World Health Organization

HEALTH

EVALUATING INTERSECTORAL PROCESSES FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH: LEARNING FROM KEY INFORMANTS

DEBATES, POLICY & PRACTICE, CASE STUDIES

EVALUATING INTERSECTORAL PROCESSES FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH:
LEARNING FROM KEY INFORMANTS

Layout by L'IV Com Sàrl, Villars-sous-Yens, Switzerland.
Printed in Switzerland.

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Abbreviations

CCP	Center for Civic Partnerships (USA)
CHD	Centre for Health and Development (Slovenia)
CSDH	WHO Commission on Social Determinants of Health
EH	Environmental health
EPR	Environmental performance review
EIA	Environmental impact assessment
HIA	Health impact assessment
HiAP	Health in all Policies
IAH	Intersectoral action for health
MDG	Millennium Development Goal
NCCHPP	National Collaborating Centre for Healthy Public Policy
NST	National Support Team (UK)
PHC	Primary health care
SDH	Social determinants of health
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNRISD	United Nations Research Institute for Social Development
USA	United States of America
WHO	World Health Organization
WHO Environment	WHO Department of Public Health and Environment
WHO Euro	WHO Regional Office for Europe
WHO Nutrition	WHO Department of Nutrition for Health and Development
WCSDH	World Conference on Social Determinants of Health

Executive summary

The 2008 World Health Organization Commission on Social Determinants of Health and the 2011 Rio Political Declaration on Social Determinants of Health both articulated that policy-makers and practitioners engaging in processes for intersectoral action for health (IAH) and health in all policies (HiAP) need signals of the efficiency and effectiveness of their approaches. Evaluation can play a role in this.

This report was commissioned in December 2009 and implemented in early 2010 to explore how the evaluation of IAH and HiAP is being implemented from the experience of expertise directly involved in such work. WHO selected 11 respondents for their involvement in work on IAH and systems scale analysis. They were interviewed and the documents they provided were reviewed. The respondents were drawn from local government, national- and global-level institutions, mainly from high-income countries with only two from middle- or low-income countries. The small, non- representative sample and narrow coverage of low- and middle-income settings limits the conclusions that can be drawn, and it is recommended that future assessments be carried out in more low- and middle-income settings, and countries in South America, where the experience may be different. Notwithstanding this, the report provides previously undocumented evidence on experience within the regions covered by the evaluation of IAH.

The report outlines concepts of IAH and evaluation that informed the collection of evidence on four broad questions.

❶ What have been the motivations for evaluating IAH and HiAP?
❷ What have been the purposes of the evaluations that have been implemented, particularly in relation to testing conceptual frameworks, performance and development results, and with what issues for their design?
❸ What methods have been used for the evaluation of IAH? Are these methods unique and what lessons have been learned from practice?
❹ How has the evidence from evaluations of IAH been reported and used?

The findings suggest that having an explicit and shared conceptual framework for IAH work at inception is necessary to clarify the pathways for change, the outcomes and measures for assessing performance and impact, to prioritize action and to test the thinking informing IAH work. While the learning from this may be context-specific, learning networks provide a means for a meta- analysis of case studies, to build more generic knowledge around conceptual frameworks.

In the initial stages of IAH, respondents used a range of mapping, appraisal, diagnosis or assessment tools to raise policy recognition, build shared diagnosis and initiate action. Evaluation of performance was prioritized in the early stages over concept or impact evaluation. Answering the question 'How are we doing?' was reported to support strategic review and build confidence for and effectiveness of action. Such performance or process evaluation assessed changes in capacities, information sharing, institutional performance, spending patterns, outputs and perceptions of change through diverse methods, and the sharing of disaggregated data across sectors. Respondents called for greater exchange on methods and tools for performance evaluation, given its importance in sustaining policy and resource support for IAH.

In more mature IAH processes (over seven years of practice) greater attention was given to the evaluation of development results in terms of institutional capacities and functioning (e.g. partnerships, governance, knowledge, management practices), policies, and health and human development. Impact evaluation raises challenges of measurement, attribution and time scales. While there was one report of external summative evaluation, mainly for policy influence, the evaluation of impact was more often through periodic internal assessments to support strategic review, and used to mobilize political or budget support, and to motivate increasing levels of integration.

For the majority of respondents, a model of reflexive or negotiated evaluations was seen as most useful for concept, performance and impact evaluation, embedded within the planning and implementation of IAH, with knowledge jointly constructed by different actors, including local communities, and linked to the review of practice.

All those interviewed encouraged further work to develop approaches and methods for the evaluation of IAH. While noting the limitations on generalizations due to the small sample, the findings suggest some recommendations for supporting promising practice on the evaluation of IAH.

Within IAH programmes
1. During the design stage and as part of the planning, clarify with those involved the conceptual framework, theory of change, outcomes and pathways for achieving them, and develop feasible measures for evaluating performance and progress in the achievement of outcomes.
2. As part of the planning and implementation of IAH, embed reflexive/realistic and participatory evaluation approaches that involve the different sectors, and the affected communities to inform strategic review, and build confidence, trust and support.
3. With relevant modifications, draw on proven tools for scoping, mapping, assessment and data gathering on the actors, processes and content of IAH, and on outcomes (such as those presented in the report).
4. Provide resources for those brokering and facilitating IAH processes to ensure documentation, data gathering, consultation and reflection necessary for evaluation.
5. Include resources for reflection/strategic review of findings and thinking on IAH, and for inputs to learning networks, mailing lists and exchange visits.
6. Use cross-sectoral review groups, public forums and research meetings to strengthen peer review and data quality, and the uptake of evidence from the evaluation of IAH.
7. Widen the publication of findings from work on the evaluation of IAH, including in national research meetings, peer reviewed journals and the media.

Broadly within the field
1. Develop and test the conceptual frameworks and change theories to understand IAH, and to advance the integration of health in all policies, particularly through learning networks on IAH and making links to research programmes.
2. Provide a portal for linkages to online databases and resources, to share and review the methods and tools used for conceptual, process and impact evaluation of IAH.
3. Develop a reader on reflexive methods for the evaluation of IAH, with information on the methods and their application, sources, and bias and error, and including peer reviewed publications on examples of their application in practice.
4. Support mailing lists, exchange visits, learning networks, communities of practice, observatories, meta-analyses and systematic reviews on the evaluation of IAH to build general knowledge from case studies and sites of practice.
5. Promote the peer review of conceptual frameworks, methods, tools and results, and the publication of findings in the media for public, policy and scientific communities.

1 Introduction

n its final report, the World Health Organization (WHO) Commission on Social Determinants of Health (CSDH) (2005–2008) made three overarching recommendations for improving health equity and closing unfair gaps in health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action *(1)*.

In October 2011, the Rio Political Declaration on Social Determinants of Health was adopted during the World Conference on Social Determinants of Health (WCSDH). The declaration was further endorsed by Member States at the Sixty-fifth World Health Assembly in May 2012 through resolution WHA65.8. The Rio Political Declaration makes clear that action on the social determinants of health requires approaches that involve all sectors of government:

We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an "all for equity" and "health for all" global action.

Rio Political Declaration, 2011*(2)*

The Rio Political Declaration on Social Determinants of Health asserted that collaboration in terms of health in all policies, and through intersectoral cooperation and action provide promising approaches to promote health equity. The declaration includes five key action areas critical to addressing health inequities to: (i) adopt better governance for health and development; (ii) promote participation in policy-making and implementation; (iii) further reorient the health sector towards reducing health inequities; (iv) strengthen global governance and collaboration; and (v) monitor progress and increase accountability to inform policies on SDH. In this latter area, the declaration identifies that monitoring the trends in health inequities and the impacts of actions to tackle them is critical in achieving meaningful progress and in guiding policy-making in all sectors, including through systematically sharing relevant evidence on trends and assessments of impacts among different sectors to inform policy and action *(2)*.

The CSDH report and Rio Declaration both recognized that policy-makers and practitioners engaging in processes for intersectoral action for health (IAH) and health in all policies (HiAP) need signals of the efficiency and effectiveness of their approaches. Evaluation can play a role in this, in providing lessons learned to support the design of IAH and HiAP, in assisting the processes to review their effectiveness, to promote understanding of the factors associated with success in addressing the social determinants of health, and in facilitating transferability of experiences.

This report was commissioned in December 2009 and implemented in early 2010 (before the WCSDH), to assist WHO in understanding how progress in intersectoral processes aimed at tackling the social determinants of health can be and is being evaluated, as a contribution to WHO's guidance on IAH and HiAP. WHO sought to explore how the evaluation of IAH and HiAP is being implemented from the experience of expertise directly involved in such work.

The report is based largely on interviews carried out in 2010, in line with the terms of reference provided by WHO. The limitations of the timing and scope of the interviews are discussed in section 3. It is recognized that this is a dynamic field, with scope for exchange and update as work progresses, and experiences and learning develop. For example, subsequent to this work being done, some of the case studies presented in the 2011 WCSDH provided useful further experience in evaluation. These are referred to and cited as further resources on evaluating HiAP and IAH.

2 Concepts and analytical framework

This section briefly outlines some of the concepts used in the discussion of the experiences in the evaluation of HiAP and IAH.

The Commission on Social Determinants of Health's final report raised the fact that strengthening health equity meant going beyond concentrating on the immediate causes of disease to examine the causes within the structures of social hierarchy and the socially determined conditions these create in which people grow, live, work and age. With this understanding, interventions and policies to reduce health inequities that tackle these underlying determinants call for coordinated action across sectors, and involve society to tackle social stratification, unequal exposure and vulnerability to health risks, and the unequal health consequences of this. The conceptual frameworks developed to inform these approaches are summarized in Annex 1.

2.1 Intersectoral action for health

Intersectoral action refers to processes in which "the objectives, strategies, activities and resources of each sector are considered in terms of their implications and impact on objectives, strategies, activities and resources of other sectors" *(3)*. It is advanced as a means for overcoming policy fragmentation, as a way to plan, implement and monitor service delivery, and as a means to address 'upstream' the determinants of health.

Solar et al (2009) *(3)* propose a range of levels of IAH. In information sharing and cooperation, the health sector's autonomy is maintained but greater efficiencies are perceived in building linkages. In

'coordination', the health sector has less autonomy and a leadership mandate, while in 'integrated' approaches the actions that promote health are integrated within the policies and work of other sectors (or HiAP), with a shared vision and integration of the objectives, and interdependent work to address the social production of health (see Figure 1). Actions can thus be defined by the relationship of health with other sectors, the pattern of social participation; the mechanisms and entry points for exercising influence in other sectors, for financing and for sustainability.

The entry points through which integrated strategies are applied in practice include those based on:

- geographical area and *population*: when local authorities, municipalities (or cities) take on global projects or goals, such as improving citizens' quality of life, improving social participation or confronting social exclusion (for example the 'healthy cities' approach);
- geographical areas and *the family*, to address the problems of specific vulnerable groups within an area, such as the *Chile Crece Contigo* (Chile Grows with You) programme or programmes aimed at early child development in vulnerable children;
- a specific issue that crosses sectors, such as the Pan American Alliance for Nutrition, Health and Development created in July 2009 by the regional directors of the United Nations agencies meeting at Pan American Health Organization (PAHO), which aims to develop and implement comprehensive, intersectoral programmes *(3)*.

While there is a substantial body of literature on intersectoral processes as a way of addressing

Figure 1. Possible modes to engage with other sectors
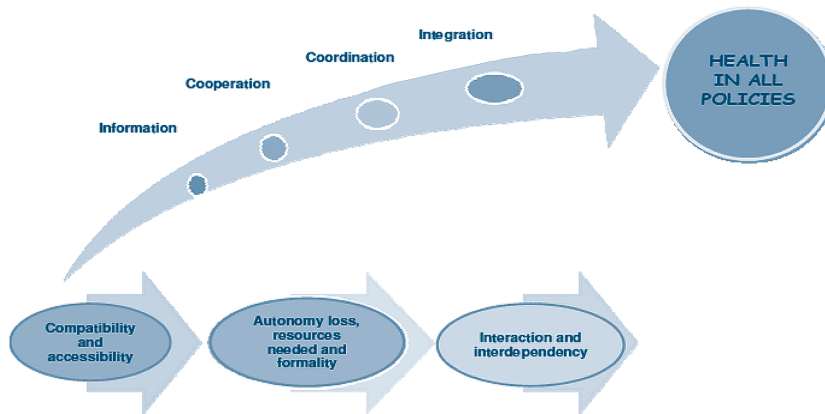
Source: *(3)*.

the social determinants of inequalities in health, this paper seeks rather to understand how those implementing such intersectoral processes for health are assessing the effectiveness of their actions.

This in itself is not a simple issue. As St Pierre et al. (2009) note:

> *There are challenges in assessing the effectiveness of HiAP scientifically. There is no gold standard for the evaluation of governance strategies and tools; there are methodological problems that limit evaluation's scientific robustness of governance strategies and tools. In addition there is a lack of scientific literature with regard to governance tools and frameworks for HiAP, perhaps owing to the newness of the field of work. (4)*

St Pierre L et al. 2009

2.2 Evaluation

In simple terms, evaluation is a process of collecting and analysing information for the purpose of making decisions. It is an assessment at one or more points in time to analyse the results of and learning from actions, and may cover one or more goals, including assessing:
- the theories driving action;
- the performance of the mechanisms (institutions, people, cultures, processes skills, etc., taking action);
- the outcomes of action.

It can thus inform decision-making across a range of areas. Evaluation can provide evidence for the development of more useful, well-founded theory and more effective practice, to enhance the achievement of intended outcomes.

Monitoring generally refers to an on-going process of routinely collecting and analysing information about the progress of work over time as an input to on-going review, decision-making and planning.

Evaluations may be internal and participatory, the gathering of evidence for reflection and analysis by those involved in supporting the action, or external, undertaken by outside actors to provide an objective review of the action. It may also involve both parties. Evaluations may be:

- summative, a method of judging the worth of a programme's activities focusing on outcome; or
- formative, a method of judging the worth of a programme while the activities are in progress.

In general, evaluation processes are set up to test three main elements.

- **Conceptual frameworks** and guide decisions (**how well are we thinking?**): This tests the validity and effectiveness of the conceptual frameworks (the assumptions, principles, understanding of context, theories and models) informing decision-making and action. For example, an evaluation may test our thinking and assumptions about the level of integration of the vision and objectives informing the strategies chosen for intersectoral action for health.

- **Internal performance** of the actions used to produce change (**how are we doing?**): This reviews the extent, effectiveness and efficiency of actions (approaches, strategies, actors, processes and methodologies) in the achievement of desired changes and outcomes. It can be matched to what is sometimes termed 'process' evaluation. For example, an evaluation may assess the functioning of the entry points and mechanisms used for IAH and the functioning and changes in relationships built across sectors.

- **Development results** or the outcomes and impacts of decisions and actions (**what difference are we making?**): This reviews the results of actions (the political, policy, institutional, programme, resource, social impacts, and the impacts on the social determinants of health and health equity). It can be matched to what is sometimes termed 'outcome' or 'impact' evaluation *(5,6,7)*.

Sridharan and Nakalma (2009) argue that the conventional view that evaluations ask these questions in a manner external to (or independent of) the planning and implementation of interventions may not be relevant to the evaluation of work addressing health equity through IAH *(5)*. Given the necessary focus of intersectoral work on catalysing and building change in the way systems work, evaluation approaches may be more useful when they connect to the planning and implementation of interventions, and inform strategic review. In this case, evaluation is not simply a means to assess differences, but to raise questions and generate learning and institutional interactions *that contributing to making a difference.*

2.3 Exploring experiences of evaluation of intersectoral action for health

This report draws on the conceptualization of evaluation outlined above to assess past experiences of evaluating IAH. The CSDH's Measurement and Evidence Knowledge Network pointed to problems in evaluating complex social interventions such as IAH, because of difficulties in the attribution of complex causal pathways, and because of their size and need to address multiple problems, often with shifting political environments *(8)*. Based on the terms of reference provided by WHO, the work reported here sought to explore existing experiences of the evaluation of IAH, against the content and features of IAH implemented and categorized within the modes of engagement shown in Figure 1. These were used to explore the questions below.

1. What have been the motivations for evaluating IAH and HiAP?
2. What was the purpose of the evaluations that have been undertaken, particularly in relation to testing conceptual frameworks, performance and development results, and what issues were raised regarding their design?
3. What methods have been used for the evaluation of IAH? Are these methods unique and what lessons have been learnt from practice?
4. How has the evidence from the evaluation of IAH been reported and used?

3 Methodologies

Given that evidence was drawn from existing evaluations of IAH, the primary method used was key informant interviews, combined with document reviews emanating from these interviews.

3.1 Sampling the key informants and case studies of IAH

The selection of key informant interview respondents was carried out by WHO's Department of Ethics, Equity, Trade and Human Rights (ETH) in consultation with the WHO regional offices. The inclusion criteria used by WHO was that respondents should be involved in work on intersectoral action for health (and health equity beyond individual pilots or projects) that have a systems scale, whether applied at local, national or global levels. The final set of 11 interviews set up and implemented between 15 December 2009 and 5 March 2010 is shown in Table 1. The respondents included:

- four from institutions with mainly global-level scope, and seven from institutions in countries, of which four also explicitly work at local-government level;
- three from national institutions that also have regional/international roles, particularly through links with WHO;
- nine from high-income countries and two from middle- or low-income countries;
- eight from institutions with direct health sector links and three from institutions with indirect but still close health sector links (research, university, civil society).

3.2 The interview schedule

A framework interview schedule was prepared based on the four questions in section 2.3, specifically including questions on:

- the content and features of IAH implemented;
- the activities underway to evaluate IAH;
- the motivations (incentives/disincentives) for the evaluation;
- the purpose, design and timing of the evaluation (including which of the three broad evaluation areas above were being tested);
- the process (external/internal and participatory, or both), methods, tools and resources used for the evaluation, and the lessons learnt;
- the way the evaluation was reported and used in the implementation of IAH;
- the respondents' learning of evaluation from the practice and issues raised;
- the resources and references recommended by the interviewees (see annex 2).

The interview schedule was reviewed by WHO and used as a guide for the interviews. Prior to the interviews, wherever possible, background material on the area of focus and experience of the interviewee was sourced from the Internet and from WHO. Interviews took an hour on average, and were implemented by 'phone (nine) or face to face (two). After the interviews, further materials, resources or useful web sites sourced from respondents were included in the evidence. The interviews were documented and analysed using content and thematic analysis in line with the analytical frameworks outlined in section 2, within the key themes of the inquiry. The reports

on the interviews were sent to respondents for corrections and permission obtained for the information to be reported in the public domain.

3.3 Limitations of the methods

There are clearly significant limits to the sample for this report. It is small, not selected on a representative basis and has very limited cover of low- and middle-income settings. This limits the conclusions that can be drawn. Clearly, further work needs to be done to widen the scope of assessment, particularly to more low- and middle-income settings, and to more countries in South America, where the experience may be different.

Notwithstanding this obvious limitation, and noting the value of learning from case studies, the interviews do yield previously undocumented evidence of existing experience within the regions covered, and present the methods, perspectives, insights and resources drawn from people who play key roles in systems-level work on IAH, and health equity across a spectrum of workplaces and settings. The compilation contributes to shared knowledge in this area. Given the limited, purposive and non-representative nature of the sample, the information is presented on a case-by-case basis, and the common and different issues summarized across the cases are not generalized to the field as a whole.

3.4 The respondents

This sub-section provides an overview of the respondents, both to give a descriptive outline of IAH underway, and to provide the context for the evaluation processes that have been implemented.

The types of work underway and being evaluated are summarized in Table 1 for the 11 respondents, together with an indication of how they are situated in relation to the information shown in Figure 1. All respondents cover different dimensions of social determinants and change processes linking health to sectors outside health. Across the 11 institutions, respondents' work and capacities included research, strategic information, normative guidance, policy, budget, regulatory development and implementation, catalysing

change processes within government, and facilitating social dialogue and social participation.

The spectrum of work shown in Table 1 ranges from local to global level, from direct action across sectors, and within communities and families to change living conditions, to analysis, information gathering, policy dialogue and intervention to build or contribute to policy and wider systems-level changes at national and global level.

Two institutions (the United Nations Research Institute for Social Development – UNRISD – and the American University in Cairo) engage in research and analysis, which includes research to guide policy dialogue. Other institutions play a more direct role in supporting policy and intervention, through direct work with local communities, local and national government mechanisms, and through IAH processes that bridge local and national level processes, capacities and policy dialogue. Others work across countries focusing on policies, processes and resources at global level.

The background documents for the programmes highlight supportive contexts for IAH in terms of availability of information on SDH and health equity, political support, socioeconomic stability, medium- to high-income level conditions, cultural conditions promoting cohesion, and policy entrepreneurs linking work on SDH to political support and skills for convening work across sectors. 'Brokers' working in the health sector, in agencies linked to or funded by the state (Canada, Norway, Slovenia, and the United Kingdom) or civil society (USA), appear to have played a role in facilitating work with local government and organized communities; bridging links between local and national levels; promoting dialogue across sectors; and drawing from and linking to learning networks within their region and internationally. The Canada, Slovenia and the United Kingdom case studies identified the fact that making a link across local and national levels was important in bringing local work to population and systems scale, and in linking local changes to national laws, policies, budgets and incentives[1] (see, for example, Box 1).

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1 Some respondents (e.g. Norway) facilitated outreach of national-level opportunities to local-level action, others (Slovenia, USA) brought local-level experience to national engagement and some (Canada, Kenya and the United Kingdom) worked at both levels.

Table 1. Summary of features of the respondent work on IAH

Institution, country and web site	Area of IAH	Nature of the intersectoral process*
WHO regional offices experts' proposals		
Coordinator Public Health and the Environment Department, WHO, Switzerland http://www.who.int/phe/en/	Intersectoral action on environmental health in Europe through WHO EURO and Member States in accession countries. In Africa, using HIA on natural resources (oil, forests) and use for human development, with African development banks and European – African cooperation.	In Europe, *cooperation* across sectors facilitated by national environment performance reviews or project health impact assessment. In Africa, *information* exchange to promote the integration of health in economic, development, trade policies, measures, funding mechanisms. Demand coming from economic and health sectors *(9)*.
Nutrition Department, WHO, Switzerland http://www.who.int/nutrition/en/	Cross-sector work on food security and nutrition on capacities, policies, programmes, actions, strategies and plans, and for information sharing at both global and national levels.	*Information sharing; coordination* across agencies. WHO and UN agencies cooperating on food security globally. Country nutrition group building on existing mechanisms.
Associate Director Evidence, Monitoring and Policy Department, UNAIDS, Switzerland http://www.unaids.org/en/	Normative guidance and frameworks for combination human immuno-deficiency virus (HIV) prevention using intersectoral processes on the social determinants of HIV transmission. Supporting countries to meet the UN HIV prevention commitments at national, regional, and international levels.	Paradigm *integrates* biomedical, behavioural, social and structural determinants recognizing structural determinants as essential to prevention. Reviews acquired immunodeficiency syndrome (AIDS) spending on this basis through UNAIDS at global level and national AIDS councils at national level. United Nations General Assembly Special Session (UNGASS) and civil society key catalysts.
Research Coordinator UNRISD, Switzerland http://www.unrisd.org	Research and analysis of country experience on transformative social policy and protection to inform policy.	UNRISD and country researchers using conceptual *integration* on transformative social policy by readjusting economic, social and political relations *(10)*.
Head of Projects, National Collaborating Centre for Healthy Public Policy (NCCHPP), Canada http://www.healthypublicpolicy.ca	Local and regional work to catalyse and support governance and dialogue across mayors and public health actors for IAH in municipal sites, nationwide.	*Information exchange, cooperation, some coordination on* governance mechanisms to promote IAH *(4)* working through local public health and municipal personnel.
WHO regional offices proposals of policy catalysts		
Senior Adviser Norwegian Directorate for Health, Norway http://www.helsedirektoratet.no	Implementing a national strategy, data analysis and inter-ministerial collaboration on SDH to reduce inequity within national budgets, regulations, policies and investments.	*Information sharing, coordination with increasing levels of integration* across sectors *(11)* through an expert group composed of members from different institutions and disciplines facilitated by Directorate of Health.
Director, Centre for Health and Development, Murska Sobota, Slovenia	Interdisciplinary work on investment for health and development within a region, including food science and nutrition, physical activity, product development, marketing, health promotion, planning, agriculture, education, tourism development. Also a resource centre for European Union (EU) work.	*Coordination and integration* through development, planning and management of health promoting agriculture, nutrition, spatial planning, education and tourism development *(12)*. Works with national and regional public health and development agencies, and with local partnerships for investment in health and development.
Head of Health Inequalities, National Support Team (NST), United Kingdom http://webarchive.nationalarchives.gov.uk/	Work in over 50 of the most deprived local authority areas in England with poorest health to support primary care trusts, local authorities and local partners to analyse, and respond to prioritized contributors of inequalities.	*Coordination* between health, local authorities and other sectors. Integration through systematic approach to diagnosis, commissioning and delivery of interventions with population level impact *(13)*.
Head, Department of Family Health, Ministry of Public Health and Sanitation, Kenya http://www.statehousekenya.go.ke/government/health.htm	Work with intersectoral mechanisms – national inter-ministerial mechanisms and district level stakeholder forums – on policy, service delivery on SDH, including for AIDS, reproductive health, child health, gender.	*Information sharing, cooperation* mechanisms, drawing on integrating concepts such as PHC, gender-based violence, with funding for cross sectoral work in the constituency development fund, and social participation.

Institution, country and web site	Area of IAH	Nature of the intersectoral process*
WHO regional offices experts' proposals		
Research Professor, Social Research Center, American University in Cairo, Egypt http://www.aucegypt. edu/research/src/Pages/ default.asp	Multi-disciplinary social science research on population, poverty, women's political participation, urbanization, environment. Evaluation of primary health care (PHC) incentive scheme in Egypt. Review of mechanisms to promote health equity.	Potential for increased *coordination* through PHC is limited regionally by legal constraints on the exchange of official data; vertical disease-based programmes and constraints in institutional mechanisms and capacities *(14,15)*. Researchers interact with public sector, non-governmental and civil society institutions to remove data constraints.
Executive Director, Center for Civic Partnerships (CCP), Public Health Institute, USA http://www. civicpartnerships.org	20-year plus programme in over 70 municipal- or community-based programmes in lower income communities in California, USA, in sites across the state on city government's role in establishing the conditions for health, through education, environment and measures for quality of life.	*Information exchange and cooperation* across state and non-profit organizations. Some sites showing integration in the use of resources for health-related activities in economic sectors, e.g. business and integration into health department activities and partnerships *(16)*. Local resident-community sector coalitions facilitated by the CCP.

* Levels of IAH are assigned in line with the typology by Solar et al. (2009) on the basis of the evidence provided in the literature and interviews *(3)*.

Box 1. National framework for local initiatives on health equity

The National Support Teams (NSTs) for Health Inequalities in the UK Department of Health was set up in 2007 to support local areas in reducing by at least 10 per cent the gap between the five areas with the worst health and deprivation indicators (Spearhead areas) and the population as a whole. The team uses a diagnostic model to help local primary care trusts, local government and other sectors, non-state actors and community members to identify key interventions, with a focus on improved population, personal and community health. The processes focus on supporting local decision-making, to raise the profile of what is being done, and the opportunities for improved practice in areas relating to alcohol, tobacco, housing, employment, income and other social determinants of mortality relevant to the specific area. While the districts may share features of deprivation, their realities, cultures, profiles, causes of inequalities are very different, even in cases where they are in the same geographical area. This diversity of context is an important entry point and means that processes for intervention must start from the individual realities of the districts. The process is thus one that raises strategic questions with key institutions and actors to engage on the entry points for action in a particular area. At the same time, it raises the challenge of how to take actions, which are often being addressed at individual level or in an ad hoc manner, to population and systems scale, through organizations and frontline services locally that have the leverage to do this, and in a manner that reaches out to, involves and includes 'seldom seen, seldom heard' groups.

NST has a 'high challenge, high support' relationship at local level – raising questions, facilitating reappraisal, reflection and dialogue, and then providing information and support to local actors in taking action to systems scale. At the national level, to succeed in closing the gap between diverse areas through intersectoral action, local variability needs to be taken into account. To connect and support local systems, the national level needs to identify weaknesses or barriers that arise at central level that reduce local action, and to provide incentives for local action. National policy should provide a framework within which local initiatives can take place. Positioned between the national policy level and the frontline, the NST has an opportunity to bridge these two levels. It provides unique opportunities, such as by organizing learning and dialogue on linking systems change at different levels, or by facilitating information flow between levels, such as on local evidence revealing barriers to action caused by national policy, or national evidence showing promising practice that has been prioritized in local areas.

Source: *(13)*, interview.

Within these broad contexts some specific factors were identified as triggers, opening opportunities for the work. In Europe, for example, the Common Agriculture Policy was reported to have raised concerns in eastern European states on measures to protect smallholder farmers, nutrition and health, stimulating work linking agriculture, trade and nutrition. For the Joint United Nations Programme on HIV/AIDS (UNAIDS), a social demand to address the structural, social drivers of HIV transmission and to meet UNGASS and Millennium Development Goal (MDG) targets were reported to have stimulated intersectoral processes for 'combination HIV prevention' (see Box 2).

Across both high- and low-income settings, there were also conditions that posed barriers to the uptake of opportunities for IAH. Hence, one respondent noted that while an international commitment to revitalize primary health care provided a unique opportunity for IAH, the orientation of national capacities and resources towards a biomedical model and individual or family care, and the presence of conflict and the lack of international investment in intersectoral approaches have weakened the translation of policy support to institutional action *(14)*. In the USA, a high-income setting, the financial crisis was noted to have generated resource insecurity, undermining investment in IAH.

The next section discusses the experiences and features of the evaluations being carried out in these areas of IAH work.

Box 2. Paradigm and policy shifts supporting intersectoral processes for health

Two case studies (from Norway and UNAIDS) provide interesting insight into relatively recent paradigm or policy shifts towards adopting SDH and IAH.

The first is a shift towards the acceptance of intervention on structural determinants as an essential component to prevention over the last 20 years of the AIDS epidemic. A position that the AIDS response is incomplete without intervention on structural determinants and that 'AIDS' resources should be spent on these interventions has long been debated. A paradigm shift underpinning intersectoral action on prevention emerged in 2008 from the contradictions in current strategies (e.g. on harm reduction in the context of policy action on drug abuse); from expert review of the role of the determinants published in *The Lancet*, and from global evidence of stigma as one of the top six social barriers to global targets for universal access. This was consolidated by a policy shift to 'combination prevention' demanding the inclusion of legal, social and educational strategies, which shifted the debate and demand for evidence to how to intervene and where to spend money (critical questions for evaluation).

In the Norwegian case, the combined role of evidence, expertise and institutional catalyst were important levers in the progression to political recognition, national strategies and institutionalized mechanisms for IAH, consolidated by formal documents (white papers, strategies, legislation). This suggests an incremental process, where the demand for evidence interfaces with media, political and technical processes and, in turn, generates new demands for evidence. The concern is to broaden competencies and widen the number of people with competencies for IAH. This type of change calls for 'policy entrepreneurs' or policy catalysts to manage and support these political, technical and institutional processes.

Source: *(11,17),* interviews.

4 Findings on the evaluation of IAH and HiAP

The findings of the interviews and the background documents on the 11 cases are summarized below for each of the key areas outlined in section 2.

❶ What have been the motivations for evaluating IAH and HiAP?
❷ What was the purpose of the evaluations that have been undertaken, particularly in relation to testing conceptual frameworks, performance and development results, and what issues were raised in their design?
❸ What methods have been used for the evaluation of IAH? Are these methods unique and what lessons have been learnt from practice?
❹ How has the evidence from the evaluation of IAH been reported and used?

The tables and text provide the findings by respondent, including through more detailed tabulations in Annex 2, and discuss the themes emerging across respondents. Annex 3 provides the detailed information on the evaluations underway, in terms of:

- scope/area of work evaluated
- focus, whether evaluation of concept, performance or results
- design
- parameters assessed
- methods and tools used
- difficulties and issues raised.

As noted earlier, not all respondents are implementing formalized evaluations, but all are collecting evidence to monitor, report on and review their work. The paper takes a broad view of the term evaluation to include this monitoring and review.

4.1 Motivations for evaluating IAH and HiAP

The motivations and incentives (and disincentives) for implementing evaluations in the individual cases as reported by respondents are shown in detail in Annex 3 based on the information from the interviews and not a stakeholder or process mapping of motivations. Respondents pointed to the broad reasons for implementing the evaluations and the issues they sought the evaluation to address.

Is the paradigm credible?
UNAIDS and UNRISD raised this question directly in relation to testing the social determinants perspective. Indirectly, WHO is working with other agencies on environment and health, and on nutrition. The Centre for Health and Development (CHD) in Slovenia and the learning network in the WHO Regional Office for Europe (WHO Euro) on IAH are also seeking to deepen understanding of the implications of addressing the social determinants of health (SDH) equity through a more integrated health and development paradigm, including in terms of the governance arrangements for this. The work in Egypt sought to assess the role and limitations of the current PHC paradigm as a means of addressing the SDH. Work in Canada, Kenya and the United Kingdom sought to explore through practice how relations between communities, agencies, and local and central levels of government affect how SDH are defined and acted upon.

Do the policies reflect the paradigm?
Respondents from Kenya, Norway, Slovenia, the United Kingdom, UNAIDS and WHO Public Health and Environment (WHO Environment) were concerned to assess whether governments

are delivering on equity and SDH commitments in their policy decisions. Respondents from Canada, Kenya and the WHO Department of Nutrition for Health and Development (WHO Nutrition) were also concerned to assess how far a social determinants and equity lens was perceived as useful to and being used by decision-makers outside the health sector.
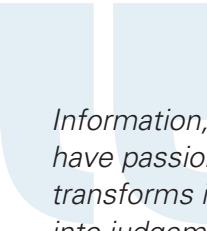
What affects the performance of the IAH strategies?

All respondents raised issues related to this concern. UNAIDS asked if the right combination of sectors and strategies are being included. The team from the United Kingdom sought to better understand how local IAH initiatives to address deprivation can be taken to population level and systems scale, including in terms of the national-level incentives and systems needed to support this. Many respondents saw a need to find out whether programmes and spending are being oriented to the needs identified through SDH approaches, and whether there are competencies to manage and implement IAH/HiAP.

What impact are the strategies having?

All respondents indicated that they would like to assess the impact of IAH work and to know whether strategies are effective (Canada, Egypt, Kenya, Norway, Slovenia, the United Kingdom, USA, UNAIDS, WHO); whether interventions are reaching the most vulnerable groups (Egypt, Kenya, Norway, Slovenia, the United Kingdom, UNAIDS); whether the work is having any effect on the working and service culture or policy process (Canada, Kenya, Norway, Slovenia, the United Kingdom, USA, WHO's environment and nutrition departments); and whether the use of resources through IAH approaches is effective in terms of both the efficiency of the process, and the benefits for health and development (Kenya, Slovenia, UNAIDS, WHO Environment).

As noted in the discussion on the context for the work in section 3, these motivations arise within the context of conditions and windows of opportunity to do work on IAH that are being tapped by the respondents, and thus often relate to reinforcing those conditions. The evaluations are thus both scientific and strategic tools.

Information, raw data, does not have passion, until someone transforms it into intelligence, into judgements of comparative advantage, or raises a particular issue in context of local socio-political trends.

Dora C, HELI project (unpublished).

All levels of respondents (local, national and international) sought to understand the effectiveness of processes in encouraging social participation, raising recognition and awareness, widening the competencies and involvement of different actors, and in overcoming asymmetries of power and information that influence uptake of IAH. There were some differences in other motivations across different levels of actors. Leveraging policy commitment was mainly seen to be a concern for national and international institutions within and beyond the health sector. National- to middle-level managers were concerned about programme design issues. Central governments, international agencies and local civil societies were more often noted to be concerned to know about effectiveness and return on investments, and accountability on commitments and performance.

4.2 Purpose and design of evaluation work

This sub-section discusses the purpose and design of the evaluations reported in relation to the three different evaluation questions raised in the conceptual framework. While the motivations for evaluation cover all the questions, as discussed in section 4.1, most of the cases (eight respondents) focused more on evaluations of the internal processes and performance of the IAH, with fewer (six respondents) assessing the conceptual thinking behind the IAH, or the results in terms of impacts/outcomes (four respondents).

Table 2 summarizes whether and how the different case studies are addressing the different evaluation questions raised in the conceptual framework.

Table 2. Work addressing the different evaluation questions

Focus of the evaluation	Respondents addressing this focus	Approaches used*
Test **conceptual frameworks** and guide decisions (**how well are we thinking?**)	UNRISD	Through country case studies, analysis of intergovernmental databases and review of secondary evidence, UNRISD research is testing how concepts of transformative social policy are applied within country experiences.
	UNAIDS	Identifying measures for assessing outcomes (in structural determinants and HIV) of work on a combination of HIV prevention approaches.
	WHO Nutrition	Integrated databases to review elements of a comprehensive conceptual framework for determinants of nutrition outcomes.
	WHO Euro	Review of case studies for analysis of intersectoral processes in Europe.
	CHD, Slovenia	Survey and routine data analysis to examine a model for the integration of health (SDH and health equity) into investment through intersectoral work.
	CCP, USA	Tracking of outcomes of IAH for strategic review of how to advance health promoting policy and governance with civil society.
Test **internal performance** of the actions used to produce change (**i.e. how are we doing?**) Sometimes termed 'process' evaluation	WHO Environment	Repeat of environment performance reviews (national) and health impact assessments (project) to assess change in process and practice on environment and health.
	WHO Nutrition	Landscape analysis and country assessments to compare capacities, policies with actions and outcomes.
	NCCHPP, Canada	HIA to review decision-making processes and changes in governance on SDH.
	CCP, USA	Tracking of outcomes for process review with civil society. External participatory evaluation of processes.
	CHD, Slovenia	Local surveys, capacity assessments, participatory reviews to assess relationships between process and outcomes, resource allocation and systems changes.
	HINST, UK	Appraisals, joint strategic assessments, review to assess systems change. National external process evaluation.
	Dept of Health, Norway	Stakeholder mapping, HIA, monitoring and annual review of routine data to assess performance.
	University of Cairo, Egypt	External case control evaluation of primary health care programme to assess performance against policy.
Test the **development results**, or the outcomes and impacts of decisions and actions: (**i.e. what difference are we making?**) Sometimes termed 'outcome' or 'impact' evaluation	WHO Nutrition	Integrated databases to review elements of a comprehensive conceptual framework for determinants of nutrition outcomes where trends over time can be linked to changes in process and capacity indicators.
	CHD, Slovenia	Survey and routine data analysis to examine the impact of intersectoral work on investment, SDH and health equity.
	Dept of Health, Norway	Evidence on SDH and health equity outcomes collected and reviewed by theme working groups to assess relationships with budgets and actions.
	Ministry of Health, Kenya	Community health information system and demographic health surveys provide evidence of outcomes that can be used to evaluate national policies and programmes (not yet underway).
* Further detailed provided in Annex 3.		

Testing conceptual frameworks: How are we thinking?

All respondents recognized the importance of innovative thinking to change practice. They are working from conceptual frameworks that involve assumptions, values and theories of change. As most noted that they are consolidating or tapping political or policy windows of opportunity to build new practice across sectors on SDH, there was greater preoccupation amongst respondents to address questions of 'How are we doing?' in order to reinforce practice than to interrogate conceptual frameworks.

For UNRISD, as a research institution, testing conceptual frameworks was more central to its work. UNRISD is implementing work to test theories of transformative social policy, specifically, the hypothesis that the equitable transformation of society is only possible through mutually reinforcing policy actions – within and between government, market and civil society, across the sectors, and by readjusting unjust economic, social and political relations, to change the position of disadvantaged people in society. This work is being undertaken through country case studies, analysis of intergovernmental databases, and reviews of secondary evidence *(10)*. The evidence gathered is used to stimulate policy dialogue on thinking about social policy, the actions across sectors, and within and between service providers and users, to inform dialogue between countries and international/ global agencies, and to present learning relevant to policy, including global policy such as the International Labour Organization's global social protection policy. Without direct obligations for policy implementation, UNRISD is positioned through its research networks and papers to draw lessons across the 'natural experiments' of country practice, to analyse evidence and stimulate dialogue on thinking about social policy. It was noted during the interview that more systematic methods and data sources need to be developed for this, to collect, organize and produce new knowledge from country experiences, including on how policy measures and services affect social cohesion, and change institutional and power relations.

There were other examples of work that reflect on the paradigms and concepts driving IAH, noted in Table 2 (CHD Slovenia, CCP USA, UNAIDS, WHO Nutrition, WHO Euro). Case studies were often used to provide the depth of information needed to reflect on conceptual approaches linked to learning networks and strategic review. WHO Euro has, for example, used reflection on country case studies at different stages of IAH work to reflect on the thinking on IAH in terms of the health determinants landscape and agenda setting on SDH and health equity, on how cross-government policies are being framed and articulated, as well as the enabling and disabling contexts for such work (see Annex 4 for further details). Triangulation of different sources of evidence has also been used, such as in the UNAIDS-led work on combination prevention, where the methods (mode of transmission analysis, tracking of objectives, activities, and setting and national spending assessments), and the efforts to establish accepted and applied measurement strategies for social determinants, are building a triangulated base of evidence to review the theoretical premises on intersectoral action for prevention (noted to be at an early stage).

The respondents from Slovenia and UNAIDS both raised the fact that testing conceptual frameworks is something that needs to be planned and set up early, even while the analysis of outcomes may not be expected at early stages. They noted that the themes for collecting case studies, and other evidence to test theoretical premises, should be identified early on and carefully defined. Even though sufficient time needs to be given for processes to develop and outcomes to be assessed, the documentation of case studies needs to take place from inception.

Testing of "how we are thinking?" thus appeared to be associated with more mature processes. The work in Slovenia exemplifies this, where there were stages over a 7–10-year period during which the questions and focus for strategic evidence and evaluation changed from collecting the baseline evidence on inequalities to profiling issues, diagnosing problems, and building shared understanding of the causes; to showing changes in the capacities and performance of mechanisms in responding to these causes; to giving evidence on what works to orient and sustain investments in effective actions (see Box 3 below).

Similarly, the interrogation of conceptual frameworks was raised in other more mature processes that had been in place for over a decade, and in processes that have moved from

Box 3. Changing questions for evaluation at different phases of work in Slovenia

Pomurje in the north-east of Slovenia is the most underprivileged region in the country with social, economic and health indices significantly below the average for Slovenia. The programme in Pomurje integrates health within the development plans and potential of the region, and development as the basis for better health. Since 2000, the programme has identified interdependent work to restructure agriculture focusing on: (i) the local supply chain, environment, and health friendly production and distribution in order to develop health friendly tourism; and (ii) to implement vocational and higher education, and health promotion and environment protection programmes, coordinated with the regional development plan. In the first phase, data collection focused on establishing a baseline situation to clarify where to act, establish and build understanding on the causes of problems, and build a knowledge base for planning. This was complemented by initiatives at national and regional level, such as a health impact assessment of the environmental and health aspects of the Singled Programming Document 2004–2006 for Slovenia, and a 2003 health impact assessment of agriculture and food policies, to support national food and nutrition planning. As the "Let's live healthy" project in the region was developed and implemented, information needs shifted, to provide evidence of change to support political and partner commitment.

The tracked change was primarily in process indicators, and in indicators of capacities of a network for health development, such as through the Community Capacity Index *(18)*. Showing improvements in these processes, capacity and performance indicators, and strengthened commitment to and confidence in the process. A research study carried out at the beginning and at the end of the intervention on the same sample group also provided evidence of positive change in health indicators, such as blood pressure and cholesterol levels. In the third phase, from 2007, greater attention is being given to assessing impact. With understanding, capacity, mechanisms and process, greater

Health

Health Community	**Healthy Food**	**Healthy Tourist Offer**
Health Promotion In: • local community • marginal groups • school & kindergartens • workplace	Agriculture Food Industry • fruit & vegetables • organic farming • short supply chains • safe food from farm to fork	• healthy & traditional offer in gastronomy • recreation programmes • prevention programmes in health spas • ecotourism

Health Environment
Natural, living, socioeconomic

focus is being given to assessing the impact on investment patterns, and on changes in determinants of health and health equity. In 2010, the government was paying greater attention to indicators for monitoring inequalities in future national surveys.

Source: *(19,12)*, interviews.
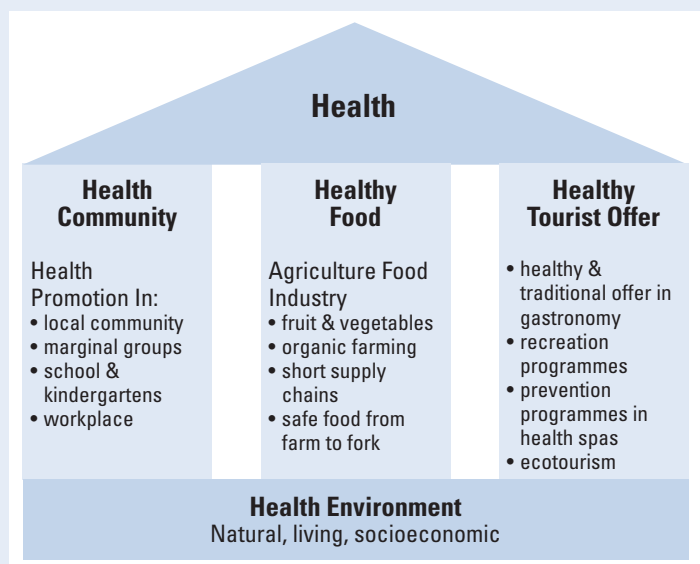
information exchange and cooperation models to integrated approaches, such as the work on environmental health in Europe (in place for 10 years) (see Box 4), or the healthy cities and communities movement in the USA, with over 20 years of practice.

Although testing conceptual thinking appeared to be more easily carried out in more mature processes, respondents also noted that there are challenges in sustaining IAH processes, particularly

in terms of political support and resources. For example, one respondent noted that analysis of structural determinants and intersectoral work on nutrition had been overshadowed by a more narrow focus on food production and prices given the pressures from the food crisis. Respondents saw that the evaluation to show positive gains in performance from IAH approaches was one way of sustaining institutional commitment and political support for IAH, even in the face of such pressures.

Box 4. Realigning economic and trade policies to integrate health and environment

The integration of health into economic and trade policies and protocols through health impact assessments for projects and environmental performance reviews, and for national-level audits is explicitly exploring how economic theory, modelling and guidance integrates both economic and human development outcomes, including health gains, by tapping into the paradigm shifts achieved by the environmental movement.

Introducing the concept of assessing the 'health footprint' of policies such as transport introduces new dimensions into the understanding of sustainable policies in economic activity. It points to new areas for inclusion in economic analysis (such as the health benefits from physical activity), including new social dimensions for the political make up of economic activities.

This not only challenges economic theory, but it also challenges disease-oriented paradigms that more commonly inform work and investment in the health sector. As new concepts are integrated into global and national policy on health and environment, and new forms of evidence are gathered and analysed around these concepts, an increasingly rich base of evidence and experience is emerging with which to inform theory.

Health impact assessments are carried out at both project and policy levels. For the latter, WHO engaged in the development of the health dimension of the international protocol (Convention on Environmental Impact Assessment – EIA) on strategic environmental assessments.

Environmental performance reviews are broad national-level audits of environmental performance, that look at the main sectors of the economy to identify hazards to the environment, measures to reduce those hazards, and policies, institutions and capacity to assess and manage them. They involve a broad range of stakeholder consultations in-country, data analysis, etc. These are led by the Organisation for Economic Co-operation and Development (OECD) in developed countries and in some developing ones, such as the People's Republic of China, and are repeated every five years or so [20]. They are voluntary, i.e. the country requests a review, which includes a peer review by experts from other Member States from relevant areas, and a data analysis. The UN Economic Commission for Europe has developed a similar analysis for eastern European countries, and WHO has teamed up with them to incorporate a health dimension. The health risks associated with specific sector activities are assessed together with relevant mitigation measures, the national capacity to address them, and relevant data and other dimensions. The work links the assessment of health and health systems with environmental assessment (the sector analysis), and thus offers opportunities to explore how economic, environmental, and health and health equity policies can benefit all. Environmental health performance reviews were carried out in 15 countries in the first round. They have now been repeated in 10 countries. The repeated reviews allow for an assessment of the extent to which the measures implemented have been able to align the policies and paradigms in health and the environment within the wider economy.

Source: [21], interview.

Assessing performance: How are we doing?

It was more common for respondents to be at earlier stages of development and implementation of their work, i.e. Egypt where policy and political recognition is still to be achieved; Kenya where mechanisms and processes are being developed or oriented to work on SDH; and Canada, Norway, the United Kingdom, where the preoccupation is with the governance and delivery of change processes, and with the performance of systems-level change taking place.

Processes that were in earlier stages focused on influencing policy and initiating action rather than evaluating conceptual frameworks or impact. In the interview with the Department of Health in Norway, for example, there was concern that external evaluation of impact was premature, and might be counterproductive if implemented too early to show outcomes in complex processes. What was needed were systems that recognized the time taken to progress, and that also rewarded and supported actions and relationships within a more holistic framework. In the work on HIV prevention, a policy opening recognizing social determinants in HIV prevention is being consolidated through mapping gaps in and links between assessments of spending and analysis of modes of transmission, to move policy support to intervention. Respondents indicated that they

wanted to better understand how effectively the relationships between individuals, institutions and processes were being negotiated and organized to co-construct knowledge and change (whether for information exchange, cooperation, coordination or integration), and how this could be sustained and taken to systems scale.

Performance evaluation was commonly embedded within the ongoing processes of IAH, with assessment tools such as landscape analysis, environmental performance reviews (EPRs), health impact analysis, or survey questionnaires being applied as the baseline and periodically repeated to gather process evidence for performance review (see Annex 3 for details). Hence, for example, WHO reported that the EPRs provided baseline information for planning IAH and, when periodically repeated, they also provided evidence on how policy and practice parameters were changing over time, and could be used as an input into the assessment of whether the specific IAH processes were changing the way systems were performing.

Interviewees cautioned that the timeframes and methods for performance evaluation needed careful thought, both in terms of how process parameters were defined, measured and analysed and in terms of the timeframes set for interventions to be institutionalized or to show systems change. As this is work with complex systems, there was call for more exchange of information on measures and tools, for technical review of methods, and for exchange of experience to support work on assessing performance on IAH. Environmental health impact assessment has, as noted earlier, been used over a sustained period, and experience from its application can support work in other areas of health impact assessment. There are also new tools to support planning and performance review such as the WHO Urban Health Equity assessment and Response Tool (Urban HEART) that have been used in different country settings (22). Generally, the area of performance assessment was raised as one that would benefit from significant levels of dialogue and exchange across countries and through learning networks. For example, a review paper by Quigly and Taylor (2003) evaluating health impact assessment processes suggested that exchanging information on promising practice directly with people, rather than through electronic methods of knowledge transfer, such as through workshops that provide for dialogue on experience and shared learning, was more likely to be associated with changes in practice (23).

The process evaluations generally produce findings that are specific to particular IAH processes and settings. Unsurprisingly, there is no shared theory of change across the respondents, although Kingdon's theory of agendas, alternatives and public policies (1995) was referred to as a conceptual source on change processes in several background documents provided by the respondents (24)[1]. There was limited evidence of performance and process evaluations from the individual cases feeding into new knowledge on how issues are given attention in government agendas, or on producing systems level change. The NCCHPP in Canada reported that they are explicitly exploring these process aspects, noting that policy-making is not linear but an outcome of a negotiated, reflective and political process in which information plays "a role" not "the role" (4). Multi-country work and learning networks such as those in WHO Euro or the WHO work on EPRs cited earlier have also used forums for meta-analysis across countries to support dialogue or systematize learning from these change processes.

Assessing results, impacts and outcomes

As noted earlier, it was more common for respondents to be gathering evidence on changes in performance than on impacts. The paucity of data on the evaluation of impacts was noted in a search for relevant systematic reviews, syntheses, or high-quality literature reviews of health impact assessments, with the conclusion that "there is currently no review-level evidence available to demonstrate if and how the HIA approach informs the decision-making process and, in particular, if it improves health and reduces health inequalities" (23). The respondent from Norway cautioned against trying to evaluate impact too early in the process, although it was also noted by UNAIDS that the measures of 'successful' outcomes need to be identified and defined early to ensure that evidence is gathered from the inception for the assessment of outcomes.

In the interviews, respondents from Norway and Slovenia, and some interagency respondents

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1 Kingdon discerns three streams of processes through which agendas are affected. Problem recognition is identified as critical to agenda setting, and is noted to depend on the means by which the participants learn about conditions and define them as a problem, such as if they violate important values, or show worse performance than expected. Developments in the political sphere are also powerful agenda setters, set through ideology, electoral issues, bargaining or interest groups. In the policy process, competing proposals are evaluated against logical criteria, but also in terms of political support and opposition. Policy windows open when political, policy and problem streams partially or fully coincide. At this point, social entrepreneurs take their favourite proposal and push for consideration, brokering people and ideas. These entrepreneurs may be visible or hidden and bring to the arena their claim to a hearing, their political connections, negotiating skills and their persistence.

working on nutrition reported efforts underway to assess health equity outcomes. Kenya and the USA reported working on the assessment of health, health system and social determinants outcomes, while UNAIDS is clarifying and defining the measures that would be used to assess outcomes (see Annex 3). The survey, and pre- and post-intervention assessment techniques being used are not unusual, and evidence is being gathered through routine reporting including community-based reporting (Kenya, USA); specific household or population surveys, or research (Kenya, Norway, Slovenia, WHO Nutrition); and national routine data systems (Kenya, Norway, Slovenia, WHO Nutrition).

While respondents from Norway and Slovenia raised the question of problems in accessing disaggregated data from some sectors working on social determinants, the most significant problem brought up by these and other respondents (Egypt, Canada, USA, UNAIDS) was on how to attribute outcomes to the IAH processes when assessing their impact. The difficulty with establishing connections between intersectoral processes and improvements in health, including in health equity, documented in a number of sources, arises due to a number of complicating factors, e.g. to multiple health and non-health determinants, and to difficulties in attributing health outcomes to any one intervention/approach *(5,6,23,25)*. Attribution is often made as a judgement on the basis of evidence, and on the basis of consistency with the pathways to outcomes premised in the design of processes. In Slovenia, pre- and post-intervention surveys and health impact surveys were periodically implemented to associate outcomes with processes in the intervening period. In Norway, working groups set up across relevant sectors to identify and review evidence on outcomes provided a means of subjecting the assumptions and judgements on attribution to more collective and transparent review, so as to improve their credibility and quality. The findings from the interviews suggest that the evaluation of impact is still an underdeveloped area, and one where further work is needed on the methods and approaches that may be applicable in different contexts.

4.3 Methods used and learning from practice in applying evaluation to IAH

This sub-section outlines the methods and methodological issues raised by the respondents, including whether these are unique approaches to the evaluation of IAH, and learning from practice..

Methodological approaches

All interview respondents saw the need to generate persuasive knowledge on what works. As noted above, many are at a stage of work where '*what works*' is in terms of performance of the actions and mechanisms used to produce change. Hence, summative external evaluation most commonly used in evaluations of interventions was not the most common method applied in this sample of IAH work, and was only noted in a few cases, e.g. the United Kingdom and the USA. This does not mean that external or summative evaluations are not being applied to IAH work, but a wider sample would give a better idea of the frequency of this approach. For instance, further examples of external evaluations were raised in the interviews, and are shown below with the issues raised.

Particular methodological challenges and institutional demands were raised in evaluating IAH that were seen to motivate more reflexive approaches. Compared to the evaluation of single issues, the multi-actor setting of intersectoral action raises a number of difficulties. In particular, the systems being evaluated are complex and the results context specific, including in relation to political, cultural, legal and other conditions that may be difficult to measure. *External* evaluation was felt to be less useful or possible as a routine form of evaluation as it was seen to be costly, to not recognize the complexity of institutional interactions and work, and to not add value to intersectoral processes. External evaluations were noted to have value when there was a need to generate deeper learning on a specific aspect of practice or to lend credibility to evidence when levering critical support, even if costly and time consuming.

The challenges of complex systems, and the demand for embedded feedback loops to help to fine-tune policies and other interventions point to the need for alternative types of evaluations that may be more useful, feasible and relevant, including *negotiated evaluation,* where knowledge is jointly constructed by actors from different paradigms, and *organized reflexivity* linking knowledge to reflection of practice *(26)*. These approaches are not new or unique to work on IAH, they are commonly used in social science research and are now being extended to health systems research. They are much less commonly

Table 3. Examples of external evaluations raised in the interviews

Area	Evaluations and issues raised
Health Action Zone, United Kingdom	Evaluation found limited performance against outcome indicators set but it was argued that the indicators selected were unrealistic given the short timeframe.
The United Kingdom, Tackling Health Inequalities	Scientific Resource Group that provides an independent assessment of the attainment of targets.
Finnish public health policy and programmes	External evaluation by WHO of health promotion in Finland in 2002. Ministries were legally required to provide information for follow-up reporting and evaluation.
Sweden national public health strategy	Monitoring of 11 objective areas, although without precise and unequivocal targets – more as guidelines, raising some subjectivity in the assessment of outcomes.
Primary health care research in WHO Regional Office for the Eastern Mediterranean (WHO/EMRO)	Research on pilot PHC initiatives in the region showed evidence on outcomes from community health work, food security and school programmes that informed the design and implementation of national PHC systems, especially in rural areas. The evidence did not, by itself, transform practice. A small group of government health officers supported by senior policy-makers were able to take successful outcomes of local-level implementation to higher levels, and to secure funds from parliament *(14)*.

used in medical sciences. Yet, as approaches to evaluation, they were seen by respondents from Kenya, Norway, Slovenia and the USA to have value as they build capacities to analyse progress. These approaches to evaluation are also useful to actors directly involved in IAH to reflect on their strategy and to make them more able to act when windows of opportunity for IAH open. They were also seen to make a more direct connection with the reflection and negotiation needed for strategic planning and management processes, and the capacities for policy engagement.

Participatory approaches to evaluation were also seen to play a positive role. Experience in Slovenia and the USA raised, for example, the importance of demand from community and local levels of systems to keep affirming IAH processes. As shown in more detail in Annex 1, Table 4, a number of settings involved local communities in the gathering and reviewing of evidence, strengthening communities' demand, and including community knowledge, such as in the participatory approaches used in the USA, the community workshops in the United Kingdom or the development of a community health information system in Kenya.

One of the case studies reported by the Center for Epidemiology and Public Health Policy, at the University of Chile during the 2011 WCSDH (not included in the interviews) provided an example of organized reflexivity that made use in stages of a mix of methods and tools to organize and link the processes of scoping and mapping, conceptualizing change and programme design. This provided the basis for defining the areas and indicators for process and outcome evaluation (see Box 5) *(28)*.

Box 5. Steps towards the health equity agenda in Chile

In Chile's programme on health equity described in the case study presented at the 2011 WCSDH, the methodology that was developed to review and redesign the six priority public health programmes incorporated in the work involved three steps: (a) an equity checklist; (b) a review cycle; and (c) a redesign cycle.

In the equity checklist, the programme team quantified the main inequities in accessing health and health care that result from the current way in which the programme provides services to the target population, in assessing the equity effectiveness of the programme by applying standardized checklist instruments, and in quantifying gaps in health outcomes by equity stratifiers using specific indicators.

The main aim of these steps is to identify the priorities to be acted on in the programme to improve equity in health outcomes, to clarify the mechanisms by which the programme's activities will contribute to the expected outcomes, in the short, medium and long term, and to identify those who will access and benefit in each key stage of the programme. The barriers and facilitators to effective coverage are identified for the specific priority groups, and the goals and targets set in the programme design to address these factors and to improve equity, including through IAH and social participation. The redesign cycle sets the specific changes for each intervention area (at national, regional and local levels) in terms of the changes to the content, organization, management, programme's performance, and the mechanisms to engage with other sectors and the community. These three stages, and particularly the redesign proposal drawn from the analysis, provide the key information used to define the short-, medium- and long-term outcomes, and the monitoring and evaluation mechanisms, and indicators.

Source: *(27)*

Methods and tools used

In this sample of respondents, pragmatic processes were more commonly used for the monitoring and evaluation of performance, outputs and outcomes, often triangulating different qualitative and quantitative sources of evidence from community focus groups and assessments to national surveys (see Annex 3). Looking across the practices there were some shared approaches, sometimes labelled by different names, that were used to test concepts, process and outcomes.

- ◉ Efforts were made to clarify and define concepts and how they can be measured, and develop, integrate and strengthen equity analysis in routine information systems as part of the work and as a platform for future evaluation.
- ◉ The analysis of actors and processes, including of stakeholders' commitment, capacities and priorities, was a key element in the evaluation of decision-making and in gathering evidence for understanding how – and for whom- things were working.

Box 6. Approaches to systematically addressing health inequalities in the United Kingdom

The work on health inequalities through the UK National Support Teams aims to: assess progress and clarify challenges; review what works; identify areas for immediate action that will help with progress towards the 2010 target, while recognizing that the target is a means of measuring progress, and not an end in itself; and set out further longer term action, including working to strengthen action across government. Achieving improvement in health inequalities is argued to depend on the organized efforts of society at four points in the population health triangle as shown in Figure 2. This model uses evidence to concentrate on interventions where research findings and professional consensus are strongest. It identifies those factors that will determine whether a given intervention will achieve its best possible outcomes in a given population, with measurements that are locally relevant and locally owned.

Figure 2. Addressing inequalities at four points in the population health triangle
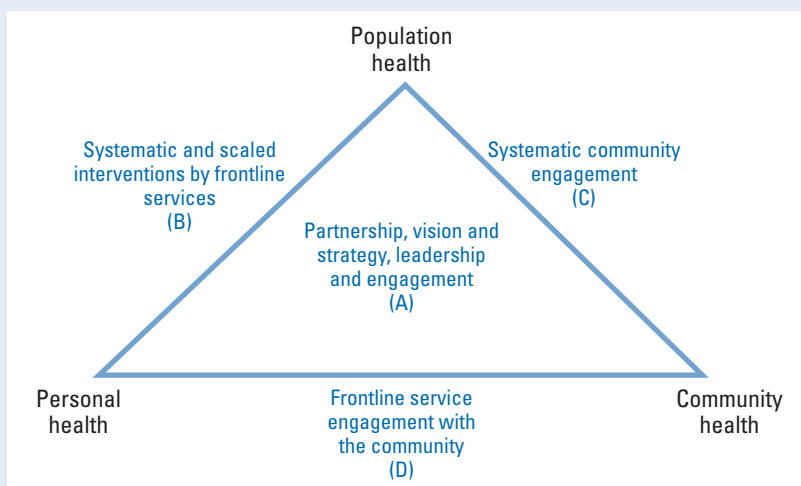
The 'Christmas tree' framework was used to develop a series of detailed workbooks to support focus group work during NST visits, on cardiovascular disease, diabetes, cancer, tobacco control, infant mortality and seasonal-excess deaths. Workbooks for chronic obstructive pulmonary disease and alcohol are under development.

The NSTs support visits, identify strengths and good practice, and make tailored recommendations on how to address gaps in planning and delivery. Good practice investigation has linked costs to outcomes so that high-cost, poor-outcome practices can be 'buddied' with low-cost, high-outcome practices to prompt beneficial change. Return NST tracking visits after six months have shown substantial changes to planning and delivery in line with key recommendations.

Source: *(13,28)*

- The tools used blended both quantitative and qualitative evidence; blended data from information systems and surveys with workshop and participatory approaches to draw conclusions on concept, process or outcomes, and included the interpretation and judgement of those affected by and involved in the IAH (see for example Box 6).
- A close link was made, with feedback loops, between the evidence gathered and the information needs identified for the effective performance of the governance mechanisms driving intersectoral processes from local to national level.

Health impact assessment was noted by several respondents to be a useful structured tool for planning IAH and, potentially, for evaluation by repeating the assessments or implementing the evaluation component of HIA. The tool has many Internet-based resources, skills and well-organized support networks available, some shown in the references and web site listing. This gives some security to the rather complex work to catalyse HiAP/IAH. However, HIA was also noted by one respondent to range from expert-driven models, where scientists make assessments that they use to engage policy-makers, to community driven, collaborative and negotiated approaches. The latter form was seen as preferable to stimulate the relations for intersectoral processes by two country-level respondents, who saw it as more important at this stage to build competencies, and ways of working across sectors and disciplines, and to build strategic planning.

Screening, scoping and review tools, and stakeholder mapping to locate the work in the policy- making process, and planning communications were perceived by respondents to be useful not only for generating evidence, but also for reinforcing processes and competencies for the strategic planning of IAH. In particular, the processes for gathering and analysing evidence were seen to need to be matched by institutional mechanisms and capacities for such strategic use of the information gathered to support HiAP. This was commonly perceived to be a process that demanded time and numerous stages, given the perception that the health sector has a poor understanding of IAH and SDH, and a need to build shared understanding, common knowledge and language, communication, and relationships

of trust within and beyond the health sector for the implementation of IAH.

The diversity of approaches and evidence, often directed to producing evidence to stimulate, prioritize and plan intervention, and systems thinking, or 'realtime' evidence to support thinking, practice and systems change, signals a field where practice and demand is driving innovation, rather than one where there are well-established methods. This makes the field exciting (and attractive for policy entrepreneurs), and one that calls for vehicles that provide a much broader exchange of methods, skills and processes than the limited sample presented in this report.

Access to information

Access to and integration across different sources was noted to be a challenge by some, as was obtaining disaggregated data from all sectors. Legislation tends to limit data access in some settings, while the collection of combined evidence can be difficult in those sectors where performance recognition and reward depend on their achievements.

Creative mechanisms were proposed or used to address these constraints, including a high-level Information and Decision Support Centre in the office of the Prime Minister in Egypt, inter-ministerial mechanisms in a number of countries, the use of research forums and conferences to encourage the use of evidence, shared development resources to encourage the sharing of evidence and the development of composite datasets and indices that all have 'buy in'. The work on nutrition and food security presents an interesting example of efforts to make data accessible through the development of a publicly accessible Internet-based integrated database for use by all organizations, including for the evaluation of intersectoral processes (see Box 7).

4.4 Reporting and use of the information from the evaluation of IAH

This final sub-section reports on the way the information and evidence from the respondents' evaluation processes were shared and used, including in terms of feedback to policy, local decision-making, management, and social participation at community level.

Box 7. Integrated databases for assessing intersectoral processes in nutrition

Landscape analysis[1] was conceived as part of WHO's efforts to strengthen its contribution, along with governments and other partners, towards the achievement of the MDGs. To support intersectoral action for improving nutrition, the landscape analysis was taken forward as an interagency collaboration to serve as a *'readiness analysis'* to assess countries' readiness to accelerate action in nutrition, particularly in the 36 high-burden countries where 90 per cent of the world's stunted children live. Readiness analysis is frequently used in the private sector for assessing where the investment of resources is likely to give the greatest return, and for determining how best to invest in order to yield the maximum benefits. It explores stakeholders' attitudes and perceptions, the old versus new skill sets required, and existing levels of risk and insecurity, institutional cohesiveness, incentives and effective communication. Through this an integrated standardized database of nutrition-related indicators has been brought together to track changes over time and monitor progress, generate easy-to-interpret country profiles, improve access to comprehensive nutrition information across multiple sources, and combine information to encourage more integrated approaches to nutrition interventions. It includes proxy indicators of country commitment (willingness to act) and capacity (ability to act). The Nutrition Landscape Information System (NLIS) incorporated as of 2012 into Global Database on the Implementation of Nutrition Actions (GINA), draws data for country profiles from databases managed by the Demographic and Health Survey (DHS), the Food and Agriculture Organization of the United Nations (FAO), the International Food Policy Research Institute (IFPRI), the International Labour Organization (ILO), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Statistics Division, WHO and the World Bank. More interactive tools provide information through maps, graphs and other visual presentations to support advocacy. This web-based tool provides nutrition and nutrition-related health and development data, where available, in the form of automated country profiles and user-defined downloadable data for all 193 Member States.

Source: (29)

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1 Landscape analysis is a process of describing and interpreting a set of features and patterns used for planning. It is usually applied to plan the ecology of an area. WHO's landscape analysis of readiness to accelerate action in nutrition is a systematic approach to assessing how to best invest and where to invest, and how to best invest to accelerate action in nutrition. "Readiness analysis" is frequently used in the private sector for assessing where invested resources are most likely to give the greatest return, and for determining how best to invest in order to yield the maximum benefits. The landscape analysis examines the readiness of stakeholders' commitment and capacity to scale up evidence-informed interventions.

Mechanisms for information exchange

- *Sharing evidence at local level:* A range of methods were used to give feedback to the local level: The Center for Civic Partnerships, USA, used a newsletter and a list serve to share information on good practice across community-level committees. Other methods reported included using the Internet to share evidence on good practice, and building learning groups and meetings between those with the greatest challenges (the United Kingdom); briefs, workshops and the integration of feedback into existing mechanisms and regular community meetings (Kenya and Slovenia).

In most cases, the task was to enhance information flow to and from existing community mechanisms, particularly those that gather together community leaders and members, and ensure that they include voice from more vulnerable or marginalized groups.

- *Sharing evidence across settings (municipalities, countries, institutions):* Numerous learning networks within and across countries were described in the sample, such as the associations working on health impact assessment, the WHO Euro learning network on IAH, the network of academic institutions on public health in WHO/EMRO, the WHO Regional Office for the Americas (WHO/AMRO) Equity, Health and Human Development List Serve, the USA network of local municipal committees, the network of spearhead local authorities in the United Kingdom, the regional network of institutions working on health and development in Slovenia, and the network of district stakeholder forums on family and reproductive health in Kenya. Such networks were seen as key conduits for sharing evidence, learning and experience within and across countries,
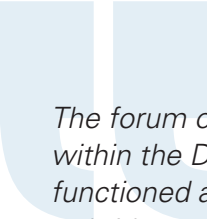
particularly those using the Internet for communication.

- *Sharing evidence at national level:* Reporting was generally through a mix of formal national or regional reports, but also through more direct meetings across ministries and stakeholders, as well as through media, the public and researchers (e.g. Norway, Slovenia). Cooperation and engagement with media in Slovenia helped to raise issues to national level, increasing the policy profile and social dialogue on the evidence. National-level intersectoral mechanisms were present in most cases, but some respondents also raised the importance of face-to-face engagement with the institutions involved on the evidence and reports to promote integration. Some respondents noted the role of credible brokers in facilitating dialogue and linkages with specific national audiences; and national focal persons in supporting information flow to and from global institutions, and in reviving and enhancing communication within intersectoral mechanisms. Making the evidence currently being gathered available to the wider community of researchers and civil society is seen as a way of boosting its use. In Norway, for example, monitoring and review reports of intersectoral work are fed into conferences on key areas (work and health, housing and health) to stimulate deeper research on IAH.

- *Sharing evidence at global level:* For work underway at global level (UNAIDS, UNRISD, WHO), the various reports (HIA, landscape analysis, social policy analysis or spending, epidemic assessments) are fed back to intergovernmental and interagency forums (reference and working groups), often through the Internet, to inform both policy and technical levels. The web sites where global data can be found are shown in the reference list (web sites and resources).

- *Published reports and scientific papers:* Many published reports have been produced from the programmes in the sample, with some included in the reference list. There

were relatively few publications in peer-reviewed journals. Significantly, the Lancet was indicated in two examples (nutrition and AIDS) as having played a role in giving policy profile to the analysis of structural determinants and intersectoral responses. It appears that much of the new knowledge generated through intersectoral processes in health is not reaching peer-reviewed journals and is, thus, not being more widely peer reviewed and cited. Institutional web sites providing publications, guidance documents and Internet-based databases are listed in the reference list.

Respondents raised the fact that, beyond the exchange of evidence, cross-country mentoring was supported by exchange visits, such as between IAH sites in WHO Euro, by regional resources and skills support, such as for PAHO's assessment of health promotion and WHO's health promotion monitoring survey, and through a range of assessment tools from other processes, including for HIA, community capacity index, spending assessment tools, policy analysis, and tools for the evaluation of health promotion. A number of respondents observed that these resources and tools become useful when adapted to the specific contexts, and when used in ways that engage actors across sectors and institutions.

Supporting uptake of information

The people and institutions that use evidence to advance intersectoral processes are an important resource. They play diverse roles – technical, social and strategic – as discussed for policy entrepreneurs who are able to link political, technical and other institutional actors, and to bring them together to open windows of opportunity.

Intermediary institutions, such as the NCCHPP (Canada), CHD (Slovenia), NST (the United Kingdom), the Center for Civic Partnerships (USA), or key personnel in state and UN institutions share information, facilitate processes, broker relations, synthesize evidence, stimulate reflection and instigate action. There is a relatively consistent and pivotal presence of such people in these processes, and they appear to be an 'essential ingredient'. They bring values, social and public health service capabilities, practical experience, and competencies to communicate and build

networks. The interviews suggest that they often work in institutions with sufficient autonomy to act creatively and have enough links to policy and programmes to influence change.

The forum of experts created within the Directorate of Health functioned as a think tank on how to bridge research and policy and present scientific rationale in an area that might be considered very political. In order to create a sense of ownership at both the political and the public sector levels, it was important to illustrate that the approach to dealing with inequity was based on both technical and theoretical points of view.

Strand et al. (2009)(11).

The development of expertise in public health is often associated with specialization and silos, but any form of work involving intersectoral processes calls for competencies in listening to, brokering and facilitating other disciplines. It not only calls for knowledge and information on health disparities and their determinants, but also for an ability to communicate this in a manner that is credible and stimulates action. A number of interviewees pointed with concern to health/medical professionals' resistance to working on upstream or structural determinants, thus weakening support for IAH. One respondent noted that working through existing structures poses a challenge as people hold on to old approaches that divide the work across sectors, as distinct to bringing sectors into combined action. At the same time, another cautioned against having a group of people who are chosen for or build skills for intersectoral processes, who then form a new silo,

and noted the need to widen the actors involved and institutionalize the work within sectors. A case study presented to the 2011 WCSDH provides an example of how existing institutions and actors were brought together in a new forum to raise specific attention to health equity and foster the design, implementation and review of IAH (see Box 8) *(32)*.

Box 8. Canadian Reference Group on Social Determinants of Health

The Canadian Reference Group (CRG) on Social Determinants of Health is a national, intersectoral mechanism for collective action to reduce health inequalities in Canada, established by the Public Health Agency of Canada in 2005. The CRG is an autonomous group of experts and stakeholders and is co-led by government and nongovernment organizations (NGOs), with strong cohesive, intersectoral partnerships supporting collaborative review and action on health inequalities covering business, labour, social and community development, education, urban planning and the environment. The CRG is a forum to review evidence, explore opportunities for action, and augment attention and resources devoted to health inequalities across member organizations and other stakeholders.

Source: *(31)*

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5 Conclusions and recommendations on future work on the evaluation of IAH

5.1 Challenges and assets for the evaluation of IAH

I t is clear that work on IAH is challenging, and a number of challenges were raised in carrying out evaluation of IAH. Complex, cross-sectoral processes that address structural causes do not easily lend themselves to evaluation, and evaluators encounter difficulties with the attribution of outcomes to specific interventions or the actions of specific actors. A review for UNAIDS by Vincent and Miskely (2009) to inform work on structural determinants of HIV stated that interventions on structural determinants are not usually amenable to experimental designs, and confirmed the difficulties raised by respondents of: building a theory of change; measuring social data; making causal attributions; generalizing beyond the specific setting; and finding adequate baseline data to test hypotheses *(32)*. It is also not always possible to attribute contributions of individual sectors or agencies when people work in an integrated way, conflicting with bureaucratic systems that reward or resource people within their sectors based on the performance or outcome targets they achieve. The medium timeframes to achieve and show impact raise challenges for sustaining political, institutional and resource support.

The work demands time and resources, and mechanisms for support and renewal. In most cases, the respondents are facilitating processes that are complex, and have significant breadth and depth. This leaves little time for the narratives and processes that are noted to inform learning. As one respondent commented, "So much time is being spent in facilitating community processes that there is inadequate time to document it." This

is likely to be even more the case in the low- and middle-income settings where resources are more limited and challenges high.

At the same time, this small interview survey highlights the many assets and capabilities brought to this area of work. Many of the teams working with intersectoral processes in health have strong values, energy and commitment, and clear paradigms driving and sustaining their work. A number are building learning around the practice of IAH, and around change in governance and systems that has value beyond IAH. The processes have involved credible actors who have facilitated links with communities, across sectors, from local to national level, and between national and global level, and have built communities of practice and networks that have provided support for IAH even when resources are limited. They have applied and developed tools in reflexive methods that build institutional ownership, confidence and support.

5.2 Building a conceptual framework for evaluation

The findings suggest that having an explicit and shared conceptual framework for IAH work at inception is necessary to clarify the pathways for change, the outcomes and measures for assessing performance and impact, and to prioritize action, as well as to test the thinking informing IAH work. The typology outlined in Figure 1 is an important contribution to such conceptual analysis, and would need to be complemented by the 'theory of change', that explains what leads to the desired outcomes and to movement along increasing levels of integration. The use of case study methods provides one means to test and build new knowledge around such conceptual frameworks, particularly when applied through

reflexive methods, and within learning networks that link research institutions to practitioners, and social theory to experience.

5.3 Embedding evaluation within the development of IAH

The findings suggest that while processes for IAH may take place at the different levels outlined in Figure 1, and may over time progress from information sharing towards approaches that integrate health within the policies and actions of other sectors, they also appear to follow stages within which strategic information needs (and key questions for evaluation) change. The figure below presents simply where the main emphasis appears to be in each of these phases, with the question that seems to apply in that phase, while noting that the processes are certainly more varied and less linear than is portrayed.

A pattern could be ascertained in the processes covered by the interviews:

❶ as intersectoral processes are implemented around policies and systems, the focus is often on **performance evaluation**, to sustain commitment to the process and facilitate strategic review of its

implementation, and of the governance arrangements;

❷ in sustained processes, there is scope to **evaluate results** in terms of the outcomes for systems, and for health equity and social determinants;

❸ the evidence on performance and results (outcomes and impacts), and the processes of strategic review, provide a basis for **conceptual evaluation**, to test the analytical frameworks and pathways that informed the intersectoral processes and the prioritized areas of intervention.

These stages are used to organize the synthesis of issues emerging from the findings.

Scoping, recognizing and diagnosing: In the initial stages, the mapping, appraisal, diagnosis or assessment is being implemented through a range of tools, using available data, interviews and collective processes to raise policy recognition and initiate action. It is not possible to be prescriptive on how to do this as it depends on the political, policy, technical and institutional context. Health impact assessment, landscape analysis, national sector policy performance reviews, public health (transmission) analysis, stakeholder analysis, appraisals, interviews and workshops,

Figure 3. Describing the emphasis of evaluation work in different phases
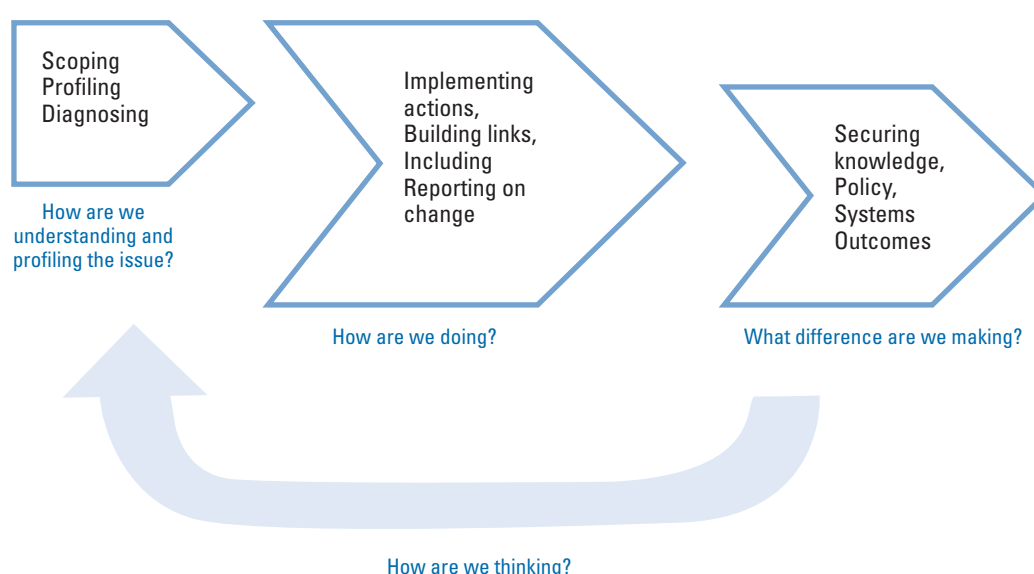
participatory reflection, analysis of existing SDH data and policy analysis are amongst the tools used by the respondents interviewed. Respondents also highlighted that the tools used should build the trust, relations and shared analysis needed to motivate IAH, by building shared diagnosis, and social participation and ownership across sectors. HIA, for example, as a clear and focused tool with a wide support network, was argued to build confidence, trust and common language across diverse actors, which is important for IAH.

Implementing change: In the initial years of processes, the respondent feedback indicates that evaluation of performance is prioritized over concept or impact evaluation, to answer the question 'how are we doing?', to support strategic review and build confidence and effectiveness of action. Performance or process evaluations assess changes in: capacities and commitment (such as with the capacity index); communication and information sharing; institutional interactions, and systems functioning and performance; how spending patterns relate to prioritized needs and actions; outputs produced; and social and institutional perceptions of change, including from the policy level. External evaluations in this phase have also focused more on changes in performance.

The work reported indicates a diversity of methods and approaches for this using evidence from routine information systems, periodic repeated surveys, capacity assessments, spending assessments, stakeholder analysis, and from the tracking of progress markers. This is a phase where respondents proposed that cooperation be strengthened to share disaggregated data across sectors. A number of practices were found to be useful for exchanging methods, tools and findings including: electronic and face-to-face exchange; learning networks across settings and countries; systematic review of the literature on methods and approaches; and electronic databases to make tools more easily accessible. Positive findings from performance evaluation are argued to build confidence in those involved in and supporting IAH, especially when shared in cross-sector working groups within countries, and networked across sites or countries.

Achieving outcomes: As work is sustained and matures there is increased demand and scope to address the question 'what difference are we making?' or to evaluate development results. This was a more limited area of work in the sample in this review, with challenges raised of measurement, attribution and time scales. To assess financial, political, economic, development and health impacts, the findings suggest that outcomes and pathways need to be identified at the outset, together with measures for tracking progress towards achieving outcomes. Evidence also needs to be collected from the onset to be able to assess change. The findings indicate that impacts are being assessed across a range of outcomes, including in terms of institutional capacities and functioning (e.g. partnerships, governance, knowledge, management practices), policies, and health and human development. The tracking of progress on outcomes may need to be through external summative evaluations to influence policy actors, but more generally the evaluation of outcomes/impact was reported as being through periodic internal assessments to support the strategic review of how IAH is organized to inform those involved. Issues of attribution in complex settings have led to the development of approaches that avoid unequivocal attribution, such as the outcome mapping approach developed by the International Development Research Centre (IDRC) *(33)*. Positive changes were noted to be useful to sustain political support, resource allocation and practice, and to motivate increasing levels of integration.

Across all phases and settings, the interviews point to some common findings and issues.

- While formal external evaluations or surveys can provide persuasive evidence to influence policy actors, for the majority of respondents, a model of reflexive or negotiated evaluations was seen as most useful for this work. This is because different actors, including local communities, jointly construct knowledge and link it to reflection on practice. Thus, evaluation is not one more burden to add to an already complex process, but a part of the process, and a tool for improving the possibility of successful outcomes. Internal evaluation, reflexive and participatory approaches more directly link the generation of knowledge to the actors involved, both in terms of capturing their experience and feeding into action. This has value both for strategic review and for conceptual thinking. Pawson *(34)*, for example, proposes 'realistic evaluation' as a means of opening up the 'black box' of programmes to identify the mechanisms responsible for change/lack of change, to

raise questions about the assumptions of the change process and drivers, and to be able to test and review these as the process proceeds. While the methods for this exist in social science, the interviews pointed to the need to build capacities to facilitate and use such approaches.

- ✔ In relation to the tools, the findings do not suggest that they are unique to IAH. They are commonly being used for scoping, mapping, checklists, assessment and data gathering on actors, processes and content in other areas of social science, and systems analysis. However, their creative modification for IAH, such as in health impact assessment, landscape analysis for nutrition, urban HEART or the capability index indicates the need to share and test them more actively across wider settings, as raised by interview respondents. With the complexity of the processes in IAH and the need to triangulate evidence from different sources, evidence on issues may be gathered from more than one tool.

- ✔ In relation to the analysis, the interviews highlight the importance of clearly defining concepts and measures. However even when the parameters are clear and measurable, there were concerns with data access and quality, especially in terms of disaggregated data from different sectors. Cross-sectoral review groups, transparency in analysis, public reporting and reporting in research forums were seen to support improvements in data quality and analysis.

- ✔ The interviews also point to the usefulness of 'meta' processes such as learning networks and communities of practice, that exchange and build capacities, support the definition of measures and methods, share information, and build integrated databases and knowledge across sites and countries. Such networks can support observatory-type arrangements that can build meta-analysis of commonly structured case studies or assessments in different local authority areas or countries, to build more generic knowledge and theory from evaluations *(32,35)*.

There was strong support for improved information flow in this area, strengthening current measures, such as newsletters, mailing lists and the Internet,

as well as through more face-to-face processes, such as meetings and exchange visits. The role of credible and competent brokers and facilitators was seen to be important for linking local, national and international levels, and for communicating across sectors, disciplines and between constituencies. In the sample included in this review, the work of evaluating IAH was not widely published in peer-review journals, although this could facilitate exchange and bring policy recognition.

5.4 Recommendations

The proposals from the 2011 Rio Political Declaration on Social Determinants of Health on monitoring and evaluation raised in the introduction included a commitment to monitor the impacts of actions taken to tackle inequalities in health to guide policy-making and support IAH in all sectors. This is to be carried out through systematically sharing relevant evidence on trends and assessments of impacts among different sectors to inform policy and action *(2)*. All those interviewed in this review encouraged further work to develop approaches and methods for the evaluation of IAH.

As noted in the introduction, the limitations of the sample hinder the generalizations and strength of recommendations that can be made. One recommendation is to widen the gathering and exchange of evidence from other cases and regions, particularly from low- and middle-income settings, using a shared template. However, given the importance of experience in building the field, it is still important to share the learning and issues raised from the cases included.

Notwithstanding the caveat of the limited sample, the findings suggest some recommendations for supporting promising practice on the evaluation of IAH.

Within IAH programmes
- ❶ In the design stage and as part of the planning, clarify with those involved the conceptual framework, theory of change, outcomes and pathways for achieving them and develop feasible measures for evaluating performance and progress in the achievement of outcomes.
- ❷ As part of the planning and implementation of IAH, embed reflexive/realistic and participatory evaluation approaches that involve the different sectors and the

affected communities to inform strategic review, and build confidence, trust and support.

❸ Draw on proven tools for scoping, mapping, assessing and data gathering, on the actors, processes and content of IAH, and on outcomes (such as those presented in the report and with relevant modifications).

❹ Provide resources for those brokering and facilitating IAH processes to ensure the documentation, data gathering, consultation and reflection necessary for evaluation.

❺ Include resources for reflection/strategic review of findings and of thinking on IAH, and for inputs to learning networks, mailing lists and exchange visits.

❻ Use cross-sectoral review groups, public forums and research meetings to strengthen peer review and data quality, and uptake of evidence from evaluation of IAH,

❼ Widen the publication of findings from the evaluation of IAH, including in national research meetings, peer-reviewed journals and media.

Broadly within the field

❶ Develop and test the conceptual frameworks and change theories for understanding IAH and for advancing integration of health in all policies, particularly through learning networks on IAH and making links to research programmes.

❷ Provide a portal for linkages to Internet databases and resources, to share and review the methods and tools used for conceptual, process and impact evaluation of IAH.

❸ Develop a reader on reflexive methods for the evaluation of IAH, with information on the methods and their application, sources, and bias and error, and including peer-reviewed publications on examples of their application in practice.

❹ Support mailing lists, exchange visits, learning networks, communities of practice, observatories, meta-analyses and systematic reviews on the evaluation of IAH to build generalized knowledge from case studies and sites of practice.

❺ Promote the peer review of conceptual frameworks, methods, tools and results, and the publication of findings in media for public, policy and scientific communities.

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Web sites (including training)

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2. Landscape Analysis http://www.who.int/nutrition/topics/landscape_analysis/en/index.html

3. Nutrition Landscape Information System http://www.who.int/nutrition/nlis/en/index.html

4. Nutrition Department, World Health Organization http://www.who.int/nutrition/en/

5. Public Health and the Environment Department World Health Organization http://www.who.int/phe/en/

6. Environment performance reviews of eastern European countries main website http://www.unece.org/env/epr/V and http://www.euro.who.int/document/eehc/25th_eehc_milan_infdoc16.pdf

7. Transport environment and health work in Euro http://www.thepep.org/en/welcome.htmhttp://www.thepep.org/en/welcome.htm

8. An outline of promising practice examples, practical recommendations for improving the application of Health Impact Assessment evaluation in England. Heath Impact Assessment Gateway–Health Development Agency web site (http://www.hiagateway.org.uk).

9. Convention on public participation access to information and to environmental justice http://www.unece.org/env/pp/

10. UNECE protocol on Protocol on Strategic Environmental Assessment http://www.unece.org/env/eia/sea_protocol.htm

11. Various resources, training information on Health Impact Assessment
    http://www.who.int/hia; http://www.hiaconnect.edu.au/
    http://www.hiaconnect.edu.au/files/Health_Impact_Assessment_A_Practical_Guide.pdf
    http://healthimpactassessment.blogspot.com/2009/01/3-day-training-course-on-hia-sydney-25.html and
    http://www.apho.org.uk/default.aspx?QN=P_HIA

12. WHO European Office for Investment for Health and Development, Venice
    Resources on social determinants http://www.euro.who.int/socialdeterminants

13. UNRISD Social policy programme http://www.unrisd.org/80256B3C005BB128/(httpProgrammeAreasForR
    esearchHome)/BFA13785EC135F568025718B003C5FA7?OpenDocument

14. National Collaborating Centre for Healthy Public Policy http://www.ncchpp.ca/2/Home.htm

15. Training Program in Research Methods for Guiding Policy and Evaluation with Special Application
    to Population and Health http://www1.aucegypt.edu/src/rm/ (The Social Research Centre, American
    University in Cairo organizes a three-month training program annually for the Arab region on research
    methods with special emphasis on social determinants of health and health equity).

16. Social Research Center American Univesity in Cairo http://www.aucegypt.edu/ResearchatAUC/rc/src/
    Pages/default.aspx

17. Norwegian Directorate for Health http://www.helsedirektoratet.no/

18. Health Inequalities National Support Team, UK http://www.dh.gov.uk/en/Publichealth/
    Healthimprovement/NationalSupportTeams/HealthInequalities/index.htm

19. The Health Inequalities Intervention Tool for Spearheads; developed by the Association of Public Health
    Observatories, working in partnership with the UK Department of Health. http://www.lho.org.uk/LHO_
    Topics/Analytic_Tools/HealthInequalitiesSpearhead2007.aspx

20. Centre for Health and Development Murska Sobota http://www.czr.si/en/arhiv.asp?id_meta_type=5

21. Centre for Civic Partnerships, USA, http://www.civicpartnerships.org

22. Useful page on the web site on evaluation resources and links http://www.civicpartnerships.org/docs/tools_
    resources/Evaluation%209.07.htm

Annexes

Annex 1. Conceptualizing action on SDH

Conceptual framework of determinants of health of the Commission on the Social Determinants of Health
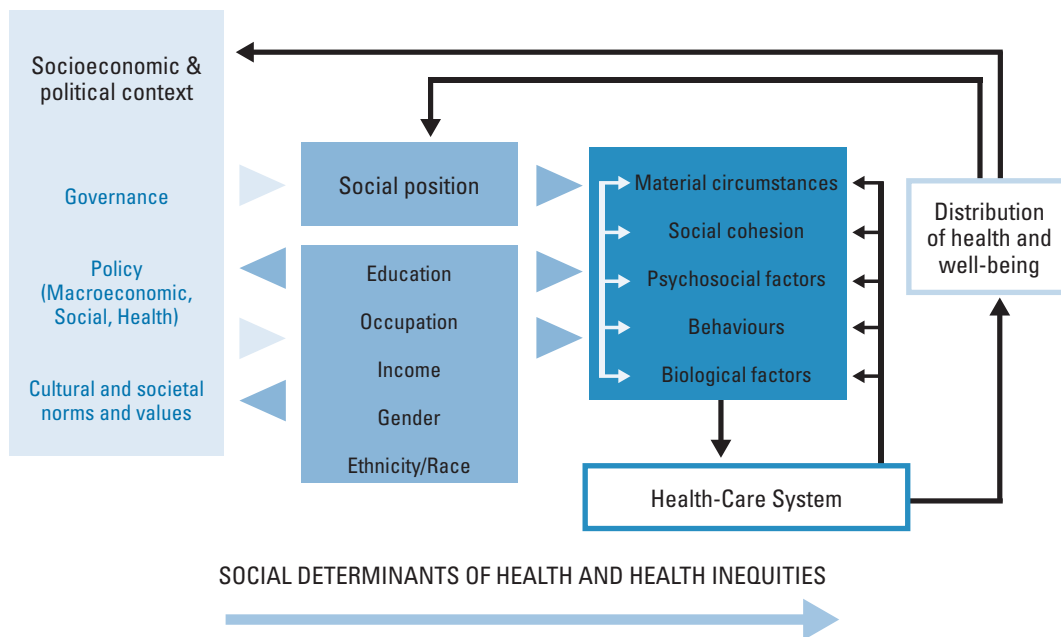
Source: WHO 2008. Commission on Social Determinants of Health Final Report. Closing the Gap in a generation.

Conceptual framework of policies and interventions to tackle the underlying determinants of health inequities

Context-specific strategies tackling both structural and intermediary determinants

Key dimensions and directions for policy

Intersectoral Action

Social participation and empowerment

Globalization Environment

Macro Level: Public Policies

Mesa Level: Community

Micro Level: Individual interaction

Policies on stratification to reduce inequalities, mitigate effects of stratification

Policies to reduce exposures of disadvantaged people to health-damaging factors

Policies to reduce vulnerabilities of disadvantaged people

Policies to reduce unequal consequences of illness in on social, economic and health terms

- Monitoring and follow-up of health equity and SDH

- Evidence on interventions to tackle social determinants of health across government.

- Include health equity as a goal in health policy and other social policies

Source: Solar & Irwin 2010. Social Determinants of Health Discussion Paper 2. A conceptual framework for action on the social determinants of health.

Annex 2. Interview guide: Understanding how to evaluate progress in intersectoral processes aimed at tackling the social determinants of health

December 9 2009

"How do we evaluate progress on intersectoral action policy frameworks or strategies and their implementation to improve health equity?"

What are the needs and experiences of evaluation from experts who are working in the field of evaluation of intersectoral policy processes and tools, and from policy catalysts who are actively pursuing work on intersectoral action to address the SDH in countries.

Scope:

The work is exploring the (internal and external, formative and summative) evaluation processes that countries and agencies implementing intersectoral action for health (IAH) are using to collect and analyze information for decision making on IAH/HiAP . These evaluation processes are set up to

- Test **conceptual frameworks** and guide decisions (**how well are we thinking?**): This tests the validity and effectiveness of the conceptual frameworks (the assumptions, principles, understanding of context, theories, models) informing decision making and action.

- Test **internal performance** of the actions used to produce change: (**i.e., how are we doing?**): This reviews the extent, effectiveness, efficiency of actions (approaches, strategies, actors, processes and methodologies) in the achievement of desired changes and outcomes.

- Test the **development results,** or the outcomes and impacts of decisions and actions: (**ie what difference are we making?**): This reviews the results of actions (*the political, policy, institutional, programme, resource, social (eg SDH and health equity) impacts*).

The work will also obtain information on monitoring of IAH, i.e. routine collection and analysis of information about the progress of work over time as an input to ongoing review, decision making and planning, particularly as it is linked to evaluation.

It explores experiences and perspectives from
- people who have implemented evaluations
- institutional expertise on IAH evaluation.

The areas for the interview are shown below. *Note the interview questions were revised for each interview depending on the exact nature of the respondent and the work they are doing. Review of background documents from each interviewee on their work was used to focus generic questions more directly to their domain of work.*

Questions:

1. What work was done on IAH/HiAP evaluation or related areas of evaluation relevant to IAH – what areas of IAH/ areas of policy debate, what entry points? Provide features of the IAH – level of integration – information, co-operation, co-ordination, integration– scale, focus, features, duration, source of funding?

2. What have been the motivations / incentives for doing evaluation? What have been the contexts for these motivations. Is there any documented experience that was used in enabling the evaluation? What have been the disincentives?

3. The purpose for and focus of the evaluation – was it directed at conceptual frameworks; performance and processes, or the development of results, or all of these aspects? What were the implications for the design and implementation? What resources were used in framing the evaluation?

4. Design of the evaluation of IAH / HiAP: what resource materials / inputs were used in design? What factors affect design? How was reach of the evaluation to socially excluded groups included? What difficulties, issues and learning is there for future work?

5. Major indicators and parameters used in the evaluation for process/ performance, outcomes/ results: how was this defined? What lessons have you learnt in selecting parameters/ indicators? What knowledge gaps have you faced?

6. Methods and tools used? Based on what resources, materials or expertise? What issues faced in implementation? What lessons have you learnt on methods and tools? What knowledge and skills gaps have you faced? What resources and sources of support have you faced?

7. How has information on results of the evaluation of IAH/ HiAP been used (i.e. in reporting; strategic / policy review; action; for resource allocation/ investments; in learning networks?) Describe any perceived gaps and priorities on information dissemination and exchange on evaluation.

8. What have been the enabling / disabling factors in the contexts for IAH/HiAP evaluation (i.e. country socio-economic context, preconditions, facilitating factors, policy, political, legal and institutional environment).

9. What are major unresolved problems / issues that need to be addressed on IAH evaluation?

10. What are important sources of expertise? What top three readings are recommended for future work on evaluation of IAH?

Annex 3. Summary tables on the findings from interviews conducted in 2009-2010

(a) Summary of work related to evaluation on intersectoral processes and action as reported by respondents – WHO Environment, WHO Nutrition, UNAIDS, NCCHPP, CCP

Evaluation work on intersectoral processes	Respondents				
	Public Health and the Environment Department, WHO/HQ	Nutrition Department WHO/HQ	UNAIDS, Geneva	National Collaborating Centre for Healthy Public Policy, Montreal	Center for Civic Partnerships, Sacramento, CA
Area of work that covers evaluation or is useful for evaluation of intersectoral processes	HIA is used to assess expected health impacts from investments, projects and policies in different sectors and to promote health in all policies. Environmental performance reviews involve the evaluation of national policies in various sectors, their impacts on environmental health, and actions to improve EH performance. National government propose EPRs as a way of comparing how they are performing vis-à-vis other countries, and to identify where and how they can improve EH performance	Landscape analysis of technical, strategic and capacity indicators in relation to intersectoral processes for nutrition in 36 high-burden countries. Further in-depth assessments in eight countries through intersectoral working groups, and questionnaire survey in 80 countries to assess nutrition governance and intersectoral policy translation. Stakeholder review for information on country processes.	Measures are being defined, and data gathered and organized for national decisions-makers to orient programmes and support decision-making on the design of intersectoral work on structural determinants. This feeds into policy dialogue and accountability. It also feeds into UNGASS reporting (e.g. by gender).	NCCHPP use health impact assessments as a tool to support governance changes and decision-making for IAH, and to understand the features of practice.	A large-scale external evaluation has been implemented in 20 sites. In municipal sites, six-monthly reports are produced on workplans with process and outcome measures, including resources leveraged. Tracking and reporting on selected processes and outcomes is embedded within activities.
Description of the evaluation work and category (evaluation of concept, performance or results)	HIA and EPRs are systematic evaluations (performance and results) using common methods. HIA includes expert analysis and stakeholders' reviews, projected (and by repeat assessment) performance and health impact of policies, plans and projects. EPRs in 15 countries were developed in the late 1990s, and a new set is underway, with several completed.	Assessment processes through the landscape analysis and country surveys evaluate performance (capacities and intentions versus nutrition outcomes). No formal evaluation of the assessment process (recently initiated). Establishment of integrated database to track nutrition progress, outcomes (so a means to evaluate results).	Development of measures for outcomes to support the evaluation of results. National AIDS spending assessments (100 countries). Evidence on programme inputs (who's doing what where). Modes of transmission, analysis to assess which sectors need to be involved, and to support performance evaluation.	'Negotiated' evaluation, co-constructing knowledge to evaluate performance of governance arrangements to support intersectoral processes	External evaluation using a participatory process to assess performance and outcomes. Internal monitoring of markers of progress, e.g. systems reform, prioritized programme areas, budget allocations, allocation of personnel by city, governments and services, and private sector to assess performance and results.
Design	HIAs are done early in the planning of a policy plan or project to identify health risks, propose mitigation and promotion measures, monitoring and follow-up. EPRs – expert analysis of needs, policies, policy and enforcement capacities; report reviewed by national stakeholders in open plenaries; intergovernmental reporting and review. Every five years, an EPR is implemented, an enabling report on design, performance, trend on policies, actions and assessment of impact.	The work is implemented through a mix of approaches using secondary data, primary data collection and review of routine or secondary data, i.e. expert analyses in cross-sectional assessments using available data, stakeholder review, integrated cross-agency database, survey of countries.	Assessments provide evidence for comparison of spending patterns to epidemic patterns. Using transmission analysis to identify sectors to involve. Gap analysis between spending and combination prevention priorities based on epidemic pattern. Stakeholder review (e.g. Asia A^2 analysis and advocacy). Expect that assessments will be repeated.	Within the HIA, process of mapping, assessment, dialogue.	Large scale: case study of 20 communities. Site specific: six-month reports on workplans with process and outcome measures.

Parameters assessed	EPRs: national policies, potential EH issues, and response to those issues, views from different stakeholders on the above, data, research findings. EPRs collect evidence on policies in different sectors, EH issues and response to those issues, monitoring information, research findings, and opinions from stakeholders. Institutional mechanisms lead to assessment of EH performance and impact (across time). HIA collect evidence on expected health impacts of proposed policy/project alternatives/options (including doing nothing) are estimated using science and stakeholder views and experience from similar projects. Evaluation of performance built into some HIAs (e.g. the United Kingdom) by documenting steps taken during the HIA, identifying constraints experienced, and useful lessons through descriptive review of reports.	Commitment and capacity for intersectoral processes in nutrition. Assessment of policy, programmes and action. Indicators of: nutrition problems, commitment capacity, general conditions and context factors. Questionnaire survey: policy actors, institutions, process. (see Box 7)	In national AIDS spending assessments: domestic, ODA, out-of-pocket expenditures. Identifying measures for capturing social barriers. Evidence on programme inputs: audience, objective, activity, setting. Disaggregation of UNGASS indicators, e.g. by gender. National composite index. Modes of transmission analysis – social context, expanded programme on immunization programming.	–	Large evaluation: civic, individual, participation, organizational, inter-organizational, community outcomes. Monitoring: process, outcome, resources leveraged indicators and use of proxy indicators due to data scarcity. Leadership questionnaire on vision, participation, city buy-in. Checklist of activities, health-promoting policies.
Methods and tools used	Standard HIA methods and tools. Legal framework requirement – health in Strategic Environment Assessment Protocol. EPRs – national government request for assessment, expert group includes from other countries – peer reviewers/exchange of experience.	Analysis of data, interviews, focus groups, stakeholder review. Combined nutrition information to track progress.	Building common language, method to collect evidence on inputs.	HIA Policy analysis Risk assessment	Large evaluation: key informant interviews, focus groups, document review. Routine: workplan reports. Self-administered leadership questionnaire
Difficulties and issues raised	EPRs are costly and involve many actors and stakeholders. Health sector has few incentives to adequately engage with health determinants. HIA tends to focus on the assessment, need to integrate more routinely monitoring and evaluation.	Difficulty with gathering commitment and capacity data for nutrition information system. Assessments, review and building of intersectoral mechanisms needs adequate time.	Moving from a 'division of labour' to combining multiple strategies and skills sets. Information on inputs inadequate, categories difficult to compare, lack of common language make learning from programme experience difficult.	IAH/HiAP refers to complex systems. The evaluation approach: tools used in understanding health promotion in complex systems are being explored.	Large-scale evaluation useful but difficult to do as time consuming and very costly (+$500 000) and resources not available. Diversity of efforts, confounders, difficulty with using 'community' as the unit of analysis. Need to build learning into processes as it evolves.

(b) Summary of evaluation work on intersectoral processes and action on health equity reported by respondents – Slovenia, United Kingdom, Norway, Kenya, Egypt

Evaluation work on intersectoral processes	Respondents				
	Centre for Health and Development, Slovenia	Health Inequalities National Support Team, United Kingdom	Directorate for Health, Norway	Dept. of Family Health Ministry of Public Health and Sanitation, Kenya	University of Cairo, Egypt
Area of work that covers evaluation or is useful for the evaluation of intersectoral processes	Different purposes across phases. First phase of evaluating whether actions were underway, in line with identified priorities, and whether there was political, financial and technical support. For each area of intervention, outputs assessed. In later phases evaluation more focused on economic, environment, health and human development improvements.	Working towards target to close the mortality gap between the 20% most deprived local authorities (50+ spearhead areas) and the rest. Appraisals and review to build learning on systems scale change and evaluate performance. Also, formal external evaluation of performance implemented by national audit office. Aim to support local ownership, analysis of step changes to targets, good practice and systems change.	Principal of action no. 2: policies must be evidence-based. Measures "must be evaluated very thoroughly". Review and reporting system for annual policy review, to redirect existing budgets, develop tools, to provide feedback on policies, identify those that have "no impact", and to advance knowledge.	Focus at this stage on establishing mechanisms, so evidence from annual surveys, demographic and health surveys, the health management information system and other sources seen as key to initiating processes and assessing change.	Formal evaluation of PHC, i.e. the effect of a performance-based incentive payment scheme on public sector providers' behaviours in primary health care units.
Description of the evaluation work and category (concept, performance or results)	Mix of methods: analysing indicators relevant to project in national public health surveys; local surveys (e.g. telephone survey of school procurement, survey of Roma community); capacity assessment; now taking to national-level indicators for monitoring inequity.	Appraisal of causes of mortality through data and 5-6 workshops in joint strategic needs assessments. Feedback to discuss causes and define intervention through local strategic partnerships and local area agreements. Focused follow-up on key areas. Assessment of change and cost linked to resource allocation.	Review and reporting system to manage implementation, under directorate of health to inform theme working groups on areas of IAH. Plans for review and reporting system were approved by parliament.	Information gathering used for prioritization, resource allocation, engaging at community level using community health information on priorities for use of development funds.	External evaluation of a pilot scheme.
Design	Health impact surveys Mix of pre- and post-intervention sample surveys; specific focused assessments and analyses of existing routine data to monitor trends; health monitoring survey for health promotion information.	A mix of quantitative (evidence from data sources) and qualitative (evidence from interviews) in appraisals and reviews. Efforts made to engage 'seldom seen, seldom heard' elements of the population. External evaluation through interviews.	Stakeholder mapping to set up process. HIA used, will widen use of HIA backed by new law. Evidence collected: inequalities in SDH, health outcomes, actions and budget allocations driven by strategic objectives. Review in working groups.	Through health information system, annual sample surveys and period household demographic and health surveys.	Case-control, quasi experimental study design (post-test only)
Parameters assessed	Social determinants of health: scenarios and projections linked to health impact assessment; indicators linked to programme areas, health promotion indicators in WHO monitoring survey; economic and financial indicators of investments, spending, programme performance, community capacities to implement.	Use of workbooks to support data collection and qualitative interviews and analysis on cardiovascular disease, diabetes, cancer, tobacco control, infant mortality, and seasonal excess deaths. Parameters at individual, community (e.g. culture) and population level (e.g. laws, tax incentives). Focus in next phase on more structural determinants of inequalities (income, employment, debt) but using similar approach.	Use existing data. Integrating SE differentials is key and indicators negotiated across the sectors. Determinants with distributional indicators reviewed and developed. Changes in determinants themselves seen as outcomes that trigger policy. Do not see health outcomes as being only outcome indicators. Lots of areas do not have indicators so use proxies and time trends not always available.	Indicators relating to school health; gender violence; reproductive and adolescent health; local-level priorities and resource needs and allocation.	Indicators of the incentive payment scheme, and other measures of patient satisfaction, responsiveness and quality of services.

Methods and tools used	Integrating health and SDH into existing monitoring, and inequity in national and regional monitoring. Specific tools for assessments, e.g. health impact assessment and Community Capacity Index *(18)*.	Initial classification of local areas. Within areas, data review; interviews used for slide report and interrogating evidence with local leadership. Use of workbooks to support data collection. Database of good practice on intervention to draw on to support actions.	Stakeholder analysis as part of policy analysis. Health equity impact analysis (aim to include in all plans but not seen as a 'silver bullet'). Equity checklist with indicators defined through review.	Facility health information system; a community health information system now being set up to complement this for local planning linked to PHC. Also through household surveys.	Mixed methods using structured questionnaires for exit interviews; in-depth interviews with district managers and health-care professionals.
Difficulties and issues raised	Information needs shifting across phases of the work based on functional and strategic needs. Triangulating different information sources (routine surveys, specific analyses, research projects); difficulties in attribution and challenge still to collect the distributional data for equity analysis.	Focus on strengths, local ownership in the analysis enables challenges to be raised (appraisal report does not go to other levels). Databases often give a limited picture compared to interviews. Need to do both. Challenge for national approaches to recognize diversity and provide incentives for local initiatives.	Rewards are structured within sectors so may be less commitment if credit to sector and individual unclear. Too early for evaluation of impact – process and early 'wins' key at this stage.	Key issue of gathering, analysing and using evidence at local level to motivate action. Need for skills and methods for this locally, also in District Health Management Teams to catalyse response at national level.	A concern of the biomedical focus on PHC so that the incentives and performance are still largely in this domain and the role of IAH not well recognized

(c) Motivations for implementing evaluations of intersectoral processes for health equity, respondents citing areas of demand by institution based on interviews conducted in 2009-2010

Why implement? Who has the concern?	To raise the policy profile, lever commitment legitimacy	For policy, programme design and review: to test and inform models, assumptions	To assess investments, resources and incentives	To review internal performance and systems	To generate knowledge, learning	To encourage social participation	For accountability on commitments and performance
National (ministers, executive), local political	Egypt, Kenya, Slovenia, UNAIDS, WHO Nutrition: raising policy advocacy, shift, attention and commitment; equipping policy leaders with evidence.	Norway, UNAIDS, WHO/EURO (environmental action): using HIA, spending assessments etc. to orient programming and spending in line with policy commitments.	Slovenia, USA, UNAIDSWHO: need to see return on investments; to assess gaps between need and spending to improve health performance of investments.	Canada, Egypt, Norway, United Kingdom, WHO/ EURO: to assess the performance of new strategies; to integrate IAH into existing workplans and budgets.	Canada, Egypt, Kenya, Slovenia, United Kingdom, UNAIDS, UNRISD, WHO: on policy approaches, governance and processes.	Canada, Norway, Slovenia: to raise awareness of HiAP work	Canada, Kenya, Norway, United Kingdom, UNAIS, USA: in relation to global and regional treaties, commitments, MDG targets, national targets.
Ministries of finance, funding schemes	Canada, Kenya Slovenia: to show savings of approach; motivate for increasing resources and investments.	Slovenia, WHO Environment: economic sectors seeking tools to show cost, benefit of safeguarding human development in policies.	Canada, Kenya, United Kingdom: to motivate and demonstrate effective use of public funds; analyse returns on investments.	–	–	–	
International finance, funding agencies	UNAIDS, WHO: advocacy for resources, e.g. for nutrition promotion, combination prevention.	Solvenia, WHO Environment: to assess human development returns on bank lending benefit incidence of policies; assess financing and lending (e.g. European Union structural funds, devt. banks).	WHO Environment, WHO Nutrition: using HIA as one lending tool.	–	UNAIDS, UNRISD: to link policy approaches with inputs, resources, targets.	WHO Nutrition: to support global and national mechanisms and capacities.	–
Health sector decision-makers, senior bureaucrats		Kenya, Norway, Slovenia, United Kingdom: to support systems scale actions and draw in evidence on good practice.	–	Canada, Kenya: to track activities and use of resources and assess performance.	Slovenia: to generate evidence on what works.	Kenya, Norway: to widen competencies for actions across sectors; social perceptions and responses.	
Other sector decision-makers, senior bureaucrats		Slovenia, United Kingdom, UNAIDS, WHO Environment: to review performance of policies, systems; to support dialogue across sectors in local authority on actions.	UNAIDS: to inform training and workforce planning for SDH.	Kenya, Slovenia, United Kingdom, UNAIDS: to build relationships across ministries, bureaucrats, civil society.	United Kingdom, WHO Environment: for exchange of good practice.	Canada, Norway: to raise awareness of HiAP work; to build capacities for reporting on SE differentials.	–

Health workers, managers	–	–	–	Canada: to show whether strategies are working.	–	–	–
Other sector workers, managers	Slovenia: to show change to enhance commitment.	–	–	–	–	–	–
Non-state service sector and actors	–	–	–	–	–	Canada: to raise awareness of HiAP.	WHO Environment: on multisectoral actions on health and environment.
Civil society and community	–	–	USA, WHO Environment: for communities to see the outcomes of time and resource contributed; to give information on health impacts of economic activity.	Kenya: to plan and track use of the Constituent Development fund (2% Kenya budget to community level).	–	Canada, WHO Environment: to raise awareness for people's input to policy; to overcome assymetries of power and information.	UNAIDS, WHO Environment: for transparency of decision-making on national policies; to global prevention targets; resource allocation.
Media	Norway, Slovenia: to raise social and policy recognition.	–	–	–	–	–	–

Annex 4. Information gathered in the WHO policy learning cases

WHO Euro (Venice office) is supporting documentation of case studies of work on IAH on SDHE to demonstrate how policy and government agendas, investments and action have been and can be influenced to address the social determinants of health and reduction of health inequities. Case studies have been implemented in Norway, Scotland and Slovenia, and others are planned. Using Kingdom's model, the policy learning case studies are capturing evidence on:

❶ the health determinants landscape;

❷ how SD and equity in health policy, and as a cross government priority, are being articulated;

❸ which stakeholders and mechanisms have enabled this;

❹ what policy progress has taken place in addressing SDH and reducing health inequities and what has enabled or impeded this.
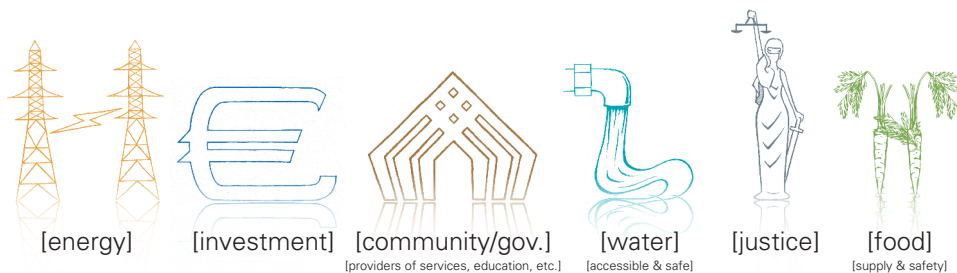
The table below outlines areas for information and learning being captured in the cases and the key areas of content, and performance being examined.

Information and learning being captured by the case studies

Process	Information/learning to be captured by the cases	Issues covered
1. Agenda setting	• How the SDH/HI issues were framed, i.e. how the reason for inequities are explained and the evidence for this • The key influences on the policy environment and critical factors in putting SDH/HI on the policy agenda • Factors and mechanisms that facilitated the combination of political will, technical experts, policy-makers and public support for action on SDH	• Incentives for addressing SDH • Approach to explaining inequities • Role and interaction of stakeholders • Main challenges in policy • Mechanisms used for agenda setting e.g. research evidence, political pressure, external events • Critical factors that shaped the agenda setting process
2. Policy options	• How the issue of SDH/HI has been translated into priorities for action, i.e. gap, gradient, vulnerable groups approach or a mix of these • Translated into policy options – i.e. policies and programmes elaborated • Process and mechanisms through which the priorities and policy options were generated and tested • The stakeholders that were involved • The role they played • Through what mechanisms	• Factors that influenced selection of the main policy approach • Why this approach had resonance within the political, policy arena • Role played by key stakeholders in generating policy options • Mechanisms for generating and testing policy options • Role and function of MoH in developing the approach • Incentives for MoH and other sectors to develop the approach • Role played by other policy sectors
3. Managing implementation	*Implementing, maintaining and reviewing policy progress* specifically including: • mechanisms, stakeholders' processes and tools used including targets, indicators, incentives and or controls (i.e. legislation, standards), and the process by which these were decided; • challenges and opportunities in the political and policy arena that have either helped or hindered the implementation process over time; • how challenges and barriers were managed, i.e. processes, stakeholders and mechanisms.	• Issues and mechanisms for managing policy implementation over time • Factors that have played a critical role in keeping SDH/HI on the agenda • Lessons learned • Mechanisms for turning policy choice into strategies and programmes for implementation, e.g. incentives, targets, funding mechanisms research/evidence • Reasons and mechanisms for policy review and monitoring

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]
                            [providers of services, education, etc.]   [accessible & safe]   [supply & safety]