

Intersectoral Health Strategies: From Discourse to Action

By Pastor Castell-Florit, MD, PhD, DrSc

The global distribution of disease burden reveals alarming inequities that can only be tackled by generating the political will and organizational capacity for sustained intersectoral action (ISA) to address both health outcomes and the social determinants underlying population health indicators.

To bridge the gap often found between discourse and implementation, such action requires not only commitment and dedication of resources by leaders, central governments and the health sector itself but also empowerment of local communities—especially the poor and disenfranchised—to become a force for constructing health.

In Cuba and other countries where political will is most palpable in practice and results, much still remains to be done to harness society's energies in favor of better health outcomes. The aim of course is not simply ISA induced from above, but conscious multi-sector involvement to work towards commonly agreed-upon goals.

In this context, the health sector—ministries, institutions and health professionals—is called upon to play a pivotal role and thus to take stock, adopt new strategies, produce more evidence and information to support integrated action, build capacity in the social practice of multi-sector approaches to health promotion, and pay more attention to opportunities at the local level.

- **Health strategies need reorientation** to broaden intersectoral action beyond its use in crises or campaigns such as disaster preparedness, vaccination drives, and epidemic situations like the recent spread of H1N1 influenza. We must stop thinking of intersectorality as a way to solve immediate problems, but instead as a pro-active strategy for progressively achieving set objectives aimed at improving the quality of life of individuals and populations. Effective intersectoral work is sustained, building consciousness and long-term “buy-in”. National health plans should be formulated that implicate other sectors from the start, by addressing environment, nutrition, education and other health determinants. One example is the 2006 adoption of *Public Health Projections in Cuba for 2015*, a health sector attempt to broaden the range of health-related goals, with the stated objective of intersectoral action and responsibility.
- **More information and evidence** need to be developed and shared. The health sector should set an example of greater transparency by providing information on how resources are allocated and used, identifying successful institutions and those with problems, and sharing epidemiological research on health trends, among other data. This offers a point of departure for intersectoral analysis of health problems.
- **Build capacity to practice intersectoral approaches.** Intersectoral activity induced from above can be acceptable but doesn't generate either a culture of collaboration or stable use of intersectoral strategies. That can only be done by empowering those whose health is at stake and other relevant sectors, and then working toward a “win-win”

point at which all become stakeholders. This, in turn, is a consensus-building process involving many whose priorities and interests, while not antagonistic to achieving better health outcomes, do not always coincide and must be addressed in finding solutions. And not everyone comes to the table equally prepared for the negotiation that leads to conscious, participatory conclusions and action. Intersectoral work is not spontaneous: continuous capacity-building of all actors is essential, even in countries like Cuba, where the basic predisposition for success may exist.

- **Pay greater attention to local-level opportunities:** As the WHO Commission on Social Determinants report notes: “While highest-level government oversight is needed to push and coordinate intersectoral action and to ensure sustainability, local-level government and community ownership is a prerequisite to sustained results.”[1]

This is borne out by the fact that we most often see practical results of intersectoral work in neighborhoods and municipalities, where a common understanding of health problems and goals is more easily achieved, taking into account the concrete situation, culture and local formal and informal leadership. This presupposes certain autonomy of local government, organizations and other sectors to take initiatives based on their collective analysis of health problems.

One step towards opening up local opportunities was taken in Cuba years ago by mandating that the municipal and provincial directors of public health serve as vice-presidents of their respective levels of government administration. And involvement of local social organizations has been a hallmark of community-based health promotion for years. However, much more could be done to involve local entities in environmental control, sports, culture, the media, and public works, as well as family businesses, cooperatives and the self-employed.

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Even when leaders, government and the health sector have proven their commitment to generating better health and health equity, broad and sustained intersectoral action is still a goal, not a given.

In Cuba's own case, our recent research[2] among leaders and professionals in ten sectors, including civil society, reveals that while there is adequate overall understanding of the importance of working together, most perceive that ISA is induced from above and have difficulty pointing to health problems that have been effectively solved through common effort. Nevertheless, the health sector was recognized by a majority for its intersectoral leadership—pointing the way for others to follow and make the public's health their responsibility as well. 

1. World Health Organization Commission on Social Determinants of Health. Closing the gap in a generation: Health equity through action on the social determinants of health. Geneva: WHO; 2008. p. 118.
2. Castell-Florit P. Sostenibilidad de la intersectorialidad en Cuba. Havana: Editorial Ciencias Médicas; 2009.