World Health Organization

Intersectoral action to tackle the social determinants of health and the role of evaluation

Report of the first Meeting of the WHO Policy Maker Resource Group on Social Determinants of Health, Viña del Mar, Chile, 27-29 January 2010.

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Contributors

This report summarizes and synthesizes the presentations and discussions of participants at the World Health Organization (WHO) Social Determinants of Health Policy Maker Resource Group Meeting on *Intersectoral action to tackle the social determinants of health and the role of evaluation*, which took place in Viña del Mar, Chile, in January 2010.

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Contents

Contents

List of Boxes

List of Figures

List of Tables

Executive Summary

Background

Thirty experts and policy makers, convened by WHO, met in Viña del Mar, Chile, in January 2010 to discuss how evaluation methods and systems could be improved in order to support intersectoral action (ISA) for tackling the social determinants of health (SDH). The meeting assembled experts from the ranks of the former Commission on Social Determinants of Health and its knowledge networks. In addition, researchers and policy makers with experience in intersectoral work, public administration, economic evaluation, and health promotion and formal evaluation disciplines were present. The scope of their deliberations and recommendations have implications for actors involved in the health sector, public sector reforms, research and in commissioning evaluations of development work.

Defining intersectoral action

Participants discussed the meaning of intersectoral action in terms of the integration of health considerations into the policies and work of other government sectors. Participants took the perspective that ISA for SDH differed from intersectoral action for health with respect to: a) its focus on an SDH framework of understanding health and the associated interventions; b) having as an ultimate goal to impact on health equity; and c) its focus on social participation as a key value and driver of sustainability. Participants were of the view that ISA should be evaluated both in terms of the processes involved, for both their instrumental and intrinsic values, as well as with respect to the particular interventions and their impact. Together, the processes and interventions were seen as constructing an incremental, iterative process by which health equity could be integrated into a greater number of policy areas, through increasingly more systematic governance processes.

Tackling structural determinants of health equity was noted as being the major challenge for intersectoral action for social determinants of health. It was noted that tackling structural determinants in particular needed a mode of intersectoral action labeled "integration", which required conceptualization of the policy problems and discussion of possible solutions prior to policy development.

Viability of ISA in government

It was noted that normal government processes are not facilitating intersectoral action in a satisfactory way for achieving social and health equity. It was also noted that policy catalysts promoting ISA for SDH tended to be a marginalized group within the health sector.

Participants indicated that it was necessary for more space to be created for systematic dialogues between sectors earlier on in policy development processes and well as for addressing power imbalances across sectors within government and across society. They identified the need for recognizing the dual political and technical nature of the changes required for better health equity governance. They observed how, currently, the health sector's approach to intersectoral action on or for SDH is frequently siloed, and how intersectoral processes for health equity are fragile. It was noted that "results-based" public sector reforms frequently ignored incentives for intersectoral action and thereby provided disincentives to intersectoral collaboration.

Participants discussed the range of evaluation methods and tools currently being used by policy catalysts working in different stages of ISA. These spanned tools generating strategic information to tools related to external evaluations. In general the use of informal methods and tools related to strategic information gathering were cited as more helpful and more needed by practitioners at this stage. The use of tools drawing on health impact assessment approaches were cited as being useful at different points in intersectoral processes as well as giving marginalized actors some "authority" given the wide international professional base from which it draws.

Building the evidence base from practice

In relation to evaluating the success of ISA for SDH, which is frequently built on case studies, a more accommodating yet rigorous approach is needed. This involves better definition of the topic area using typologies of ISA processes and SDH interventions. In practice, more rigorous methodologies need to be applied more routinely to evaluating processes. More rigor is needed in evaluating all parts of the causal chain, from the intersectoral process and its related tools, to the interventions and how they are implemented in different contexts and impacts on the determinants of health equity.

ISA for SDH as both a political and technical agenda was noted. From this perspective, the importance of the context and in particular, the welfare state and the extent of the drive towards universalism in other sectors (including health care) was noted. The dimensions of social participation, how governmental power is conceptualized, public sector administration systems and systems for managing knowledge and information, were cited as important dimensions of context and process evaluations. Evaluations of these dimensions may also assist in understanding what conditions need to be present to support intersectoral action. To illustrate the importance of knowledge production systems for ISA, the example of how the Quebec government uses a knowledge production system to impact on the policies of other sectors was discussed.

Evaluation methods and systems as ISA drivers

With respect to the evaluation methodologies used to evaluate policy options for particular sectors and promote action, several examples were cited on the use of economic evaluations, the use of theory-based evaluations and typologies, and the use of evidence from natural experiments.

With respect to public sector administration systems and donor funded evaluations, it was noted that these processes frequently did not provide conducive environments for intersectoral work.

One challenge outlined was for existing evaluation methods and systems to take into account the multiple benefits accruing from both the processes and the interventions, as well as the additional layer of complexity associated with benefits not being defined solely by specific sectoral interests. To deal with this complexity, several options were cited related to linking to development plans and overarching social and human development agendas and goals (e.g. as with the MDGs), and reorganizing governance structures around intersectoral problems. It was noted that additional intersectoral budgeting tools were possibly still needed to deal with sectoral based public sector administrations.

The fragility of the health equity agenda was also cited as requiring special evaluation techniques that explore relationship building and changing boundary partner behaviours. The characteristic of complexity was also noted as having implications for changing the "evidence" criteria being used to decide the worth or merit of interventions or tools. Traditionally, evidence gathering systems associate merit or worth in relation to the "gold standard" of randomized control trials. Participants discussed the need for more coherent international standards and systems for evaluating intersectoral processes and policies and overall strategies for SDH.

Knowledge gaps

Several knowledge gaps were cited as barriers to evaluating ISA for SDH. These may point to areas for further research:

- an "actionable theory" of how to galvanize action on SDH and sustain public policy processes in favour of health equity;
- a clearer understanding of the mechanisms by which different interventions in different socioeconomic contexts, different welfare regimes, and over time impact on health equity; and
- how to combine systematically the range of inter-disciplinary methods that are needed to understand the choice and impacts of different intersectoral strategies, processes and interventions and how to apply them in the policy setting. In particular the use of economic evaluations was cited as a much needed knowledge gap, but more work needed to be done on the exact economic evaluation methods best used.

Recommendations

Recommendations spanned several different themes. Using evaluation methods and tools to promote ISA on SDH was an important theme. It was suggested that a concept of a *prerequisite for intersectoral action for SDH* that could be readily used by health and diverse sectors might be a useful device to support ISA for SDH. WHO was encouraged to use its role as an honest broker to further the types of evaluation methods to be applied to ISA for SDH and for systematic sharing of practices, and in developing standards and tools for developing evidence for ISA for SDH. WHO needed to show the added value of new evaluation methods for ISA for SDH in planning and reporting frameworks for development and health policy processes; and to support confidence in the use of outcomes measures on the less material aspects of SDH like social exclusion, empowerment and autonomy through linking with existing global work in these areas. Promoting future scanning and predictive models based on associated micro-scenario simulations was also viewed as promising areas for future development. Finally, several capacity building needs were noted. In particular it was important for health sectors to be able to negotiate with other sectors, as well as to assist in the involvement of the intended beneficiaries of policies. It was recommended that WHO build capacity for evaluation by connecting existing assets for evaluation in both national and international contexts and by supporting greater harmonization in evaluation practices for SDH across the UN system.

Background

Articulating evidence-informed policy options plays a critical role in all WHO's work. This is particularly so in the case of stimulating action on the tackling the social determinants of health (SDH) to improve health equity. The WHO Commission on Social Determinants of Health (CSDH) (2005-2008) compiled a mass of evidence on how public policies ("interventions" e.g. labour, economic, social and welfare, education and child development, gender, urban settings, social exclusion, conflict) in a number of policy areas affect health equity. This has significantly boosted the existing evidence-base and impetus for action.

Persuaded by the CSDH evidence, policy-makers have signalled their commitment to take action through the World Health Organization's Governing Assembly Resolution on *Reducing Health Inequities through Action on the Social Determinants of Health*.

Policy makers and health managers around the world are interested in action on SDH - both within the health sector and to champion or promote the recommended "interventions" in other sectors. However, policy-makers are unsure of where to start, what processes to systematize, how interventions should be implemented in different contexts, and how this all adds up to social and institutional change for sustaining action on SDH.

There is therefore an urgent need to build an evidence-informed knowledge base for taking action. This requires a theory of how to promote, implement and sustain action - "an actionable approach", in addition to knowledge of how policy interventions are implemented. The Measurement and Evidence Knowledge Network of the CSDH had previously described successful action or implementation plans to tackle the social determinants of health as, "at a minimum [being able to]…support effective evaluation to ensure that learning from practice happens, in particular learning about the barriers and solutions to effective implementation (programme evaluation)." In other words, in addition to building the evidence base, evaluation capacity building offers one mechanism for advancing action on SDH.

This report is based on the meeting on Intersectoral action (ISA) to tackle the social determinants of health (in order to improve health equity) and the role of evaluation, held in Viña del Mar, Chile in January 2010. It contains key messages and examples from countries, drawn from the presentations of leading participants. They were asked to orient their contributions around a list of organizing questions developed jointly by the Organizing Committee (see Annex 1). The presentations are summarized in a narrative according to key subject areas.

The aim of this report is to provoke and support more systematic thinking on how to strategize, implement and learn from ISA on the social determinants of health. It is also intended to provide support to WHO programming on SDH within Strategic Objective 7 of the Organization's work plan.

While elaborating a full actionable approach for SDH went beyond its remits, the meeting began to scope relevant themes and knowledge, which will contribute to this understanding, with a particular focus on *intersectoral action for the social determinants of health*.

The meeting was jointly organized by WHO headquarters, technical counterparts in the Regional Offices of Europe and the Americas, and collaborating partners on the work on intersectoral action from the Public Health Agency of Canada and the Ministry of Health, Chile. Participants (see Annex 2) were invited because of their previous work with the Commission on Social Determinants of Health, their involvement in the emerging field of Health in All Policies, expertise in evaluation, and in their capacities as being active in country processes for tackling SDH.

1 Presentations

1.1. Intersectoral action, SDH and the policy context

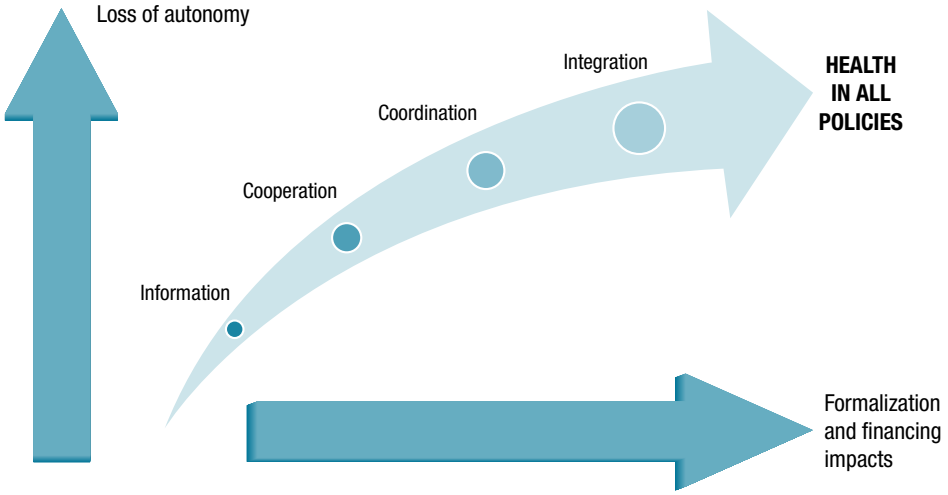
1.1.1. Modes of and strategies for ISA

Orielle Solar discussed what differentiates ISA to tackle SDH from ISA for health. One different element is that in using the CSDH conceptual framework, ISA is characterized by having social or health equity as a goal rather than "the average level of health". The understanding of an SDH framework for interventions also distinguishes between tackling structural determinants of social inequities versus interventions addressing intermediate exposures and vulnerabilities. A third element is the need to incorporate social participation in interventions and intersectoral strategies. Social participation was distinguished by degree of influence disadvantaged groups have in decision-making processes, ranging from being informed, to informing, to having power over decisions made.

The three elements of ISA, health equity and social participation (empowerment) were discussed as being both important values as well as important areas for the development of implementation mechanisms and knowledge. This characterization lifts ISA for SDH from being solely about the technical efficiencies of joined-up government in providing inter-disciplinary solutions for complex social problems to including the distribution of power and power relations across society and government.

The presentation highlighted the usefulness of distinguishing across different practices or "modes" of ISA as they would be associated with different contextual opportunities, social issues, and resource needs. Literature from environmental policy and public administration fields had differentiated ISA according to a sector's loss of autonomy and increasing formalization of the relationship and financing. These "modes of collaboration" were characterized as information sharing, coordination, more formal cooperation and, finally, integration. This last mode would facilitate the achievement of health in all policies, the highest degree of collaboration among sectors for health and well-being and the most desirable form of governance for health. In this final step health considerations contribute to framing new policies as opposed to solely being involved in solutions, and generally, policies are formulated in terms of quality of life and well-being.

FIGURE 1 Different modes of relating to other sectors (presented by O Solar)



The second issue covered was mechanisms for ensuring the success of intersectoral action both in a single iteration, for example, for a particular issue, as well as over time and scaled up and institutionalized (the latter referred to as "ISA strategies"). These mechanisms needed to attend to influence over sectors (policies, strategies, plans, etc), budget /financing integration, and sustainability.

Finally, two sets of strategies for employing ISA in the pursuit of integration were highlighted. One set was based on opportunism: using windows of opportunity that may relate to: (i) administrative planning processes (e.g. national strategic plans); (ii) current issues (e.g. sustainable development); (iii) outside pressures (e.g. indigenous rights); or (iv) public health conditions (e.g. HIV/AIDS, TB). A second set was distinguished by the use of public sector management strategies, which by their very nature provided an integration force, namely through: (i) strategies for integrating needs found in particular geographical areas or jurisdictions; (ii) strategies related to particular vulnerable groups; and (iii) strategies transcending needs of a particular sector, e.g. nutrition.

1.1.2. Making ISA viable in the modern state: core features of ISA

Nuria Cunill developed the theme of what makes ISA *viable* in the modern state. Her work over several decades in Latin America has shown that major obstacles to ISA have been associated with differences in power and divergence of interests - whether only in appearance or in reality. Essential strategies for dealing with this relate to *developing trust* and *joint planning*. For creating trust, the establishment of permanent rather than sporadic discussion forums was an essential pre-requisite. Without prior commitment to this, ISA should not be embarked upon. Joint planning processes too are important because they not only create the possibility for influencing other sectors, but also because they offer a means of balancing power differences. A negative example of how this criterion is not applied in ISA, but commonly seen across countries, is the establishment of intersectoral committees for developing intersectoral work *post* design of specific sectoral policies.

Joint implementation processes were also found to increase the successfulness of ISA and are necessary if ISA is to be wholly effective. In some countries, this is brought about through the creation of new government accountability mechanisms focussed on social problems/solutions. In other cases, at the very least, service delivery networks need to be designed around the family or around geographical areas. Linked to these organizational structures for implementation are the necessary financial accountability arrangements.

Currently, many Latin America countries are introducing state reforms to improve efficiency based on results-based management principles that include evaluation frameworks emphasizing sectoral-based incentives, the privatization of benefits for individual citizens and sectors, and quantitative measures and targets. These approaches exacerbate competition between sectors, transfer risk to citizens, and make ISA more difficult. It should be feasible to have evaluation systems that include the sector's contribution to social change and equity and which acknowledge intersectoral collaboration, as is being demonstrated in some local government settings in Brazil, but this requires political will.

Citizens' participation was identified by *Nuria Cunill* as a key element. From the experience of ECLAD, it was insufficient to have citizen participation at the functional level only, according to a particular interest issue (e.g. children). For successful ISA, citizen representation by geographical area was an important integrating force on the development and implementation of intersectoral policies.

Finally, training was highlighted as a frequently omitted yet essential aspect of any intersectoral action strategy. It is required in order to change organizational and sectoral cultures, which have created the rules of the game and the very values which encourage fragmentation of policy-making and services.

Heather Fraser summarized what had been learned from case studies of ISA experiences in 18 countries, based on the case study synthesis commissioned and published by WHO and the Public Health Agency of Canada in 2008. *Ms Fraser* then went on to describe Canada's experiences with implementing this agenda (see the country section for this part of the presentation). Key learnings highlighted from the 18 country case studies were:

- ISA has many forms and has operated at and between many levels of decision making;
- ISA to address complex social problems required framing issues broadly to ensure buy-in and for all sectors to see their role;
- values and mechanisms related to shared decision-making built the strongest case;

- although not systematically evaluated all intersectoral initiatives attributed some positive outcomes to ISA;
- the role of the health sector has successfully varied from supportive to leadership according to extent of direct influence over the health determinant in question;
- partner relationships took time but this time permitted better understanding of each other's contributions, service gaps and barriers;
- there was a lack of systematic evaluation and accountability mechanisms and tools for intersectoral action.

1.1.3. The importance of the welfare state context

Carlos Muntaner described how the existing political and welfare state context influenced the likely choice and success of intersectoral interventions/policies. In his factor analysis of over 100 intersectoral interventions across more than 25 countries and jurisdictions, interventions were classified according to two bivariate criteria – the target population (universal or targeted vulnerable group) and the number of determinants involved (single or multiple determinants and sectors). (Box 1 shows how interventions can be classified according to whether they strategically target just one determinant (across 1 or 2 sectors) or several (across multiple sectors) and the target population.)

BOX 1 Different categories of intersectoral interventions varying in prevalence by welfare state contexts (presented by C Muntaner)

Evaluating the effectiveness of intersectoral policies- the "synergistic" effect

Characteristics Target population	Comprehensive (participation of all relevant sectors)	Focused (intervention on key determinants of health)
Universal (enhance the health of the general population)	Enhance the health of the general population throughthe participation of all relevant sectors	Enhance the health of the general population through the intervention on key determinants of health
Targeted (improve health equity by focusing on vulnerable population)	Improve health equity by focusing on vulnerable population through participation of all relevant sectors	Improve health equity by focusing on vulnerable population through the intervention on key determinants of health

His analysis indicated it was likely that universal intersectoral interventions involving more than one sector or determinants would successfully arise in political traditions with strong welfare states and where human rights are advanced as social entitlements.

Muntaner's findings pointed to the fact that it was likely that ISA for SDH benefited from "synergistic" effects of egalitarian policies from different sectors (health, labour market, social services). This accounted for some countries having several examples to showcase while others have nothing.

Another insight shared was how combining and sequencing different interventions over time can be a successful strategy in reducing health inequities. Finland was an example of how targeted ISA interventions began in the part of the country with higher mortality rates of coronary heart disease (North Karelia) and were made universal thereafter enabling a reduction in health inequities. Based on these preliminary findings, it was recommended that it would be important to put more effort into documenting and evaluating what intersectoral interventions and strategies for sequencing interventions are more successful in different contexts and why.

Margaret Whitehead's presentation also focused on the policy context for SDH interventions but adopted a different focus and methodological approach. *Prof Whitehead* focused on how, when the policy issue is identified by politicians and policy makers, researchers can think through the impacts of interventions in different contexts and define an intervention clearly to facilitate like-with-like comparisons for effectiveness.

The example of return to work policies and interventions was selected as a case study for a "typology" method (which is one approach recommended in the evaluation of complex interventions (Sheppard et al. 2009)). She highlighted how "contrasting macro-level policies in different welfare systems act as natural policy experiments."The typology approach needs to be used alongside cross-country comparisons; within country time series information; and the analysis of policies and legislation.

The policy problem for both health and broader government was framed in terms the importance of work to diverse sectors: how "work is the glue that sticks our society together". Employment is an important determinant for an individual's health and inclusion in society, but also for society as a whole - 6% of the OECD working-age population was on disability benefits in 2007 with such benefits amounting to 1.2% of GDP on average. Employment rates among people with disabilities are much lower than for people without disabilities (40% versus 75% across the OECD). Policy-makers ask which policies and interventions help chronically ill and people with disabilities to return to work, and which help reduce social inequities in return to work chances?

The example drilled down into the mechanisms by which specific features of context influence the implementation and impact of the interventions to make the point that no two interventions are exactly the same - they are always altered to some degree by context.

The specific features of context examined were:

- the macro-economy (what happens in times of increases and decreases in economic production);
- labour market policies (its flexibility, social security provisions, and active labour policies); and
- the social welfare system influencing who is classed as sick, who receives benefits.

In order to construct a typology to evaluate interventions that are necessarily altered by context, it was essential to describe all interventions according to:

- the perceived problem;
- the programme logic;
- the impact and its level (individual or work environment) and scale;
- the impact of context on their implementation with respect to social and health equity; and
- and any unintended consequences.

Interventions from different countries could then be grouped according to the driver behind the program logic in order to more easily compare like-with-like when reviewing impact information, that should also use qualitative information from qualitative studies to provide incites on any unintended consequences.

Using this approach, the example of return to work policies and interventions resulted in an intervention typology of eight categories:

(i) legislation against discrimination;
(ii) workplace and employment accessibility;
(iii) financial incentives to employers;
(iv) enhanced return-to-work planning;
(v) financial incentives/disincentives for welfare claimants/long-term sick;
(vi) individual case-management and job-search assistance;
(vii) education, vocational training and work trial; and
(viii) medical rehabilitation and health-condition management.

In summary, evaluations of possible policies and interventions options should take into account at least the macroeconomic context, the welfare state context, and how these affect the implementation processes of the interventions. The framing of the problem and the intervention logic are key tools to unpicking the various components of policy and intervention implementation and their impact.

1.2. Evaluation orientations, methods and tools

In the first part of the meeting, participants had presented on intersectoral action – "what is it?" – intersectoral action for the social determinants of health. Its goal was identified – in line with the CSDH conceptual framework – as being social and health equity, the interventions were identified as complex and largely (for structural determinants) in the domains of other sectors; the strategies for implementation were identified as needing to draw on technical and political processes and mechanisms, and an understanding of state institutions, power balances and reform, and strategic entry points. The impact of context in all these spheres was elaborated upon. At this point in the programme, the group turned to discussion centred on formal evaluation frameworks, methods and needs expressed by policy makers.

1.2.1. Overview of evaluation theory

Sanjeev Sridharan opened the discussions with a presentation on the formal evaluation literature. Two definitions of evaluation presented were:

> "…a means of assessing performance and to identify alternative ways to deliver"
> "…the systematic collection and analysis of evidence on the outcomes of programmes to make judgements about their relevance, performance and alternative ways to deliver them or achieve the same result."

The purpose of evaluation was alternatively described (from Mark, Henry and Julnes, 2000) as:

- assessing merit and worth (usually answering causal questions through RTCs, observational studies and also referred to as substantive evaluation);
- programme and organization improvement (usually referred to as formative evaluation);
- oversight and compliance; and
- knowledge development (much neglected).

It was noted that in the case of ISA for SDH, the interventions prescribed or recommended were complex. Complex interventions are characterized by:

- being non-linear but history/path dependent;
- with multiple goals;
- embedded and shaped by social context;
- governed by feedback and change during implementation through learning as stakeholders themselves learn; and
- subject to policy resistance from the system itself.

It was further noted that as ISA in terms of the process to promote integration of health into all policies is itself an intervention, so is the act of evaluation an intervention and one which can assist in the process of ISA on SDH, or detract from it.

The presentation then went on to cover a 10-point checklist for designing an evaluation:

(i) what are the elements of the intervention(s) and how stable or complex are the interventions?
(ii) what is the "programme theory"?
(iii) does the evidence base and synthesis support the programme theory?
(iv) what is the anticipated timeline of impact and trajectory (some studies showing worsening before improvement – the j-curve phenomenon)
(v) why would the evaluation make a difference – what is the framework of learning and what are the pathways of influence – in particular of importance for social change and complex interventions – it is not about any final report which would arrive too late in most cases to have the desired impact on practice;
(vi) connecting evaluation design to programme theory and framework of learning, leveraging innovative methods, and paying attention to the policy landscape;
(vii) learning about intervention (programme or policy) theory;
(viii) learning from methods;
(ix) framework of spread;
(x) framework of sustainability.

1.2.2. The contribution of economics to evaluating ISA for SDH

Peter Smith presented on the use of economic evaluations. The presentation underscored the key advantage that economics brings to this agenda. This was framed as economics as having in common with high level politicians their concerns with respect to questions of who gains and who pays. It answers these through focussing on individuals, the incentives they face, they constraints they face and the outcomes that are achieved for them.

A first example was an evaluation of the use of incentives to reduce waiting times in the UK by 2008. This illustrated the impact that incentives could have on implementing policies. It also showed how in some cases, the incentives had unintended consequences, sometimes more related to the way targets were formulated than the actual policies and interventions themselves. This said more about the way the targets were formulated than about the actual policy and incentives.

A second example illustrated evaluation of a more complex topic - reduction in the year-on-year rise in child obesity in England. The target was held jointly be three ministries (culture/media/sport; education; and health). The National Audit Office found that the range of initiatives was being introduced in an uncoordinated manner by relatively junior officials across the three ministries. These initiatives were not based any evidence that they would result in children eating healthier, nor on cost-effectiveness evidence but on the belief of co-benefits beyond health and obesity. But the key issue hindering progress was the question of who pays?

A third and final anecdotal story regarding the repair of an elevator was made by way of comment on the issue of complex interventions. It illustrated that while many of the interventions might be costly and complex, it might be quite simple details which made them successful.

In relation to the specific tools economics has to offer, while cost-effectiveness has proved very useful for simpler interventions within the health system, for more complex interventions the use of cost-benefit analysis was highlighted. Within this context, Professor Smith stressed that equity was an outcome of interest to economists already, but that it would be more feasible to build the evidence base across studies if there were more standardizations in the categorizations. The use of micro-simulations could also be a specific approach to cost-benefit analyses. These are currently being used to model the impact on individuals of change in taxes or income. They require research evidence on how households or groups of household respond to policy changes. Also, a detailed analysis of the intervention logic to inform transferability of interventions will be facilitated by having case studies and evaluations that include documented information on context and implementation process.

Peter Smith then went on to highlight the following areas for evaluation beyond the equity outcomes of the intervention:

- to evaluate the impact of the changes we are making to our governance systems and enabling learning from that;
- to be sharper about attribution - what specific aspect of the intervention is success attributed to?
- to get better intermediate indicators of success that are good enough so that we don't have to wait for 25 years or more to observe changes in health outcomes.

Finally, Professor Smith emphasized that the one big lesson from economics for intersectoral processes and interventions and their transferability was always to consider the use of *incentives*. Analyses conducted as part of the Audit Commission in the UK, which audits and helps improve local public services, found that frequently partnerships were not working well - people were involved because they were told they had to be and their engagement was often deflecting from the ultimate goals. A great amount of thought needs to go into what binds different partners or sector together. A second issue relates to accountability incentives. Very often governments fail (just as markets fail), and partnerships and collaborations may continue without proper challenge. This is why the accountability arrangements need to be a critical component of any evaluation. Whereas a key role of the state is to collect taxes and redistribute wealth from rich to poor, it is not obvious from economic theory that the state should be providing many of the services it funds. A last critical point related to the evaluation and design of intersectoral interventions is how they provide incentives to individuals to change behaviours impacting on health.

1.2.3. Qualitative interviews on practices, tools, and gaps

Rene Loewenson reported her preliminary findings from a qualitative study which is being conducted for WHO. She was commissioned to conduct in-depth interviews with actors involved in different types of global, national and local intersectoral work on SDH and to synthesize related background information. Key issues being raised in the interviews were: (a) how is progress on ISA for SDH being evaluated; (b) how is evaluation being used; (c) what learning or resources could be shared; (d) what were the challenges and gaps? Actors interviewed thus far at the global level came from WHO departments of healthy environments and nutrition, and UNAIDS "combination prevention"; at the national level, from Norway on integrating SDH across all policies and from Canada on studies done on governance tools for health in all policies; at the local level from California, a centre for civic partnerships supporting municipalities part of the healthy cities network. All actors were working from a health background but using an "upstream", social determinants framework and were trying to take advantage of windows of opportunity to bring about or consolidate change. Generally they expressed being quite marginalized/siloed within the health sector itself.

The evaluation framework *Dr Loewenson* presented had three focus areas and interviewee responses were summarized in relation to these:

(i) conceptual frameworks evaluation - how well are we thinking?
(ii) internal performance evaluations- how are we doing? and
(iii) development results - what difference are we making?

In terms of conceptual evaluations, interviewees were mostly interested in evaluation to know which governance approaches to use, and the conceptual theories in the domains of organizational change, creating different mandates and dialogue mechanisms. Generally, they reported little interest in using evaluation to build knowledge for conceptual theories on what impacts SDH. They saw the role of actors as bringing about change, and they were therefore mostly interested in a second use of evaluation - "internal performance" - how well they were doing to bring about or "catalyse" change. They wanted to learn how to make the process happen. In general, they were measuring internal performance by asking questions about their daily work, such as: "Are our investment and spending patterns matching the socially-determined health equity patterns? How adequate and effective are the processes and competencies we are bringing to the table?" For evaluation of results, "what different are we making?", there was a concern with timeframes for showing results and an interest in profiling changes in determinants, rather than solely health outcome changes, provided the theoretical links to health were proven.

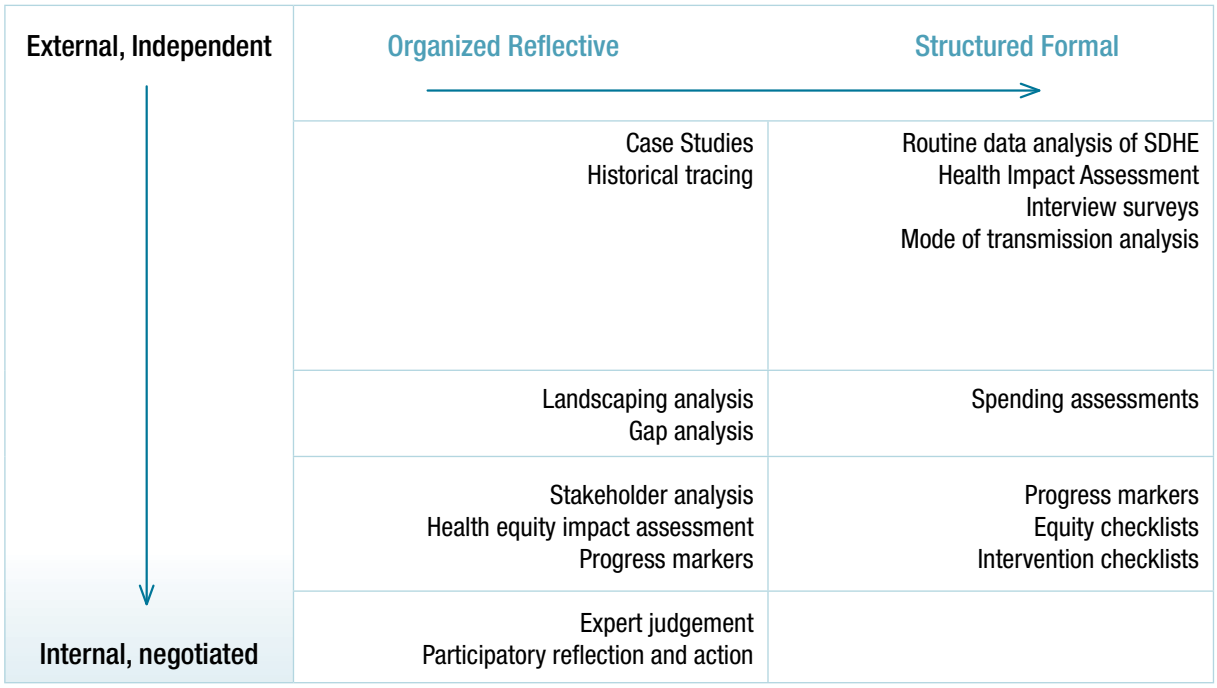
Concerns with conducting evaluations expressed by interviewees were:

- a lack of confidence with measures available on the less material aspects of SDH, such as social exclusion and autonomy;
- taking actions perceived as "judgemental", such as "evaluation", which may jeopardize fragile relationships being built and close down windows of opportunity. The process was described as involving removing individual rewards for individual sector and creating joint rewards for several sectors and that bringing evaluation in too early on may jeopardize progress. On the positive side, Norway had reported how health's use of disaggregated data and evaluations of socially determined health inequities had made a positive impact on another sector and acted to build relationships;
- the issue of cost for external evaluations was also raised by one group who had undertaken a large expensive external evaluation and wondered whether the money would not have been better used for their own struggling programmes.

Rene Loewenson displayed a mapping of various tools being used by interviewees to build knowledge as part of the processes they are involved in. These were described according to two characteristics - formality (on a notional scale from structured formal to organized reflective) and independence (external independent to internal negotiated). Overall, there seemed more of a need for tools that were internally negotiated and organized reflectively. Other specific points on tools were noted. From the interviews it became clear that the different tools are being situated in different parts of the process. For example, health impacts assessments and health equity assessments are being used upfront in strategic planning processes but then again to review progress. Often, action is initiated by organizing existing data and information on SDH to create awareness of the problem. In several cases, similar methods or assessment tools were being labelled with different names, which reiterated the concern with duplication and silos of tools being created. For example, WHO healthy environments used "health impact assessments" that looked similar

to the WHO nutrition "landscape analyses", which was similar to the UNAIDS "transmission analysis". All measured health situations and their drivers, and competencies for response. Case studies and historical tracing was being used to disseminate and explore information on what works across different contexts. Traditional interview surveys and expert opinion were being used to evaluate practice. Expert judgement and participatory reflection were being used to assess changes in processes.

FIGURE 2: Evaluation tools mapped from key informant interviews (presented by R Loewenson)



Overall, it was noted how the emphasis placed by interviewees on the role of catalysts in processes for change would be quite well supported by the evaluation approach offered by "Outcome Mapping (OM)" tools. Outcome Mapping, more so than traditional input-output approaches to evaluation, operates under the principle that interventions are by nature political and complex. It therefore focuses performance appraisal on behaviour changes in boundary partners (e.g. other sectors) and power shifts.

Several cautions were noted as strategic considerations for the development of new tools for evaluation of ISA on SDH:

- There was a need to avoid parallel processes and tools and encourage tools that support the learning that catalysts are already engaged in with respect to scoping, assessing, monitoring, reporting and reviewing. It was also noted how actors derive security from a tool that is internationally standardized, with practice and learning community around it, yet that can be blended with local tools and processes (like health impact assessment).
- Most interviewees reported having to play the role of "integrators" of theory, pragmatism and politics. To do this they are using tools and information that builds a common language. To measure progress they use proxies for indicators, building on social determinants, which are more accessible to other sectors, rather than health outcomes.
- Most interviewees are looking for networks of learning and sharing with boundary partners and others, using shared methods but which allow for experimentation for local contexts.
- Interviewees felt that their role was as catalysts but there was a concern that there was being created a silo of catalysts on ISA on SDH and wondered how to ensure they were integrated. The silo issue raised the question of how evaluation for SDH linked to evaluation efforts in other sectors and tools like OM.
- Finally, the informal way that information on ISA for SDH is being organized provides an opportunity for information brokers to make the information more widely available.

1.2.4. Evaluating ISA: comparing two cases

Francois Gagnon's presentation was based on a comparative evaluation of two intersectoral initiatives, with particular emphasis on how the strategies were conceptualized (evidence of theory - or how are we thinking?) and then operationalized with respect to their processes and mechanisms for engaging with other sectors. Both cases were from Canada and convened many sectors around goals to improve population health and well-being. The evaluation was based on the report by *Gagnon et al.* (2009), which was distributed as a background document prior to the meeting. The presentation began with a short summary of the two initiatives.

Beginning with ActNowBC, from the province of British Colombia, the initiative was described as coming from the premier, to use the 2010 Winter Olympics as an opportunity for coordinating provincial ministries, municipal public agencies and private partners "to support healthy lifestyle choices and reduce the burden of disease" (ActNowBC, 2006a, p1). The initiative's goals and targets did not specifically focus on health equity and the initiative was conceived of as having a limited life. The Ministry of Tourism, Sport and the Arts (MTSA) was made responsible for the implementation of ActNow BC, because of its expertise in marketing and business development and work related to sport. The MTSA set up a team that was supported by the Ministry of Health (on health promotion and population health assessment expertise) and the Public Affairs Bureau (for branding and communications in general). Financial support was made available for activities forming part of the initiative and participation was prescribed by the premier as was incorporation into their annual planning. Internal evaluations were conceived of as part of the process in order "to verify whether the implementation of programmes has been carried out according to plan; to provide an assessment of the changes brought about by the programmes; and to assess the adequacy of resource allocation and use".

Section 54 of the Public Health Act, tabled by the *Ministère de la Santé et des Services Sociaux (MSSS)* of Quebec province aimed to reform public health practice. It authorized the MSSS to give any advice to another sector related to the impact of their policies on population health and well-being as well as requiring other sectors to consult the MSSS in the development of an act or legislation as to its impact on population health and well-being. The implementation strategy by the MSSS included enhancing knowledge transfer about the healthy public policies (through inter-disciplinary research initiatives and strengthening national public health institutes) and an intra-governmental health impact assessment mechanism. The intragovernmental health impact assessment mechanism was facilitated by network of interministerial respondents; a procedure for processing requests; a series of analysis instruments and tools; and the distribution of information on health determinants (*Gagnon et al, p8).* A budget was made available to the Ministry of Heath and its partners to perform these functions.

In comparing the initiatives, it was noted that each intersectoral initiative operates according to different assumptions with respect to *governmental power.* It was postulated that when comparing the mechanisms used in intersectoral initiative, it was necessary to test the assumptions of governmental power. One school of thought views governmental power as "legal, constitutional and constraining". Citing the literature on a second main school of thought, it was observed that government was seen as not being derived from the top but from different levels of government - international, national, local - and quasi governmental agencies, and its ability to use all these resources towards policy ends[1].

The control mechanism adopted by ActnowBC's applied the former concept of governmental power. Consequently, control mechanisms emphasized agents including local government and the private sectors and on providing financial incentives. The mechanisms for Section 54 adopted the latter concept of governmental power and emphasized involvement of central state actors and using a policy evaluation system to constrain the potential negative impacts of acts and regulations emerging from other sectors.

Another important feature to analyse in this type of conceptual and process evaluation is the use of knowledge production systems to influence policies. ActnowBC's knowledge systems were based on supported existing practices that would contribute to the platform's objectives. The knowledge base of risk factors was implicit to the targets set.

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[1] "Flinders maintains…that the power of states to develop and implement public policies is increasingly dependent of forces working on them not only from "above" (think of transnational organizations such as the International Monetary Fund, for example), but also "from the side" (quasi-autonomous agencies—take, for example, the Société des Alcools du Québec (Québec liquor commission) or the organizations managing gambling in all Canadian provinces) and "from below" (such as regional public authorities - the Greater Vancouver Transportation Authority, for example)" (Gagnon p13).

In section 54, production of scientific and expert knowledge about links between public policies and public health" was emphasized within a framework more aligned with the social determinants of health.

BOX 2: Features of successful knowledge production systems (Gagnon et al. 2009, p17)

(1) To discern the availability of relevant, reliable and valid knowledge and document both the extent of the problem and the likelihood of links between public policies and the population's health.

(2) To lead to an understanding of the specificity of the social and cultural circumstances or contexts of these perceived relationships between public policy and population health.

(3) To provide an assessment of the political and social consensus (or social acceptability) surrounding the relationship between population health and the public policies being proposed.

(4) To lead to an appraisal of the availability, within the organizations concerned, of resources (human, intellectual, instrumental) allowing the knowledge produced to be used within the context of the development and implementation of the public policies concerned.

(5) To set up procedures so that the knowledge produced can be used by actors within the organizations involved in the development and implementation of the public policies.

1.3. Country experiences

1.3.1. Cuba's approach to ISA

Pastor Castell-Florit Serrate characterized the role of public health in improving the quantity and quality of life years of the population as centring around four technical strategies: models for changing behaviour, communication, empowerment and ISA. He described how the learning gained in Cuba on ISA and tools was developed over a period of decades from the 1960s to the present. ISA was defined as

> "interventions coordinated by more than one social sector, with actions destined to solve fully or partially problems related to health, well-being and quality of life".

ISA was implemented to take account of three groups of factors:

(i) determining factors that arise from problems that demand coordinated action from one or more sectors;
(ii) conditioning factors, given the policies, attitudes, and capabilities that the action requires;
(iii) triggering factors, based on technologies, directives, and work styles and methods that turn the action into a reality.

During their practice of ISA, Cuba had played special attention to technical tools related to methodological educational approach in ISA for medical qualifications, as well as practice-based instruments related to analysis and sustainability, and educative technologies such as books, documents, adult learning courses and other publications.

In their more recent experience, they had conducted studies to evaluate how ISA was being implemented. One study they had conducted and reported on in 2007 was aimed at understanding sustainability practice of intersectoral action in municipalities in Cuba. Key institutions relevant to the process were senior level bureaucrats at Municipal Administration Council and the Municipal Health Directorate. The study instruments dealt with the following factors:

- level of knowledge about ISA among players in the health sector;
- level of knowledge about ISA in other sectors;
- presence of ISA in the strategic objectives of the municipality;
- self-responsibility of the sectors regarding their role in health problems;
- presence of ISA in the administrative council;

- presence of ISA in the municipal health council;
- presence of ISA in the council of people's councils; and
- use of analysis of the health situation as the basis for projects and decision making.

The study results showed a growth in activities between health and other sectors as measured by formal agreements for joint work. Within the intersectoral initiatives examined, several lessons were highlighted for improvement, including closer linkages between national and local intersectoral work. Across specific projects it was noted that there was a need to improve the articulation of health targets, for each sector's responsibilities to be clearly delineated and more measures taken to facilitate interpersonal communication, and communication within health and sectoral partners.

1.3.2. Evaluation of health promotion and ISA in Latin American countries

The results shared by *Ligia de Salazar* came from a study undertaken by a network of evaluators in Latin America, with funding from the government of France, and commissioned by PAHO, IUHPE and CDC. The study was conducted through document review, field visits and expert discussions. The scope of the health promotion initiatives reviewed were generally quite narrow and were not engaged with concrete strategies for public policies, strategic alliances, advocacy and empowerment to balance power relations. Instead, the actual interventions focussed more on behaviour change.

Implementation practices in general were described as being a "black box" and proceeded without being based on sound programme/intervention logic. The way evaluators understood effectiveness varied, unintentionally, from case to case. In some cases, effectiveness was judged in terms of the decision-making process, in others, for the services providers, and in yet others, for the community. This points to the possible need for some common minimal criteria by which to judge the effectiveness of health promotion interventions. Other observations were that in general interventions were of short duration, and more about cooperation than integration, with insufficient resources and no legal or political backing to give them continuity. It could be said that interventions were health- sector based, and dependent on the norms of current health systems and the responsible actors' implementation capacity, with sector thinking, planning and execution governing them.

Overall, little attention was paid to having established the conditions for making interventions work, such as:

- a shared health vision;
- structures and processes to sustain social and political changes - in most cases, evaluation protocols only included traditional morbidity, mortality and risk factor indicators, and nothing related to the change processes that needed to be brought about to make the interventions sustainable;
- strategies for collective learning; and
- advocacy.

The summary comment on the study results was that "health promotion is in danger of becoming rhetoric and intention with little chance of success if strategies and effective concrete mechanisms are not created to influence the structural factors that impede or limit implementation."

1.3.3. Norway's experience of implementing a strategy for action on SDH

Janne Strandrud's presentation focused on the reporting system that Norway had established to monitor progress with the implementation of their strategy for action on SDH that was accepted by parliament and translated into policy by 2007. Two key dimensions of the reporting system are:

(i) to see it as a process and the corresponding organizational structure; and
(ii) the yearly publication of a Policy Review Report. This monitors progress on the main action areas of their social determinants strategy (income, childhood conditions, work and working environment, health behaviour, health services, and social inclusion).

The reporting system aims to measure the implementation and success of the strategy, to increase the awareness across sectors of social distribution of health, and feed back into future policies. To do this, the organizational

structure of the reporting system involves all relevant ministries and working groups related to each of the action areas. Commitment is anchored at the ministerial level. Interdepartmental meetings occur as do working group meetings. The process is governed by having synergy in ISA at both the ministerial and working levels and by having a determinants rather than a "health" perspective.

Experience in running the working groups has demonstrated the importance of:

- clear objectives and expectations;
- common ownership to both process and outcome;
- involvement and mutual exchange of relevant information;
- involvement of each other's data-elaborating processes;
- flexible and pragmatic structures; and
- core values: acknowledgement and mutual respect.

The role of the health system based on their experiences was also summarized in terms of varying depending on its placement regarding knowledge on effective interventions and the means to take action.

BOX 3: Deciding on the role of the health sector according to issue (presented by J Strandrud)

ROLE	WHAT ISSUES FOR WHAT ROLE?
Leader:	Issues where health has both the knowledge about effective measures and controls the means (preventive health services, equitable health systems)
Negotiator:	Issues where health has knowledge about effective measures but do not control the measures (health promoting schools, physical activity, health school meals etc.)
Partner:	Determinants of health where the health sector have knowledge about the adverse impacts of other sectors but where the health sector does not control the means for implementation or has the exact knowledge about how measures should be framed (labour market inclusion, reducing social inequities in learning in schools, etc.)

1.3.4. Canada's experience of implementing a strategy for action on SDH

Heather Fraser described Canada's strategy for tackling problems of equity. In 2007, PHAC established the Strategic Initiatives and Innovations Directorate, which leads PHAC action on reducing health inequalities and addressing upstream determinants. A key inter-disciplinary and intersectoral working group they convene, which started out as part of Canada's work under the Commission on Social Determinants of Health, is the Canadian Reference Group on Social Determinants of Health (CRG). *Ms Fraser* indicated that she hoped the knowledge from this meeting would facilitate evaluating the progress this group was making.

Priority issues for this group include poverty reduction, indigenous peoples, and increasing awareness and understanding of SDH and health inequalities. This group also advises on efforts to develop formal federal-level horizontal collaboration mechanisms to support ISA for SDH across these various spheres in Canada. In their development process for this federal level mechanism, the Agency, with the help of this Reference Group, had identified several "must-do's" for this mechanism to work properly. These are:

- secure senior-level support;
- link mandate to broad social justice agenda;
- articulate role of diverse sectors;
- define holistic mandate and objectives;
- develop co-ordinated accountability mechanisms;
- connect objective to department priorities;
- utilize central secretariat and accountability structures;
- engage vertical and external support (i.e media, NGOs);
- find appropriate mechanisms to pool and align funds; and

- determine funding and resource commitments early.

Ms Fraser described in some detail the poverty-reduction strategies that are being developed and implemented at the provincial level in six out of Canada's 12 provinces and their evaluation approaches. The poverty-reduction strategies have inter-ministerial committees that facilitate planning and implementation. Two out of the six provinces have mechanisms to ensure coherence in the form of a Social Prosperity Framework. All six provinces have monitoring and evaluation strategies but of these only two have included non-income social determinants measures (e.g. birth weights, standards of living). Other accountability and evaluation measures being used included annual reporting and standard bureaucratic accountability mechanisms.

Areas that remain challenging for PHAC relate to fostering political will, understanding how and when to take intersectoral action,and monitoring and evaluating it. Making the economic case for SDH interventions is also a priority area for the Agency's future work.

1.3.5. Spain's update on plans for the EU presidency and beyond

Begona Merino and Pilar Campos briefly outlined some of the research, education and policy initiatives undertaken in Spain on SDH over the past two decades. They highlighted a number of important process steps undertaken more recently since the establishment of the WHO Commission on Social Determinants of Health. In 2008 the General Directorate of Public Health appointed a National Experts Commission on Health Inequities to propose interventions to reduce inequities (short, middle and long-term). In 2009, having conducted a review of all European and national policies on health inequities, this group proposed 152 interventions, with 52 prioritized for the health sector. Specific action plans were being developed in the identified areas. Spain had also provided funding to WHO for follow-up on the CSDH Report and was contributing to on-going related work on the European Union agenda, in particular setting the scene for the report on the European Union's role in global health. In the run-up to the meetings on SDH being convened as part of Spain's EU presidency, several activities were well underway. Key outputs related to:

- the report *"Moving Forward Equity in Health: Monitoring social determinants of health and the reduction of Health Inequalities"*, and
- the Conclusions on *"Equity and Health in All Policies"*.[2]

[2] Approved last 8th June 2010 in the Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) Council of Ministers. With these conclusions the Directorate General of Public Health and Foreign Health of the Ministry of Health and Social Policy has contributed to efforts, from a global perspective, to integrate **health in all sectors** to reduce health inequities. See Annex I of the document and in the webpage of the Council of the European Union: http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/en/lsa/114994.pdf

2 Synthesis findings

2.1. Defining and constructing intersectoral action

"We talk about intersectoral action but quite a lot of our questions are about integrating health into the actions of other sectors…"

"We need to focus on what it is specifically for addressing social determinants of health and health equity. We're not talking about intersectoral action generally."

"There are different degrees of intersectoral action, ranging from information sharing to integration. So one of the critical questions raised was what kind of intersectoral action is needed for a specific problem. And that may vary with the problem. There were issues about clarifying the underlying value base of intersectoral action. Because it's not a neutral action; it has a value in itself…"

Participants' words, Viña del Mar, 2010

1. Participants at the meeting explained how ISA is not a well-defined concept. They elucidated a clearer understanding, as was done in *Leatherman et al (2010)*, through focussing on the characteristics, aims and principles associated with undertaking ISA. Core agreement was reached in terms of:

   - they noted that not all practices of intersectoral action were aimed at tackling social determinants of health and improving health equity;
   - framing the concept as integrating health equity concerns related to the social determinants of health into the work of other sectors, and hence the phrase, *intersectoral action for addressing the social determinants of health to improve health equity*, or intersectoral action for or on the social determinants of health, was coined;
   - the term "sectors" referred to *economic or policy* sectors rather than *social* sectors (referred to as social participation) or *levels of government* (referred to as vertical integration of government);
   - social participation was a key dimension of any ISA strategy for SDH. Different degrees of social participation required for sustaining ISA were discussed, ranging from information sharing to real involvement in decision-making.

2. *Intersectoral action on the social determinants* of health was discussed in terms of not being "usual" government practice.Yet there is a necessity for ISA due to increased complexity of social problems and to ensure orientation of the state and its bureaucracy around the needs of its citizens.

3. Obstacles to ISA were discussed with reference to:

   - barriers present in current organizational configurations of public administrations e.g. through some variants of results-based management reforms to the public sector;
   - power battles across government cabinets;
   - powerful interest groups against the political and redistributive agenda associated with improving health and social equity;
   - the evident successes of usual "siloed" government (e.g. evidenced by road networks, housing, schools etc.); and
   - the disciplinary organization of professional training.

"The complex nature of societal problems has fuelled arguments that such issues can only be addressed by holistic responses which are informed by high-quality policy, practice and techno-scientific research." (p290)

"….Manicas has argued that the establishment of modern disciplinary boundaries was driven by the twin forces of .professionalization and scientization. Professionalization impelled the formalizing of institutional spaces within which specializations could be developed. Scientization, in the social sciences, forced adoption of language from the physical sciences in order to bestow authority and legitimacy on these nascent disciplinary demarcations (Manicas 2007, 7.8)" (p291).

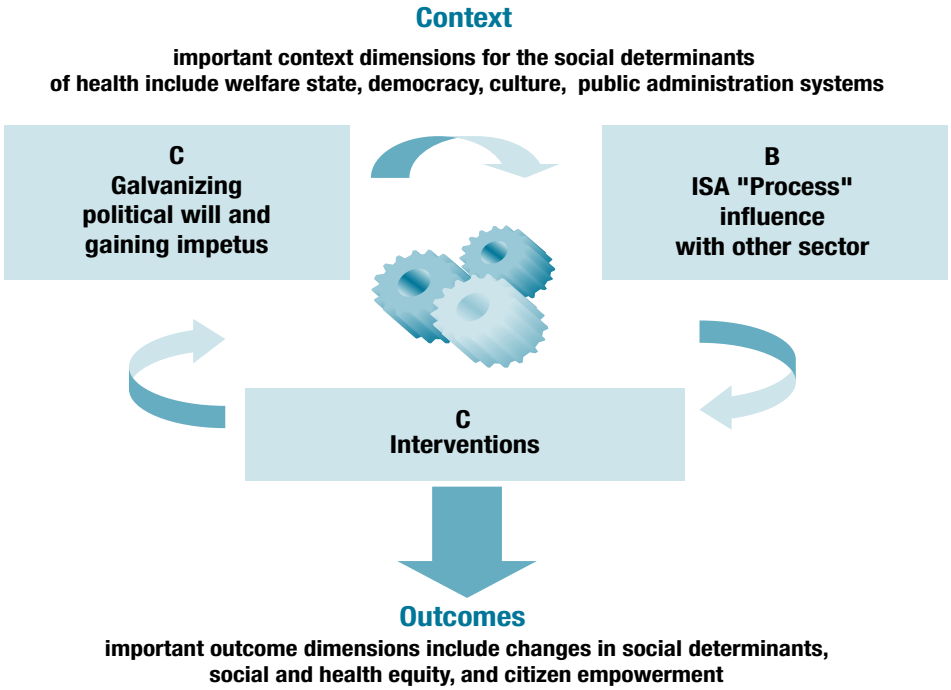
Philip Catney and David N Lerner. Managing Multidisciplinarity: Lessons from SUBR:IM. *Interdisciplinary Science Reviews, Vol. 34 No. 4, December, 2009.*

4. A question was raised as to whether, in addition to instrumental values, ISA was valued for intrinsic reasons. Some reasons why it might be so were offered. These were related to the promotion of social inclusion and solidarity; and the potential intrinsic value of promoting inter-disciplinary problem solving[1].

5. The political, economic and cultural context influences the success of ISA strategies and interventions for social determinants of health. Constructing successful ISA strategies for SDH necessarily imply actions towards strengthening the welfare state, universal coverage, and citizen's values related to social solidarity to maintain universality.

6. This led to a discussion of the political context and nature of ISA for SDH, in addition to its technical features. Given this inherent transformative agenda, current health sector initiatives for ISA on the social determinants of health were described as fragile. Building sustainability and spread (e.g. starting with one intersectoral intervention and multiplying to several interventions and a system of government favouring "integrated" problem solving) was highlighted. This was seen as consisting of nonlinear, iterative, processes that could be characterized by the following stages portrayed in relation to "context" in figure 3:

FIGURE 3: Key components of intersectoral action strategies for tackling SDH



[1] The literature on interdisciplinarity suggests that it potentially takes one of three forms: *Multidisciplinary:* disciplines retain their autonomy, with little attempt to synthesize theoretical/methodological approaches. The tendency is for research to be based around a theme, rather than to be directed at problem solving. *Interdisciplinary:* researchers seek to form a uniform, discipline-transcending terminology or common methodology and to cooperate within a common disciplinary framework. Greater focus is given to addressing cross-cutting problems, though work still retains aspects of disciplinary concerns. *Transdisciplinary:* research is based on common theoretical understandings and accompanied by a fusion of methodologies and epistemologies/ontologies. It is solely focused on developing solutions to problems rather than disciplinary concerns." (Klein 1990; Knights and Willmott 1997; Raco and Dixon 2007, quoted in Catney, P, Lerner, DN (2009))

A. **Galvanizing or increasing political will or gaining impetus** (related to windows of opportunity) – this may come about through linking to an important issue, a particular vulnerable group, existing public administration reforms, political agendas of senior politicians, or opportunities created through civil society and other forms of pressures related to human and civilian rights.

B. **Sustaining effective processes for influencing other sectors and the related mechanisms.** This refers to the importance of running good processes and building relationships with diverse sectors. It brings up the mode of ISA, the role of health and how health builds towards institutionalized mechanisms for integration of health issues across government. The public administration literature and associated country studies show how ISA cannot be constructed without the political commitment and capacities to maintain *forums of dialogue*. Generally, efforts that have linked intersectoral processes to joint planning processes have been more highly rewarded. The likelihood of failure has been shown to be higher when intersectoral processes are set up to include health *after the design of policies.*

C. **Designing and implementing interventions.** This refers to the policies, programmes and services themselves that are created as health equity enhancing measures. For recommendations on interventions for SDH, see the CSDH Report, Closing the gap in a generation (2008). The co-existence of universal policies tend to reinforce oneanother. Both the welfare state and its historical context were described as affecting the extent to which interventions focused on more structural social determinants and the nature of interventions themselves. For the latter, while being labelled similarly (e.g. return to work policies), by virtue of differing socio-economic and welfare state contexts, interventions most often differ in how they are conceptualized and in real implementation. This requires typologies that unpick both context and implementation practices.

Grey areas and gaps

7. From a research perspective, the lack of a clear definition of ISA and its key components hampers the ability to research and evaluate ISA. Identifying the different modes of the health sector's relationship with other sectors could potentially shed light on the role and expectations of the health sector. At any point there is a range of options for health in their engagement with other sectors, which may vary with opportunities in the environment. Similarly, better understandings of how to describe welfare state and other dimensions of process context and its impact on how to evaluate intersectoral strategies, processes and interventions are important.

8. Participants declared that the focus on addressing the social determinants should not imply the necessity of direct engagement by the health sector with all other sectors. Any definition of ISA for SDH should clearly shed light on what type of ISA was needed in what circumstances and when sectors were aligned to higher social goals.

9. Also important was how the health care system and health care policy itself could act as a social determinant, in particular through financial impoverishment, and how working towards universal coverage within the health system could make a "synchronicity" contribution to policies for tackling other SDH.

2.2. Linkages between ISA and evaluation methods

"Evaluation is defined both as a means of assessing performance and to identify alternative ways to deliver"

"putting evaluation in the context of processes that are quite affected by wider phenomena."

"Es necesario tomar decisiones basadas en información suficiente para actuar, aunque insuficientes para satisfacer el intelecto. Es decir, posiblemente no tengamos toda la información que necesitamos, pero al menos aquellas con las cuales podamos hacer decisiones informadas en ese sentido; finalizo diciendo que la evaluación no es solamente un instrumento técnico, sino un instrumento político, y uno de los más poderosos, si nosotros estamos claros qué evaluamos y qué hacemos con los resultados de la evaluación."

"scoping and scanning and stakeholder and force field and so on goes well beyond evaluation. It's about initiating action as well as assessing it, etc. So we saw a much wider scope of things and especially when it's in strategic planning"

"nuestra visión es que la evaluación ha sido un mecanismo para promover el cambio"

"We need to clarify the scope of what needs evaluating and the issue of whether we are looking at macro-policies, not just focused interventions"

"evaluation itself is an intervention. That's what struck me. Evaluation itself is intervention."

Participants' words, Viña del Mar, 2010

1. Participants found the term «evaluation» to be problematic.

   - it was potentially threatening, noting that governments do not in principle like the term because it is usually associated with «external evaluations», which usually point out weaknesses in their policies or use of resources. The term was also seen as potentially harmful if used where ISA for SDH was being encouraged in countries due to the fragile partnerships being created by health actors for SDH. The process of initiating action as well as assessing it, in particular when part of strategic planning, consists of cycles of review and reflection and action and using evidence rather than just events with endpoints and evaluations.
   - the term could be confusing, as different disciplines frame the way they understand problems and successes differently.

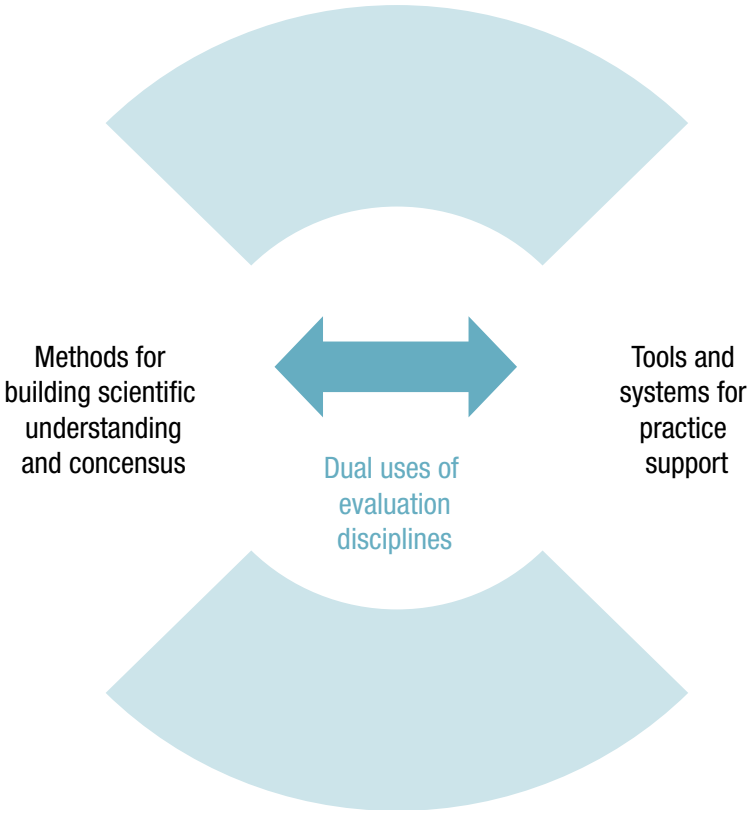
2. Participants embraced a broad definition covering activities related to «generating and managing knowledge» for moving forward ISA on SDH. They agreed that widely-accepted evaluation methods, tools and systems which practice these can contribute legitimacy to ISA on SDH.

3. The evidence base, arguing the case for ISA on SDH and ISA processes could be strengthened if there was of stronger, interdisciplinary body of knowledge on how to evaluate ISA for SDH as well as tools for practice. The areas of the ISA touched on were relate to (in no particular order):

   - building relationships;
   - showing progress relevant for other sectors processes or to advance dialogues;
   - showing the added value of health to other sectors;
   - showing progress relevant to managers and promoting learning;
   - identifying intervention/programme logic and the use of incentives in the construction of processes this logic (political, administrative, or individual);
   - identifying cause of change/solution theory;
   - identifying key elements of design that can mean success or failure;
   - adjusting intervention dimensions to context and implementation realities;
   - improving implementation;
   - linking back to intersectoral integration processes;
   - checking scale and unintended consequences (externalities);
   - helping with frameworks for document processes and costs.

4. To clarify the range of issues being discussed, participants noted that discussions covered the methods from different evaluation disciplines needed to provide adequate evidence and arguments for ISA for SDH, as well as the role of evaluation tools and systems in promoting or hindering the practice of ISA by governments (see Figure 4).

FIGURE 4 Evaluation methods, tools and systems



5. Given that a key characteristic of ISA for SDH is their "fragility", evaluation tools applied to intersectoral strategies for SDH need in the first instance to support communities of learning both across countries and with boundary partners.

6. Evaluation methods, tools and systems need to be designed around "systems" thinking for the complexity of social issues and improving health equity. The whole intersectoral action strategy could be the subject of evaluation or part of the strategy, like galvanizing political will, or the process, or the intervention. The role of participation in intersectoral strategy needs to be evaluated and, evaluations systems need to consider the timing of implementation.

7. Given the change orientation of ISA for SDH in most government settings where it is not "normal practice", evaluation tools used in processes will need to be participative and conducted with target audiences[2].

8. Given that governments have limited resources, in particular in low-income settings, it is particularly important that the object of evaluation in terms of interventions has sufficient scale to be likely to make a sizeable impact on society. The intersectoral nature of interventions for SDH imply the need to consider joint or integrated solutions across various determinants - both at the methods end and for tools and applications - e.g. integrated evaluation tools, simulations.

9. The question of for whom the evaluation is being performed and why it is being performed is paramount to understanding which framework, methods and tools to bring to bear to either retrospective or prospective evaluations. The results of interest for the "catalyst" working on the ISA strategy may be quite different from those for the targeted policy makers. Evaluation frameworks, methods and tools will be needed to respond to these purposes in parallel. A traditional list of reasons "why" evaluations are carried out is as follows:

   - persuasion;
   - gaining knowledge on merit or worth, e.g. through trials and tests;
   - administrative or other forms of accountability; and
   - organizational learning and refinement of the strategy or intervention.

[2] Some techniques like those reported in the SIDA-supported study in Bangladesh *Measuring empowerment? Ask Them (2010)* enable integration of quantitative metrics of qualitative changes that are context-appropriate, into existing results-based management evaluation frameworks.

TABLE 1: Linking evaluation methods to ISA for SDH

Stage of ISA	Decision-makers and shapers of ISA "success" at each stage	Important goals For evaluations of ISA for SDH to address -		Methods that are relevant to evaluation goals	Important domains for measures for all sectors
		Across sectors	Health catalysts		
Galvanizing political will	• Highest political leadership • Different political factions, parliament • Key administrators • Key private sector and NGO interest groups • Media (public opinion)	• Feasibility (political, cultural, bureaucratic) • Limiting negative budgetary impact • Status of country (economy, security, other)	• Reinforce strategic direction of improving social and health equity • Sustainability of ISA • Spread across policy issues/ sectors/ organizations	• Predictions of trends: concerns/technology • Opinions and interests • Costing information: cost-effectiveness (cost benefit) – who gains/ pays? • Innovation diffusion/ knowledge translation	• Governance (goals, joined-up and participative) • Welfare state changes • Economic growth • Social, health inequities • Changes in determinants
Sustaining effective processes	• Leadership in other sectors • Planning, finance, development • Bureaucracies of other sectors	• Making planning more efficient • Reaching sectoral targets • Not increasing workload • Not increasing budget constraints	• Move upstream in planning processes and integrate of equity • Institutionalization (mandate, accountability) • Build skills	• Strategic planning integration into policies, strategies, and plans and services • Process evaluation, informal, reflexive, evaluation methods • Participative methods	• Trust • Different sector's contributions • Shared vision, policy design, planning • Budget impacts
Designing and implementing interventions	• Bureaucracies of other sectors and different levels of government. • Service providers (NGO, private) • Citizens (values)	• Meeting population/ user's needs • Implementation effectiveness • Not increasing work load • Not increasing budget constraints	• Design evidence-informed equitable, SDH interventions • Prioritization • Meeting needs of disadvantaged and shifting power	• Prospective and retrospective analyses • References to other countries; other time periods • What-if/ scenarios; micro-simulations • Disaggregating	• Impacts: proxy/ intermediate outcomes specific to determinants • Health equity impacts specific to policy

10. Table 1 synthesizes the different uses of evaluation methods that were discussed using an intersectoral lens and with the view that SDH strategies are about change, complex, and yet "fragile".

2.3. Characterizing the role of the health sector

1. Various modes of ISA could be combined by the health sector in a strategic way depending on the nature of health problems and opportunities for alliances and action. As is being done in Canada and in Norway, focussing on issues for action, means at the same time using specific intersectoral action processes to help to institutionalize or systematize more generalized ISA processes.

2. Health actors advancing intersectoral action for addressing SDH are viewed as generally quite marginalized by the mainstream health sector. They are seen as change agents or «catalysts» both within health and with other sectors. These catalysts will be assisted in their work by having institutional *space* within which to operate.

3. Intersectoral action on SDH is one way the health sector can act to improve health equity. Other ways include putting its own house in order through ensuring equitable financial coverage and access to its services to address health inequities; preventing/ameliorating health damage caused by living and growing in disadvantaged circumstances; and tackling wider social determinants more directly.

4. Role performance by health was also described in terms of the issue at hand (as leader, negotiator, or partner). The key question is how to decide when to use these different roles. Health's analytical capacities and grounding in evidence-based medicine give it important capabilities in monitoring progress. Other sectors may find it useful to absorb some of these techniques with respect to developing a better understanding of implementation and access to services.

5. The health sector has an important role to play in the development of evaluation methods and evaluation systems. On the evaluation systems side, the health sector can be an advocate for state-wide evaluation systems and their methods with criteria specific to interventions on SDH.

6. Nevertheless, health should not be seen as putting up barriers to intersectoral action on SDH for want of "evidence". Sufficiency criteria for action should be based, paraphrasing the philosopher, Immanuel Kant, on knowledge for action.

> *"It is necessary to take decisions based on sufficient knowledge to act and not sufficiency with respect to satisfying curiosity".*

Participants' words, Viña del Mar, 2010

2.4. Evaluation methods and systems for ISA on SDH

> *De Savigny and Adam (2009) … have called for the application of "systems thinking" approaches both in designing interventions and evaluating them. They propose that evaluation should include process evaluation (for adequacy), context evaluation (for transferability), effects evaluation (looking at both intended impacts and unintended consequences), and economic evaluation (to address cost-effectiveness considerations). Drawing on wider thinking and experience around evaluating complex social programmes, these components also recognise the importance both of drawing multiple perspectives into the development and evaluation of large scale interventions, and of evaluation study designs that recognise multiple pathways to outcomes and the likelihood of unexpected consequences"*

Hanson et al. Scaling-up health policies and services in low- and middle-income settings. ***BMC Health Services Research, 10(Suppl),*** 2010.

1. Evaluations conducted to date of intersectoral strategies, processes and interventions, indicate that constructing policies and interventions options should take into account at least the social policy and macroeconomic *context*. In particular the welfare state can affect the implementation and effectiveness of seemingly similar interventions. Useful domains of context to include in evaluation of strategies include:

   - the economic setting;
   - welfare state;
   - nature of governmental power;
   - the scope and role of different actors being influenced;
   - the available control or steering mechanisms (legalistic versus incentives); and
   - the role of knowledge production systems.

2. Knowledge production systems, and the associated evaluation frameworks, methods and tools informing these systems, are a fundamental component of an intersectoral strategy.

3. The framing of the problem and the use of "intervention logic" in structuring intersectoral action (strategies, processes and interventions) are key for both designing interventions and for future efforts at evaluating their success. Applying the evaluation logic will enable unpicking the various components of policy and intervention implementation and impact. For example, important elements of context for labour policies include (i) the macro-economy (what happens in times of increases and decreases in economic production?); (ii) labour market policies (their flexibility, social security provisions, and active labour policies); and (iii) the social welfare system influencing who receives benefits.

> *"Evaluations should not be limited to programme impact, but must include a way of understanding and interpreting the processes through which new activities are implemented within the health system, and the processes through which new ideas become policies. More broadly, the studies support calls for new evaluation approaches that take account of the complexity of health interventions."*
>
> Hanson et al. Scaling-up health policies and services in low- and middle-income settings. ***BMC Health Services Research, 10(Suppl),*** 2010.

4. Public sector reforms aimed at solely at reinforcing the efficiency of existing siloed government have tended to increase competitiveness between administrative arms of the public sector and do not provide an easy basis for intersectoral work. These reforms also do not acknowledge either the instrumental or potential intrinsic value to intersectoral work and how it is needed to address more complex social problems generating health inequities. Within the field of public administration there is a body of literature focused on how state evaluation systems need to be configured to include rewards for inter-disciplinary problem solving, social participation, and achieving equity. In this context, public evaluation systems supportive of ISA for SDH need to pay special attention to implementation processes, and their ability to facilitate relationship building between sectors and to manage change. A useful evaluation approach and associated tools for understanding outcomes of processes exist in Outcome Mapping [3], but several instruments may also exist within other sectors and should be explored. Organizational learning and refinement of the strategy or intervention is a key purpose of evaluation, given the complex nature of SDH interventions and the need to understand institutional changes, incentives and implementation contexts.

5. In general, tools more relevant to health actors working on intersectoral action for SDH, who are characterized as "catalysts" trying to bring about social and institutional change, are more internal, reflective and informal evaluation tools, as opposed to externally-provided formal evaluations. The same tools may be relevant in different stages of intersectoral action. For example, Health Impact Assessment can be used at the beginning of processes to choose options and plan, and then again to review progress on implementation.

6. Notwithstanding the importance of process evaluations at many levels, evaluation systems need to keep emphasizing the attribution and causal pathway from various intersectoral strategies and processes to changes in determinants and other good proxies for longer term health equity outcomes. While policies and interventions in other sectors may need to be understood and evaluated by the health sector for building the evidence base on their impact on socially determined health inequities, in practice, evaluation systems that are instituted are political systems that will need to take into account compromises according to the goals of other sectors. It may be best to leave monitoring and evaluation to the level of determinants, where the choices will also be the outcome of trade-offs across competing goals.

7. Participants expressed concern about the role of commissioning agents in promoting certain types of evaluations and the potential 'silo-ing' of different types of evaluation approaches and tools. Several United Nations agencies were identified as having interests in innovative evaluation approaches, and these networks should be investigated and drawn on where possible in countries. Other important actors cited were the NONIE network of impact evaluation, Outcome Mapping networks, the African Evaluation Association, and the International Institute for Impact Evaluation (3iE). Several similar evaluation methods and related tools/techniques are emerging with different names and may cause confusion. In this context, some standardization in methods and tools would be

[3] Outcome mapping is an evaluation approach that acknowledges that many of the outcomes of concern in normal evaluation (e.g. changes in social determinants) are beyond the direct control of the initiator (i.e. health). It is therefore more concerned with bringing about behaviour changes in boundary partners, who have more direct influence over the object of interest, and other social actors. It is based on the principles of power shifting (political change). It is therefore suited to complex intervention processes promoting social change, such as in the case of intersectoral action on the social determinants of health.

useful. Policy catalysts are reassured by using internationally recognized tools that can be adapted to local settings, but with existing learning communities (e.g. as is the case with Health Impact Assessment).

8. Useful tools and approaches for action during processes will be needed for implementation in discussion with those actors in other sectors who have more direct influence over changing government policies related to the social determinants of health. Economic arguments will be key for making the political case for ISA for SDH.

Grey areas and gaps

9. As with all interventions, intersectoral strategies can have unintended side effects or externalities. Some of these may include the potential creation of silos of "intersectoral action" within the same national context related to different health conditions or issues - e.g. obesity, women, children, and so on. The institutionalization of these types of silos may be harmful, although they may also be helpful to frame problems and to galvanize political will.

10. Ministries of finance understand the language derived from economic evaluation frameworks- that is, who benefits and who pays. Related economic evaluation tools address the same concerns with trade-offs that policy-makers have. Cost-effectiveness and cost-benefit approaches can provide essential information for making the case and helping to choose between policies but they cannot be presented as the sole prioritizing tool or argument. In addition to cost-benefit analysis approaches, micro-simulations, long used by economists in the fields of tax and benefit incidence, may become immensely powerful ex-ante policy evaluation tools.

3 Recommendations

3.1. Using evaluation as a tool to promote ISA for SDH

- ***The concept of "a prerequisite for acting intersectorally"*** should be developed for application in prospective evaluations of options for action across government and funding agents.
  It could be based on the size of the impact of policies on equity in health, or a clear idea of what the policies are *not doing* that is having negative impacts. To develop this prerequisite will require having good evidence of evaluations of policies and processes from which to draw, and which can be used to build political support.
- WHO should reflect on how intersectoral action strategies for social determinants of health are supported by and integrated with ***health planning and evaluation processes*** in countries.
- WHO should advocate for evaluation on intersectoral action for social determinants of health in terms of purposes, values and instruments of health and other sectors which are conducive to ***promoting health equity***.
- Implementation phases in countries need ***clear benchmarks and targets***. How do countries monitor that they are progressively working towards integration of SDH to improve health equity in the policies and practices of other sectors?

3.2. Knowledge gaps for building guidance for evaluating ISA for SDH

- A fundamental requirement in this area is ***a WHO document that conceptualizes the key characteristics of intersectoral practice relevant to health equity***. In order to generate evidence on intersectoral action and social participation, there needs to be clear terminology that avoids the use of slogans. Once this is done, evaluation methods can more easily be identified. The theoretical basis for intersectoral action related to welfare state and intervention typologies needs to be developed and tested.
- ***A critical mass of examples*** should be accumulated on how intersectoral action functions in relation to improving equity. These examples should come from case study, evaluations and other types of studies to build up the evidence base. This information should be accessible to all and fully disseminated. Proposing successful intersectoral strategies and related interventions would be facilitated by having case studies and evaluations that systematically include information on context and implementation processes.
- There is little knowledge in health on ***how to get issues on the agenda with other sectors and then monitor progress with other sectors*** in a way that other sectors find inviting and which keep fragile processes alive. This should be investigated.
- Guidance and evidence on ***how to evaluate complex interventions with respect ISA for SDH*** should be improved.
- WHO should explore ***how economic costing and evaluation approaches and tools can contribute to advancing ISA for SDH equity***. The range of tools includes cost-benefit analyses, cost-effectiveness analyses, and micro-simulations. Having information on economic impacts can assist ministries of health and governments with prioritization of different public policy options. Some of these broader questions these analyses inform are:
  - How to trade off long and short term benefits?
  - How to ensure appropriate financing of longer term investments in social policies?
  - How to achieve economic production goals in the way that prioritizes social inclusion?
  - How to ensure appropriate financing and budgeting for intersectoral work?
- All of these aspects highlight the need for **"an actionable theory"** for social determinants of health. Several related questions for intersectoral action are shown in Box 4, next page.

BOX 4: Creating an actionable theory for SDH

How do you create opportunities for intersectoral action strategies or be ready to seize opportunities?

- How does the type of issue or intervention affect the needed type of intersectoral action?
- What is the appropriate modality of intersectoral action in different policy context, i.e. a few sectors versus multiple sectors, and which sectors?
- How do you ensure realistic understanding of barriers to intersectoral action and support for time-frames needed to build successful relationships and work towards integration

What makes for successful sequencing of intersectoral action from initiation to sustainability?

- How are political strategies developed for intersectoral action?
- How is evaluation used across the different phases of intersectoral strategies?

Which aspects of efforts to promote policy integration necessarily lead to greater health and social equity?

What next steps are recommended for prioritization for countries with different types of welfare states and at different stages of development and what are the specific implementation features of interventions for addressing different SDH ?

3.3. Using WHO's role in shaping knowledge systems

- WHO is needed as an honest broker in several areas for ***developing standards and methods for developing evidence for ISA for SDH***.
- WHO is needed as an honest broker for ***supporting exchange and learning /practice communities***, and should build a ***knowledge observatory*** that gathers and analyzes evidence from countries and other sources. This observatory would be used to interrogate, understand and demonstrate what both success and failure look like. It should particularly disseminate meta-analyses on successful strategies for getting intersectoral action for social determinants of health onto the political agenda. The evidence base and examples should stimulate approaches for learning from each other rather than just providing information. Meta-analyses should draw on learning in a way that acknowledges the need to translate ISA strategies and interventions appropriately to different cultures, welfare state contexts, and levels of developments and capabilities.
- WHO needs to show ***the added value of applying evaluation methods*** for ISA for SDH by demonstrating:
  - where and how evaluation has concretely improved practice or advanced social or health equity;
  - what was the role of the health sector and the effectiveness of this role in acting on intersectoral action for social determinants of health equity;
- WHO should build confidence in the use of ***outcomes measures*** available to evaluation practice on the less material aspects of SDH such as social exclusion, empowerment and autonomy, and link with existing global work in this area.
- WHO should ***promote future scanning and some of the micro-scenario planning work*** that relates to it.

3.4. Capacity building and mainstreaming

- It is necessary ***to build capacities for health to work across government***, in particular for linking and negotiating with other sectors, as well as with respect with health working with affected communities or intended beneficiaries of policies. Capacity needed within health includes capacities to initiate, support and evaluate intersectoral action and its relevance to impact on health equity.
- WHO should build infrastructure and competencies at national and regional levels to ***communicate knowledge relevant to SDH arising from intersectoral processes***.

- WHO should build capacity for evaluation by ***connecting the assets for information and evaluation tools*** that already exist in both national and international contexts, ensuring particular expertise in countries and regions is involved.
- In line with the Paris principles, WHO needs ***to ensure harmonized evaluation practices*** through:
  - linking to existing evaluation efforts in national planning and reporting frameworks on development and for health systems;
  - informing ministries of health on what types of evaluations to prioritize;
  - coordinating use of evaluation methodologies and tools with other UN agencies; and
  - mainstreaming health equity impacts in relevant tools being used to evaluate social and development policies in both national settings and in the UN system.

Acronyms

EPSCO	Employment, Social Policy, Health and Consumer Affairs Council
SDH	social determinants of health
ISA	intersectoral action
UN	United Nations
WHO	World Health Organization

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Annex 1: Ten organizing questions

1. How is intersectoral action for health (ISA) conceptualized in different policy models used by countries for tackling social determinants of health (SDH)?
2. What are the critical areas of ISA processes that could be facilitated with stronger evaluation knowledge and why?
3. Do and how do evaluation needs differ in intersectoral processes convened around social/welfare versus development/economic sectors?
4. Which aspects of evaluation theories and methods, including evaluation perspectives from economics, are most relevant to ISA processes to tackle SDH?
5. What steps have been taken by countries to evaluate progress on ISA?
6. How do the relevance and needs for evaluation change at different points in the intersectoral policy processes as they roll out in different cultural/institutional settings?
7. How can evaluation theory and tools help understand the conceptual underpinnings, functioning and results of ISA?
8. What advice on evaluation can be given to countries implementing actions on SDH?
9. What processes should be followed by WHO to better support countries in defining capacity building needs in evaluation as one mechanism to advance ISA?
10. Which evaluation frameworks, methods and tools should be prioritized for follow-up by WHO and what are the gaps in theories and methods?

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