longer-term options include incorporating inequality data generation in routine health information systems, conducting regular surveys to measure progress on the determinants of health and inequalities, conducting focus groups with key informants in the health system, etc.

The Delphi method is particularly useful in revealing gaps in knowledge and in quickly reaching consensus on the situation, while longer-term efforts are made to improve the evidence base. It is thus elaborated upon here in more detail (in Box 12.6). A Delphi approach can expose and help overcome gaps in disaggregated data on diseases and risk factors, as well as the gaps in explaining causes for the inequities and, e.g. the higher levels of specific disease burden compared to the benchmarking countries. Approaches to cover gaps in knowledge and reach consensus should be a vital part of the policy dialogue around the national health plan, but also around the plans for other sectors.

**Even in countries with data gaps, the inequity picture will generally come together like a mosaic, with the pattern showing up even if some of the pieces are missing. It is then time to start asking questions about what it means.**

## Box 12.6

### The Delphi method for analysing key data for health planning

**First Delphi round:** a small number of people with access to data on the level and distribution of the diseases, conditions and risk factors to be focused on; product of the first round is data presented in a standardized format, e.g. as in Fig. 12.2.

**Second round:** an expanded number of participants to include people who could help interpreting data. While continuing to fill the data gaps, start asking the why-questions and ask people to provide available evidence (reports and studies) to support the answers they offer; product of the second round is a consolidated feedback.

**Third round:** Delphi panellist receives a questionnaire that includes the items and ratings summarized by the investigators in the previous round, and is asked to revise his/her judgments or “to specify the reasons for remaining outside the consensus”.

**Fourth round:** In the fourth and often final round, the list of remaining items, their ratings, minority opinions, and items achieving consensus are distributed to the panellists; product of the fourth round should be a complete equity picture including key social determinants that shape the inequities.

This analysis can further support national health planning and be used to mobilize political will and publicity.

Each round should be reasonably short – e.g. one week to ten days – and provide full transparency in the return information, so that the participants can see their contributions reflected.

## 12.5.2 Policy dialogue and negotiation

Once the main risk factors and the social determinants that shape the population’s health situation have been identified, the next step is to find out what should be done and who could potentially do something about it. This, in the first instance, does not mean the particular organization or individual – but which sectors are already in the field and in a position to influence the risk factors and social determinants, and what would be the mechanism and strengths of their potential influence.

The findings of the analysis, including on the level and distribution of health in the population and their root causes, need to be accepted and internalized by health and non-health sector actors, including public, private, and civil society. In some countries there are already forums that can provide platforms for discussion and consensus-building. Where platforms exist, they should be fully exploited to ensure dissemination of analysis results and an honest dialogue on the causes and consequences.

In countries where such forums do not exist, it might be necessary to conduct a national consensus workshop to confirm the analysis and agree broadly on action and on who is responsible. Briefings and consultations with the highest levels of government (prime minister, cabinet, and parliament) will help in mobilizing political will and support. In parallel, effective communication of the evidence revealed by the analysis will also be critically important to inform media, politicians and the public about what shapes the health of the country’s population. The national health planning process is the ideal moment to bring attention to the vital issues of health inequities and social determinants of health so as to motivate stakeholders to propose agreements, offer concessions and reach compromises. The chosen negotiation strategies of the stakeholders will heavily



influence the tone of the discussions and the potential agreements which can be reached. Various negotiation strategies and approaches exist for emphasizing the value of cooperative negotiating from the perspective of a Health in All Policies (HiAP) approach.<sup>48</sup>

Table 12.2 shows an illustrative example of how the top five risk factors in a country (according to the burden of disease profile) could match with two of the sectors in that country. There will of course be more sectors and possibly more risk factors depending on the local country context.

Once the main risk factors and social determinants that shape the population's health situation are identified, the next step is to find out what should be done and who (which sectors) could potentially do something about it.

**Table 12.2 Illustrative examples of sector – risk factor match with mechanism and strength of influence** – other than own staff (perceived strengths of influence are rated: ★, ★★, and ★★★)

SECTOR	Top-five exposure risk factors in the country (illustrative examples)				
	Dietary risks	Smoking	Physical inactivity	Alcohol use	Occupational risks
Urban planning and transport	Easy and preferred access to healthy food (★★)	Ban smoking in public places in- and outdoor (★★)	Easy and preferred access to physical activity, including for safe walking and cycling (★★★)	Regulate location/opening hours of alcohol outlets (★★)	Plan placement of industry/business and provide public services (★)
Education	Educate on healthy diet – ban unhealthy food on premises/provide healthy food (★★★)	Inform, ban on premises, offer cessation aid (★★)	Inform, promote, provide opportunities and offer counselling (★★★)	Inform, ban on premises and offer counselling (★★)	Educate on risks and rights (★★)

All sectors can do something about all the population health risk factors. However, the type of mechanism they have at their disposal and their respective strengths of influence may vary. For example, in Table 12.2, “Urban planning and transport” is considered to have a potentially very strong influence on physical activity, medium-strong influence on dietary risks, smoking and alcohol use, and a weaker influence on occupational health. “Education”,

however, is considered having potentially strong influences on dietary risks, physical activity and medium-strong influence on smoking, alcohol use, and occupational risks. While the exact mechanisms and strengths may vary from one context to another, the onus for the intersectoral planning should be on those mechanisms where the sectors are seen to have a strong or medium-strong potential influence.

Table 12.3. shows some illustrative examples of five social determinants and two sectors – again with potential mechanisms and strength of

influence. Only two sectors and five determinants are shown and there will be more depending on country context.

**Table 12.3 Illustrative examples of sector – social determinants match with mechanism and strength of influence** – other than own staff (perceived strengths of influence are rated: ★, ★★, and ★★★)

SECTOR	Most important social determinants in the country (illustrative examples)				
	Adverse social and cultural norms and gender roles	Lack of jobs and educational opportunities	Clustering of disadvantages	Marketing, pricing and availability of tobacco, alcohol and unhealthy food	Lack of social capital in families and communities
Urban planning and transport	Diversify settlements and plan for community centres (★★)	Plan for appropriate mix of employment, educational opportunities and residential areas; ensure safe, fast and easy public transport(★★★)	Plan for public services, diversify settlements, provide access to easy public transport and green spaces (★★★)	Marketing ethics not accepting advertisements of tobacco, alcohol and unhealthy food in public space and in or on transport means (★)	Plan for integrated public social and health services and community centres, allotment gardens, etc. (★★)
Education	Teach on social and cultural norms, gender roles, rights, participation, and respect for diversity (★★★)	Provide second-chance education, align education to labour market needs, etc (★★★)	Closely monitor and act on enrolment coverage, drop-out and completion rates for vulnerable locations and population groups (★★★)	Educate students and not accept advertisements or sponsorships from providers of tobacco, alcohol and unhealthy food products (★★)	Identify vulnerable students and work with social and health services to address their special needs and those of their families (★★★)

**All sectors have the ability to impact all population health risk factors and social determinants with varying levels of strength and types of mechanisms**

All sectors can do something about all social determinants – however, to varying levels of strength. For example, in Table 12.3 “Urban planning and transport” is considered to have a very strong influence on “lack of jobs and educational opportunities” and on “clustering of disadvantages” while the influence on “lack of social capital in families and communities”

is considered medium and with the potential influence on “social and cultural norms and gender roles” and “marketing, pricing and availability of tobacco, alcohol and unhealthy food” considered weaker. The foci of the intersectoral planning should be on those mechanisms where the sectors are seen to have a strong or medium-strong potential influence.

One challenge of intersectoral planning is that while it might be reasonably straightforward to agree on the goals (the desired impact and outcomes), it might be more difficult to agree on the outputs – policies and policy-results – and the source and allocation of necessary resources (financial and human). In addition to the variations in interests mentioned in section 12.4, different sectors often have different structures, employ staff of different educations and background and sometimes have different ways of measuring success. Another challenge is that intersectoral planning for health and health equity by definition will take place across several individual sectors' plans. If care is not taken, it could end up being too complex to be implemented.

Table 12.4 illustrates how the findings in Tables 12.2 and 12.3 could move forward to commitments by the individual sectors for action and how progress, i.e. policy-results could be measured. The commitments would be reflected in the intersectoral national health plan, while the detailed activities and inputs would be reflected in the individual sector plans. That is, unlike in logical framework systems, a lower level result can contribute to more than one higher level result, e.g. in the different sectors. Likewise, what may be deemed output in one sector may be regarded outcome in another.

**Table 12.4 Illustrative example of results chain and commitments**

IMPACT	OUTCOME	OUTPUT (individual sector commitments)	
Reduced burden of disease and reduced health inequity by key equity dimensions, e.g.: ▶ Geographic location ▶ Wealth ▶ Ethnicity/gender	Reduction in risk factor prevalence and gradient, e.g. "physical inactivity"	Urban planning and transport (★★★)	<b>Policy:</b> All urban areas must provide easy access to physical activity, including safe walking and cycling <b>Policy-result indicator:</b> Proportion of urban areas that have easy access to physical activity, including safe walking and cycling
		Education (★★★)	<b>Policy:</b> All schools at all class-levels must provide opportunity for at least 60 minutes of moderate to vigorous intensity physical activity daily <b>Policy-result indicator:</b> Greater proportion of schools requiring 60 minutes of intense physical activity daily
	Reduction in adverse social determinants, e.g.: "clustering of disadvantages"	Education (★★★)	<b>Policy:</b> All school-districts must identify vulnerable locations and population groups and take appropriate action <b>Policy-result indicator:</b> Proportion of locations and population groups where enrolment and completion rates are higher than set thresholds
		Urban planning and transport (★★★)	<b>Policy:</b> All local urban areas must have adequate public services, with mixed housing opportunities, and provide access to easy public transport <b>Policy-result indicator:</b> New mixed housing opportunities available in urban areas with access to public services, increased number of public transportation options/lines to local urban areas



### 12.5.3 Monitoring and accountability

Those sectors identified in the analyses of Tables 12.2 and 12.3 as having a very strong influence on a risk factor or social determinant should be considered first. However, synergies of coordinated policy and implementation action between sectors will undoubtedly in many cases augment the strength of those considered in isolation as having medium-strong influence. Therefore, it makes sense to bring sectors together around individual or groups of risk factors and social determinants to decide who does what and when, and to commit for action and accountability for outputs.

All organizations, including public institutions and private firms, can act to positively influence the risk factors vis-à-vis their own staff. They can, for example, ban unhealthy food on their premises, and provide opportunities for healthy food instead. They can ban smoking during working hours and offer cessation services. They can also review work processes, inform, promote and provide opportunities for easy-choice physical activity and offer counselling to staff and their families; inform, ban alcohol during working hours and offer cessation and counselling to staff and their families. They can address stressful processes and other occupational risks in the work environment, and provide safe opportunities for reporting and dealing with such risks. Similarly, all organizations in all sectors can address the social determinants within their own settings and staff. For example, they can: emphasize social and cultural diversity and gender balance in their recruitment processes and equal career opportunities; provide decent employment conditions; provide employment opportunities in particular for young people; offer or refer to counselling services for staff members who are in vulnerable situations; keep marketing of tobacco, alcohol and unhealthy foods away from the work place; etc.

In the Rio Political Declaration on Social Determinants of Health,<sup>49</sup> heads of government, ministers and government representatives define health and health equity as a shared responsibility requiring engagement of all sectors of government and all segments of society. They further acknowledge that governance to address social determinants of health and health equity involves transparent and inclusive decision-making processes that give voice to all groups and sectors concerned. They also state the need for clear and measurable outcomes and for building accountability. The participating governments pledge to work across different sectors and levels of government, including through national development strategies, to enhance the accountability of policy-makers for health, while recognizing a leading role of health ministries for advocacy in this respect. Central to accountability is effective monitoring. For this, the availability of relevant data appropriately disaggregated is key. The 2030 Agenda for Sustainable Development Goals suggests that countries consider disaggregating data by income, gender, age, race, ethnicity, migratory status, disability, geographical location and other characteristics relevant in national contexts. Depending on which dimensions of inequity are relevant to monitor in a country, it will require smaller or larger changes to the sources of data collection in the country, e.g. surveillance systems, population-based sources (censuses, vital registration systems and household surveys), institution-based sources (resource records, service records and individual records), and ad hoc surveys and studies as well as the analysis, linking and communication of the resulting information. The need to strengthen countries' capacities in this respect is explicitly foreseen under "data, monitoring and accountability" in SDG 17.18 and SDG 17.19.<sup>50</sup>

In many countries, the monitoring and evaluation plan and platform is in place, although suffering from major weaknesses, in particular with respect to disaggregating data and cross-sectoral analysis. Monitoring of intersectoral action for health and health equity involves keeping track that what is planned is actually produced by different sectors and levels of society – from community to the highest levels of government – and that it has the desired effect. While the policies committed by the individual sector (e.g. “all school-districts must identify vulnerable locations and population groups and take appropriate action”) can simply be counted, indicators will be required for monitoring if the policy-results, the outcomes (e.g. “reduced clustering of adverse social determinants”) and the impacts (e.g. “reduced burden of disease and reduced health inequity by key equity dimensions”) are achieved as planned (see Table 12.4). When selecting monitoring indicators of intersectoral planning for health and health equity, it must be taken into account that there will be many different sources and several types of data, including quantitative and qualitative data. Further, the use of the data as well as the accountability for delivery will be made at different points, e.g. communities; local area councils; district administrations and councils; sectoral managers at various levels, including institutions; and cabinet and parliament. These should be viewed in the context of their individual rights and their own needs, rather than just as part of a hierarchical system producing aggregated data. It may be useful to look at:

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**Technical feasibility** – is concerned with how easy it is to acquire, analyse, and interpret the data required to monitor the impact and policy outcome indicators disaggregated by the relevant inequity dimensions and by the relevant data providers and users.

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**Technical reliability** – relates to how the data sources can be relied on to provide accurate information at present and in the future. This means ensuring that methods and measures are scientifically sound and stable over time; level of errors and missing data is acceptable; processes are transparent with credible audits; data collection and analysis are free of political interference; the data collection cycle is shorter than or comparable to the expected pace of change; there are no upcoming regulations that could impede data collection and use; and that there is stable financing and local capacity present for continued data collection.

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**Technical validity** – relates to how well the indicator captures the influence of social determinants and risk factors on the level (burden of disease) and distribution (inequity) of health in populations. In other words, it actually measures what it is supposed to measure; it is a reasonable proxy for a broader domain; it has scope for generalizing to the country as a whole. In short, it goes beyond what is directly measured by the indicator.

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**Programmatic feasibility** – relates to whether the messages from the indicators are communicable and comprehensible by politicians, sectoral policy-makers and managers, media and civil society.

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**Programmatic relevance** – is concerned with whether the messages from the indicators are useful for taking individual sector action, for intersectoral dialogue and action, and for informing the political and public debates.<sup>51</sup>

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**Monitoring is used to indicate whether policies, programmes, and practices are accomplishing what they are designed to achieve; results from monitoring can help shape eventual corrective action for policies, programmes, and practices which need improvement.**

The purpose of monitoring is to indicate whether the policies, programmes and practices are accomplishing what they are designed to achieve. If they are not, then the monitoring should be able to inform eventual corrective action. Data from monitoring of intersectoral efforts need to be understood by often very diverse groups of people with different educational and professional backgrounds, different political observance, different interests, different levels of education and insight, etc.

Ultimately, monitoring and accountability are what will hold intersectoral action together and are closely linked to the governance of not only the national health plan but also of the national development plan and, internationally, the SDGs. Monitoring is part of a continuous process of adjustments and improvements in order to maintain the pace of progress to improve health and reduce health inequities. Monitoring of intersectoral action for health equity is also part of an accountability process that goes beyond just managerial accountability to cover political and moral accountability as well – and therefore moves out into the political and public space.

In Norway, the Directorate of Health has established a cross-governmental monitoring system. Drawing from this system their annual health report brings together all the indicators of the intersectoral action for reducing health inequities. The title Folkehelsepolitisk Report [Population Health Policy Report]<sup>52</sup> underscores that the responsibility and accountability for reducing inequities is political rather than merely bureaucratic. As already mentioned, in New Zealand, indicators for social determinants of health and health inequity have been integrated into the comprehensive social reports produced by the Ministry of Social Development.<sup>53</sup>

The HiAP Monitoring Strategy of Suriname is rights-based, integrates and formalizes inclusiveness, transparency and accountability, and links with the political and public spheres. The monitoring process is set to include, for example, primary school children, ordinary citizens, civil society organizations, government and private sector staff, statisticians and other experts in various fields, as well as local and national politicians. A key tenet of the Strategy is that data should be analysed and used as close as possible to where action can be taken and where the people concerned are, as well as be appropriately consolidated for policy-making, and feedback. An annual population health report is presented to the National Assembly and an Annual National Health Forum is conducted (Box 12.7).

Once the format for the SDG reporting is established, this will provide a mechanism for national and international accountability, similar to the national accountability supported by the social reports in New Zealand. Words and concepts like “equitable access”, “equal opportunity”, “reduce inequalities”, “inclusive”, “universal”, “equal”, and “for all” appear in almost all the 17 goals. Also, the preamble to the UN General Assembly resolution (A/RES/70/1) on SDGs emphasizes that the implementation of the SDGs relies on a collaborative partnership.



## Box 12.7

### HiAP Monitoring Strategy Group<sup>54</sup>

Illustrative example of Suriname.

In Suriname the intersectoral planning and monitoring for health is coordinated by the HiAP Monitoring Strategy Group chaired by the Vice-president's Office and with the Ministry of Public Health as the Secretariat. This ensures a direct link to the day-to-day business of government, which is managed out of the Vice-president's Office. In addition, the HiAP Monitoring Strategy Group is charged to:

- ▶ prepare the Annual Population Health Report presenting the latest knowledge on the burden of disease, risk factors, inequity and social determinants at play, and policy action in Suriname – and, present it to the National Assembly;
- ▶ organize an Annual National Health Forum providing the opportunity for politicians, sectoral managers, researchers, private sector and civil society to review the newest knowledge, and policy and implementation progress, share experience; innovate and discuss the way forward.



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## 12.6 Conclusion

A national health planning process should be one of the entry points to address health inequity and social determinants of health. Intersectoral planning thus entails an explicit emphasis on health policy dialogue around intersectoral action.

Best practices exist, mainly from disease-specific or life cycle-specific programmes. The approaches these programmes adopted over the last decade to integrate intersectoral action in their global or regional strategies have resulted in multisectoral action frameworks and a better targeting of key health determinants. Many useful lessons-learned can be drawn from these experiences.

This chapter elucidates the various entry points for addressing health inequity and intersectoral collaboration in national health planning. For some of these entry points, the health sector is both the leader and the implementer; for some, the health sector emphasis is on providing leadership; while for others, the health sector may act primarily as a catalyst. These different entry points for tackling health inequalities find their correspondence in the approved SDGs, where health goes beyond Goal 3.

There is strong evidence demonstrating that socioeconomic development and health systems development are mutually reinforcing, increasing the chances for sustainable achievements. In other words, addressing the determinants of health (which intrinsically involves collaboration between sectors) needs to occur concomitantly with addressing clinical care services. This is

not an impossible task. Examples from around the world show that other sectors can be successfully engaged in joint efforts for mutual benefit. However, it requires changes in the ways ministries of health usually work. New skill sets and approaches to analysis, planning, monitoring and accountability will have to be developed. These approaches will need to reach a wider audience that involves different sectors and professions as well as communities, higher levels of government, politicians and the public at large.

Some countries have already shown the way. However, there is no fast and easy blueprint and each country will have to find its own way – while learning from the experiences of others – in order to overcome lack of coherence across government policies. This lack of coherence has in the past led to one part of government working to improve health, while other parts of the government might promote trade and industrial development with initiatives that might be harmful to health and well-being.

One reason that these inconsistencies arise is because of a lack of understanding across sectors of the linkages between health and quality of life, on the one hand, and the social and economic determinants of health, on the other. Another reason they arise is because seemingly unrelated policies may have unintended impacts that go unmeasured and unaddressed.

This chapter provides some basic ideas and principles and encouragement for health planners to get started.

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## Annex 12.1.

**Table A.12.1. Entry points for intersectoral collaboration and SDG links**

(Rating of links between entry point and SDG: very strong = ★★★; medium-strong = ★★, strong = ★; three of each per entry point – except for entry point 3 – see also Box 12.4)

ENTRY POINTS		1	2	3	
SDG		Evidence on inequities and causes	Laws, policies, standards, etc.	Causes of differentials	
1	No poverty	★★	★★	★★★	
2	Zero hunger			★★★	
3	Good health and well-being				
4	Quality education	★★	★★	★★★	
5	Gender equality	★★★	★★★	★★★	
6	Clean water and sanitation	★	★	★★★	
7	Affordable and clean energy			★★	
8	Decent work and economic growth	★★	★★	★★★	
9	Industry, innovation and infrastructure			★★	
10	Reduced inequalities	★★★	★★★	★★★	
11	Sustainable cities and communities	★	★	★★★	
12	Responsible consumption and production			★★	
13	Climate action			★★	
14	Life below water			★★	
15	Life on land			★★	
16	Peace, justice and strong institutions	★	★★★	★★★	
17	Partnerships for the goals	★★★	★	★★	



	4	5	6	7	8
	Allocation of resources	Strategies for addressing gender	Participation of civil society and individuals	Transparency and accountability	Gender balance and equity in org. processes
	★★★	★★	★★	★★	★★★
	★	★		★	
	★★	★★★★	★★★★	★★★★	★
	★★	★★★★	★★	★	★★★★
	★	★★	★★		★
	★★★★	★★	★	★★	★★
	★★				
			★★★★	★★★★	★★★★
		★	★	★	★
	★★★★	★★★★	★★★★	★★★★	★★★★
	★	★	★	★★	★★



