

# Intersectoral action – a bibliographic review

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## Introduction

The term ‘intersectoral action’ has particular importance in the universe of statements and beliefs of the World Health Organization. It came to prominence as a result of the Primary Health Care conference in the Soviet Republic of Kazakhstan in 1978 where the influential Alma Ata Declaration was developed and adopted. The Declaration and the ensuing policy directions of WHO (notably the movement toward ‘Health for All by the Year 2000’) was strongly influenced by some precursor developments like Chinese barefoot doctors, Global Southern community health workers, and the Canadian Lalonde Report. It explicitly recognised and described for the first time the important role of other fields of human endeavour to the creation, sustenance and enjoyment of health. In doing so it also challenged the primacy (and dominance) of the medical-industrial complex in dealing with ill health and disease, or so it was felt by large swathes of clinical professionals and their interest groups.

The concept of ‘intersectoral action’ was neither defined nor codified substantially for a long time. It was an article of faith in the Alma Ata Declaration, and was assumed self-explanatory for at least a decade since that pivotal moment. In that, it shares a fate with the idea of ‘knowledge translation’ – both have acquired great prominence in the health care field, but cannot be considered of any concern in any other

field of human endeavour. If ‘intersectoral action’ is important for health, it should be even more so for the economy – however, in the literature from that field (whether scholarly or promulgated by public sector pronouncements) intersectorality is not a term or issue.

A first more or less systematic perspective was offered, again, by WHO in 1986. This seminal case-based inventory identified a number of critical examples of intersectoral work in national health environments around the world. The concept is taking hold, and building on this, an Australian perspective Harris et al., 1995 identifies intersectoral action as “*A recognised relationship between part or parts of the health sector and part or parts of another sector, that has been formed to take action on an issue or to achieve health outcomes, (or intermediate health outcomes) in a way which is more effective, efficient or sustainable than could be achieved by the health sector working alone.*” This definition subsequently was adopted by an international WHO conference Kreisel, 1998.

Some confusion and interchangeability remains on two fronts. The first is between the prefixes **inter**(sectoral) and **multi**(sectoral) - and sometimes **trans**(sectoral). Semantically the terminology might be clear (inter-sectoral bridges divides between sectors, where multi-sectoral denotes more simply the involvement of more than one sector in addressing an issue; trans-sectoral seems a slightly empty neologism prevalent in the One Health sphere). However, the literature does not embrace the distinction unequivocally. Necessarily we will cross over between the **inter** and **multi**. Some word wizards have chosen to add a further -i- to the expression, turning it into inter/multi/transsectorial. We have chosen to ignore swanky word play, treat them all the same, and for the sake of readability use intersectoral, or *intersectorality*.

The second area involves the question whether intersectoral **action** is equivalent to intersectoral **policy** and even intersectoral **governance**. There is a somewhat clearer agreement on this differentiation e.g., de Leeuw, 2015, 2017, although in more applied health circles there remains (deliberate?) opacity between the three. The reason seems to be that practitioners simply do not see action different from policy or governance, or because there is value for packaging the three in a seamless heuristic that does not benefit from separation.

A final disconnect with, and challenge to the world of intersectorality is a lack of osmosis between the scholarly and applied disciplines that make (organisational) connections their main concern, and the pervasive rhetoric in the health sector. Fields such as organisational science and psychology, public management, administrative science and industrial relations, and sociology seem generally absent from intersectorality arguments in health. For instance, public management guru Peters 1998 has long been arguing that (intersectoral) policy integration is the holy grail of any level government anywhere around the world. These approaches have been labelled variously ‘Joined-Up Government’, ‘Whole-of-Government’, ‘Integrated Policy’ or ‘Horizontal policy’ see Trein, Meyer & Maggetti 2019 – none of which seems to have influenced intersectoral development much, judging from the analysis by Degeling 1995 which in its problematisation sounds as fresh in the 2020s as it was decades ago.

With these caveats, this bibliography sets out the following.

- i. History and development of intersectoral thinking
- ii. A brief outside-health scoping of the issue (partnership, interorganisational, JUG and WOG)
- iii. The WHO as an underappreciated and ill-peer reviewed font of wisdom
- iv. Health sector conceptualisations
- v. Guidance documents and reviews
- vi. Intersectoral pronouncements in a number of issue domains

de Leeuw, E. (2015) Intersectoral action, policy and governance in European Healthy Cities. *Public Health Panorama*, 1(2) 175-182

Argues from empirical research in European \*Healthy Cities\* that it is useful to make a conceptual and theoretical distinction between intersectoral action (the operational intervention and act of collaborating), intersectoral policy (the deliberate joint resolution to solve a social problem) and intersectoral governance (the systems that drive integration and collaboration)

de Leeuw, E. (2017) Engagement of sectors other than health in integrated health governance, policy, and action. *Annual review of public health*, 38, 329-349

Narrative review about the pervasive nature of all public and private policies in society influencing population health; how various efforts have called for better collaboration and integration; and how dogmatic, empirical and conceptual forms of evidence join to form a community-driven spectrum of collaborative opportunities for health.

Degeling, P. (1995). The significance of 'sectors' in calls for urban public health intersectoralism: an Australian perspective. *Policy & Politics*, 23(4), 289-301

Challenges the notion of 'sectors' as isolated silos and claims that sociology and political science can identify opportunity to break through structural and belief system barriers for better integration.

Harris, E., Wise, M., Hawe, P., Finlay, P., & Nutbeam, D. (1995). *Working together: intersectoral action for health*. Canberra: Australian Government Publishing Service.

First systematic overview of determinants of efficacious intersectoral action – identifies a number of steps in the process, and offers examples how system outcomes are improved because of collaboration.

Kreisel, W., & von Schirnding, Y. (1998). Intersectoral action for health: a cornerstone for health for all in the 21st century. *World health statistics quarterly. Rapport trimestriel de statistiques sanitaires mondiales*, 51(1), 75-78.

WHO conference report that outlines rationale and outcomes of the first WHO conference on intersectoral action for health. Adopts the vision and evidence base accumulated by WHO work on Primary Health, Health for All by the Year 2000, and significantly, \*Harris et al 1995\*

Peters B. G. (1998) *Managing horizontal government. The politics of coordination*. Research paper 21 Canadian Centre for Management Development. Minister of Supply and Services, Ottawa, Canada, Catalogue Number SC94-61/21-1998 [http://www.academia.edu/download/33172131/Guy\\_Peters\\_-\\_Policy\\_coordination.pdf](http://www.academia.edu/download/33172131/Guy_Peters_-_Policy_coordination.pdf)

One of many papers by the administrative science guru about policy integration and its barriers and determinants. In this government-commissioned report he speaks a bit more freely than in other peer-reviewed articles. Unique in identifying the political nature of fragmentation and integration. Does not specifically focus on health.

Trein, P., Meyer, I., & Maggetti, M. (2019). The integration and coordination of public policies: A systematic comparative review. *Journal of Comparative Policy Analysis: Research and Practice*, 21(4), 332-349.

A systematic review of political and administrative science concepts in integrated, horizontal, joined-up, whole-of-government public policy (in the health field \*Healthy Public Policy\* or \*Health in All Policy\*). Authors find a separation between disciplines and theories across

sectors ('integration' looks at environment and climate policy, 'JUG/WOG' at social, health and education) and welfare states.

## History and development

The earliest systematic exploration into intersectoral collaboration for (better) health is found in Shaefer 1981. He provides a compendium of experiences in collaborations around the world in environmental health and sanitation. Shaefer's charge is to provide evidence for the further implementation of considerations formulated by a technical panel in 1969 and published in WHO 1970, and the ambitions formulated in the Declaration of Alma Ata and its companion documents WHO & UNICEF 1978. The issues identified there and detailed further by Shaefer 1981 are "interagency coordination" and notably interdepartmental cooperation in the building of sanitary facilities and collaboration among workers in different sectors in carrying out activities in public health programmes. Problematic are 'the separation of functions among agencies according to various national schemes of government organization'; 'the compounding of such separations by the division of powers and responsibilities between central, local, and one or more intermediate levels of government'; 'the progressive increase in the number of agencies with environmental responsibilities, an effect of socioeconomic development itself'; and 'the impracticability of integrating ("amalgamating") environmental health programmes in single agencies because of technical, managerial, psychological, and political constraints'.

Shaefer's inventory adds weight to the international call that collaboration across society is essential for appropriate and optimal primary health. WHO continues to assemble case reports and documentary evidence, e.g., WHO 1986, a document produced across five UN agencies. Mahler 1988, then Director-General of the organisation, proffers a frank assessment of progress in making intersectoral action a reality. He sets out to describe why collaborative efforts to protect and promote health are necessary and admits *"the health sector remains on the whole a weak partner in socioeconomic policy development. Intersectoral cooperation for health is still inadequate. Several countries have established national health councils or similar bodies for the intersectoral coordination of policy-making and planning; but in many countries, such bodies, if they exist, function in an ad hoc manner, since explicit commitment by other sectors remains to be achieved. Increasing concern over social and economic inequities, and a conscious effort to reduce them, are also discernible in the national health and development policies of many countries."*

The view that the health sector is a weak partner in socioeconomic policy development is right, but wrong. De Leeuw 2017 describes the power and dominance of the healthcare sector and its professions, suggesting that public health care bureaucracies (Ministries and other healthcare public sector agents in various jurisdictions from local to global) are microcosmic representations of society as a whole – encompassing regulations and facilitations of real estate development and asset management, education and training parameters, (pharmaceutical) product development, infrastructure (transport and access) operators, etc. In many areas around the world the healthcare bureaucracy and delivery sector is the largest economic enterprise in any given region. If the health sector is a weak partner it is so because she chooses to remain so. It may simply not be in the interest of the healthcare sector to stimulate or enforce collaboration. De Leeuw 2017 hence also summarises that the main concern of the healthcare sector and its bureaucracy is not population health but treatment of disease.

de Leeuw, E. (2017). [Engagement of sectors other than health in integrated health governance, policy, and action. Annual review of public health, 38, 329-349](#)

Offers insights in the politics of healthcare sector motivations to work with other sectors toward better health, and how generally these ambitions are naïve. Evidence is presented that most of the healthcare system driven rhetoric is naïve and unaware of critical political drivers.

Mahler, H. (1988). [Present Status of WHO's Initiative, "Health For All by the Year 2000". Annual Review of Public Health, 9\(1\), 71-97](#)

Surprisingly candid account of Mahler's personal commitment to a better, healthier and more equitable world embedded in the Alma Ata Declaration and WHO's 'Health for All' policies.

Documents a modicum of global progress and a novel focus of the global health community on the politics of intersectoral action.

Schaefer, M. (1981). *Intersectoral cooperation and health in environmental management : an examination of national experience*. World Health Organization. Geneva <https://apps.who.int/iris/handle/10665/39446>

Evidence from environmental health and sanitation efforts requiring intersectoral cooperation. Excellent account how 'old public health' already crossed boundaries and needed collaboration between different government agents (e.g., infrastructure, engineering, water management). Very case- driven.

WHO (1970). *National environmental health programmes : their planning, organization, and administration*, report of a WHO Expert Committee on the Planning Organization, and Administration of National Environmental Health Programmes & World Health Organization [meeting held in Geneva from 3 to 11 June 1969]. World Health Organization technical report series ; no. 439 World Health Organization., Geneva <https://apps.who.int/iris/handle/10665/40768>

Experts from around the world compiled the evidence and need for intersectoral action for environmental health. Landmark report pre-'Club of Rome' and an important legacy of Rachel Carson's 'Silent Spring' publication. A foundational statement for intersectoral action, notably in environmental health.

WHO (1986). *Intersectoral Action for Health: The Role of Intersectoral Cooperation in National Strategies for Health For All*. Geneva: WHO. Foundational [http://apps.who.int/iris/bitstream/10665/41545/1/9241560967\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/41545/1/9241560967_eng.pdf)

Five years in the making (research and consultations started in 1981), benchmark document produced across various elements of the United Nations system (the Office of the Director-General for Development and International Economic Cooperation, United Nations; the United Nations Environment Programme (UNEP); the United Nations Centre for Human Settlements (Habitat) and the International Year of Shelter for the Homeless (IYSH); the Food and Agriculture Organization of the United Nations (FAO); and the United Nations Educational, Scientific and Cultural Organization (UNESCO)). In its analysis and importance as fresh as it was in 1986. Debates that still dominate global health discourse (e.g., equity, inclusion, slum dwelling and urban life, determinants of health, education) are documented in a series of case studies and excellent bibliography.

World Health Organization & United Nations Children's Fund (UNICEF). (1978) *International Conference on Primary Health Care (1978 : Alma-Ata, USSR)*, (1978). *Primary health care : report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 / jointly sponsored by the World Health Organization and the United Nations Children's Fund*. World Health Organization. <https://apps.who.int/iris/handle/10665/39228>

Starting point for the political and practical prominence of intersectorality. Although the driver of intersectoral action solely seems Primary Health Care, the background documents to the Alma Ata Declaration establish a firm heuristic that locates success of the approach outside the medical-industrial complex.

## Outside-health contributions

As noted in the \*introduction\*, the term 'intersectoral action' is uniquely used within health circles. This is not to say that issues of collaboration, partnership and integration are unimportant elsewhere. There is, in fact, a rich literature that explores and directs organisations and institutional arrangements toward coordinated joint efforts. Different fields of scholarship and practice have given different names and

conceptualisations to such coordinated collaboration. This is not the place to provide a full primer of each of these areas and we provide a superficial overview of different traditions.

Peters 1998 writes about public sector coordination as the 'holy grail' of governments (*Peters, p.1: No phrase expresses as frequent a complaint about the federal bureaucracy as does "lack of coordination." No suggestion for reform is more common than "what we need is more coordination."* (Pressman and Wildavsky (1984:133)). He uses the term 'horizontal government' although other scholars in his domain coined terms such as 'whole-of-government' (WOG), 'Joined-up-government' (JUG) and 'integrated policy'. Peters 1998 summarise the sentiment of these administrative experts as "*The administrative Holy Grail of coordination and "horizontality" is one of the perennial quests for the practitioners of government. From the time of the separation of governing structures into departments, ministries, and analogous organizations there have been complaints that one organization does not know what another is doing, and that their programs are contradictory, redundant or both.*"

Collaboration clearly is an important issue beyond the public sector. The Canadian Tamarack Institute (nd) has developed a 'Collaboration Spectrum' that is used across governments, communities and industries around the world to explain the shades of intensity for partnerships. These range between competing and integrating. Tamarack Institute experience demonstrates that awareness of the nature of collaboration and its dimensions is critical for establishing better ways of working together.

In organisational science and economics partnerships and mergers are another field of inspiration for intersectoral action. Hueben & De Leeuw 1991 have been the first to apply the seminal work by organisational scientist Barbara Gray 1985 to health promotion and healthy cities. They find that from an inter-organisational dynamics standpoint collaboration only works when there is a degree of readiness among stakeholders. Following Gray they suggest a three step developmental approach that includes (a) problem-setting (engagement with stakeholders that aims to establish the need for collaboration); (b) direction-setting (processes to establish the agreed-upon substance and forms of collaboration) and (c) structuring (firming up the collaborative institutional arrangement). The main argument from this body of work is that a call for intersectoral collaboration will only work when participants appreciate the need and benefits of such an approach. Principled and ideological – top-down - calls for joint work are insufficient or even counterproductive.

Another domain of research and development around institutional connectivity is found in network analysis. Within this space there is a vast literature that queries whether network research is useful to policy development or analysis (e.g., Börzel 1998); one tradition seeing networks as governance tools, another as analytical and predictive proxies (i.e., that the shape of networks predicts their outcomes). There is agreement, however, that (post-)modern public policy environments are characterised by diverse networks that include public, private and community interests. How to make such networks work for joint collaborative outcomes has been the question addressed by authors such as Provan and Kenis 2008. They outline conceptual and empirical models to firm up network performance through the maintenance of either (1) participant-governance; (2) lead organization governance; or (3) Network Administered Organizations, NAOs. Such NAOs seem superior in maintaining efficiency, performance, and coherence of collaborative networks. A philosophy-of-science perspective on the importance of such networks is offered by authors such as Callon and Latour (cf Mol 2010) who have formulated the Actor-Network Theory to describe the forming and significance of intricate connectivities between complexes of institutions and events which shape the context and opportunities for meaningful collaboration toward new ends.

For some time now there has been an argument at the interface of public health studies and political science that better integration of these two, and in particular in the deployment of conceptual understandings reciprocally in both would yield superior insights for the development of policy and institutions for health (e.g., Clavier & Bernier 2011, Greer et al 2017). Especially Greer and colleagues have advanced the intersectoral health political science dimension in this debate, e.g., Greer & Maresso 2012. They demonstrate the feasibility and superiority of interdepartmental public policy institutions in finding novel public policy solutions to complex problems. Crossing over more explicitly into the public health

domain, Baum 2019 demonstrates how policy for health and equity must find an agenda beyond health, and argues for health efforts driven by fiscal policies and enterprises, the education sector, urban planning, and (a sustainable) industry.

Baum, F. (2019) *Governing for Health. Advancing Health and Equity through Policy and Advocacy*. Oxford University Press, Oxford/New York

Fran Baum locates the onus for better, and more equitable, health squarely outside the healthcare system and sees occasionally this system as a hindrance rather than a help. Good governance for health is a societal responsibility with key roles for institutions and communities and their representatives – thus advocating a political strategy for better health equity.

Mol, A. (2010) *Actor-network theory: Sensitive terms and enduring tensions*. *Kölner Zeitschrift für Soziologie und Sozialpsychologie. Sonderheft*, 50, 253-269.

Annemarie Mol looks at the actor-network theory as a way of knowing rather than an abstraction of always observable phenomena. Argues that by having an awareness of the elements of networks of actors, institutions and events, operators can better appreciate their own position in actor-actant networks, and seize opportunities for change.

Bernier, N. F., & Clavier, C. (2011). *Public health policy research: making the case for a political science approach*. *Health promotion international*, 26(1), 109-116.

An analysis of political science frames of reference and their pertinence for public health research. If health (medicine) is politics writ large we better study the foundations of political philosophy, and then apply them to the inter-sectoral complexities in the public health field, Bernier and Clavier show. Both being Francophones this piece also offers an insight in some of the French political science literature.

Börzel, T. A. (1998). *Organizing Babylon - On the different conceptions of policy networks*. *Public administration*, 76(2), 253-273.

Börzel undertakes a conceptual review of the literature around policy networks and asks the question – are they analytical or descriptive? Analytical policy network approaches would suggest they can be used predictively (ie, looking at networks creates ways of framing their results – as policy parameters, for instance, or instrumentation tools); descriptive ones show width and depth of networks for management and governance purposes. Börzel argues one does not exclude the other.

Gray, B. (1985). *Conditions facilitating interorganizational collaboration*. *Human relations*, 38(10), 911-936.

Work at the interface between sociology, organisational and administrative science shows that there are three broad steps to create, manage and maintain collaboration: problem identification, direction setting and structuring. Each are involved processes that require respect and commitment.

Greer, S. & Maresso, A. (2012). *Intersectoral problem solving by interdepartmental units and committees*. *Eurohealth*, 18 (4), 11 - 14. European Observatory on Health Systems and Policies, World Health Organization. Regional Office for Europe. <https://apps.who.int/iris/handle/10665/333019>.

A review of the ways in which public sector organisational units can connect and better solve complex problems. As public sector agents they can work on joint arrangements for better

evidence, coordination, advocacy, monitoring, guidance development and implementation. They work within the government bureaucracy, do not require significant costs or reorganisation, can work with departments over time, and can apply sustained pressure. Their potential seems under-used.

Greer, S. L., Bekker, M., De Leeuw, E., Wismar, M., Helderma, J. K., Ribeiro, S., & Stuckler, D. (2017). Policy, politics and public health. *European Journal of Public Health*, 27(suppl\_4), 40-43.

Political analysis ('who gets what, why and when?') is rarely, and if it is, haphazardly applied in public health research. Authors argue that many of today's challenges (equity, access, efficiencies) could be much better dealt with if a political science gaze is applied. This seems particularly true for collaboration issues.

Hueben, F., & de Leeuw, E. (1991). *Intersectorale samenwerking: de theorie en de praktijk*. H. 5 [Intersectoral collaboration: the theory and the practice. Ch. 5]. *Gezonde Steden. Lokale gezondheidsbevordering in Theorie, Politiek en Praktijk* [Healthy Cities. Local Health Promotion in Theory, Politics, and Practice]. Assen/Maastricht: Van Gorcum, 87-108

Application of \*Gray's\* interorganisational heuristic to first-generation (1986-1990) Dutch Healthy Cities. Intersectoral collaboration only works if it is generated within the Healthy City, not if imposed.

Peters B. G. (1998) *Managing horizontal government. The politics of coordination*. Research paper 21 Canadian Centre for Management Development. Minister of Supply and Services, Ottawa, Canada, Catalogue Number SC94-61/21-1998 [http://www.academia.edu/download/33172131/Guy\\_Peters\\_-\\_Policy\\_coordination.pdf](http://www.academia.edu/download/33172131/Guy_Peters_-_Policy_coordination.pdf)

The eternal quest for better, more coordinated, speedy and hassle-free public policy (the 'Holy Grail of any government bureaucracy') is explored through the application of administrative and organisational science. Coordination should extend beyond the core bureaucracy (horizontally) but also within the reach of departmental structure (vertically).

Provan, K. G., & Kenis, P. (2008). Modes of network governance: Structure, management, and effectiveness. *Journal of public administration research and theory*, 18(2), 229-252.

Overview article about network governance and management. Authors identify three archetypal management structures, and argue that in post-modern complex network management Network Administrative Organisations (NAOs) yield superior results.

Tamarack Institute (nd) *Collaboration Spectrum Tool*. <https://www.tamarackcommunity.ca/library/collaboration-spectrum-tool> Tamarack Institute for Community Engagement, University of Waterloo, Ontario, Canada

A tool for the analysis and shaping of collaborations at the community level, although it has significant appeal within the broader healthcare sector. Is also used by health consumer and client groups to identify opportunities for better engagement with complex systems.

## WHO

The World Health Organization is a rich resource, both practically and rhetorically, on the dimensions, conceptualisations and occurrence of intersectoral work around the world. An exploration of its Institutional Repository for Information Sharing (IRIS - <https://apps.who.int/iris/>, a profoundly underappreciated arsenal of WHO policies, discourse and evidence) yields nearly 9000 references that directly deal with intersectoral health. Most of these are practical case study compilations (e.g., Bettcher 1997 and Von

Schirnding 1997 focus on the connection between local and global intersectoral arguments; Dowling & Ritson 1986 document an intersectoral experience in rural Tanzania).

Some more profound analysis is offered through work on intersectoral action in agriculture and health (Hawkes & Ruel 2006, see also Milio 1981 for an earlier iteration), environmental health management, including water quality management (Hunter et al 1993, Schaefer 1981), adolescent health (WHO/SEARO 2016) and lifecourse approaches in intersectoral action (Huber et al 2016) and a series of handbooks and manuals, including on intersectoral dimensions of Health Impact Assessment (Birley et al 2003).

A more scholarly ambition speaks from publications in the area of governance and intersectorality. In 2012 the European Observatory on Health Systems and Policies (an institute shared by WHO Europe and the European Union with intersectoral public and civil society inputs from Europe and beyond) published an inventory taking stock of the knowledge base and practical state of the art for intersectoral governance in pursuit of [\\*Health in All Policies\\*](#). This includes a brief account of the work by McQueen et al 2012 which exhaustively looks at a range of governance and accountability issues in intersectorality. A hands-on account for some of the key models of action is documented by Loewenson 2013. From this work it emerged that a key ingredient for successful intersectoral action is found in communicating its need and potential. WHO/EURO 2017 provides a framework to manage appropriate communication toward intersectoral arrangements.

Where communication is one type of policy instrument, the creation and maintenance of appropriate infrastructure, regulation and financial contexts are important complementary elements of the synergy of policy packaging. McDaid & Park 2016 and McDaid 2018 show how thoughtful financial and fiscal parameters can create opportunities for intersectoral policies for better health, arguments made earlier by Sassi & Belloni 2014 for Health in All Policies.

Bettcher, D. (1997). Think and act globally and intersectorally to protect national health. World Health Organization Office of Global and Integrated Environmental Health. <https://apps.who.int/iris/handle/10665/63374>

Impressive collection of international experiences, projects and policies for health policy making and intervention. Intended to provide inspiration to member states of WHO. Strong on practicalities, weak on theoretical reflection.

Birley, M. H., Furu, P., Engel, C. E. & Bos, R. (2003). Health opportunities in development : a course manual on developing intersectoral decision-making skills in support of health impact assessment. World Health Organization. <https://apps.who.int/iris/handle/10665/96618>

Health Impact Assessments (HIAs) and their variants are integral to the evidence and policy toolbox of health policy makers. This course manual allows for the development and implementation of self-run and facilitated teaching moments that actively pursue engagement across sectors that impact on health such as transport, education, and nutrition. Focuses on Middle and Lower Income Countries (MICs and LICs) but has utility elsewhere, too.

Dowling, M. A. C & Ritson, R. (1986). Think intersectoral! World health 1986 ; Mar : 22-24

In celebration of the renewed policy attention to intersectorality in WHO circles, authors document an intersectoral experience in Tanzania.

European Observatory on Health Systems and Policies (2012) Eurohealth: intersectoral governance and Health in All Policies. Eurohealth, 18 (4), World Health Organization. Regional Office for Europe. <https://apps.who.int/iris/handle/10665/332874>

Part of a series of special issues of Eurohealth magazine reviewing and advocating for intersectoral governance, specifically to advance *\*Health in All Policies\** (HiAP). Prelude to the 8th

Global Conference on Health Promotion, focusing on HiAP, held in Helsinki, Finland from 10-14 June 2013. HiAP was born and (re)invigorated in Finland and South Australia and took intersectorality to a new level.

Hawkes, C. & Ruel, M. (2006) The links between agriculture and health: an intersectoral opportunity to improve the health and livelihoods of the poor. *Bulletin of the World Health Organization*, 84 (12), 984 - 990. World Health Organization. <https://apps.who.int/iris/handle/10665/269792>

Presents an argument and evidence base that not just health wins in an intersectoral approach (for instance, in this case with agriculture and nutrition) but that collateral gain can be made in standards of living, poverty reduction, and national (economic) wellbeing.

Huber, M., Galea, G., Lazdane, G. & Kosinska, M. (2016). Implementation of the life-course approach through strengthened intersectoral action. *Eurohealth*, 22 (3), 25 - 28. World Health Organization. Regional Office for Europe. European Observatory on Health Systems and Policies <https://apps.who.int/iris/handle/10665/332691>

Driven by a programmatic and research emphasis on age-friendly environments this piece briefly argues that well thought through intersectoral action strengthens system resilience and enhances health and sustainability throughout life.

Hunter, J. M, Rey, Lu'is, Chu, K. Y, Adekolu-John, E. O, Mott, Kenneth E. et al. (1993). Parasitic diseases in water resources development : the need for intersectoral negotiation. World Health Organization. <https://apps.who.int/iris/handle/10665/38322>

Follow-up on the tradition set by the \*Shaefer report\*, identifying the need and opportunity for intersectoral action in environmental health management, specifically in the area of the control of water-borne parasitic disease. A benchmark report for sanitation and water management processes.

Loewenson, Rene (2013). Evaluating intersectoral processes for action on the social determinants of health: learning from key informants. *Social Determinants of Health Discussion Paper 5: Policy & Practice*. World Health Organization. <https://apps.who.int/iris/handle/10665/84373>

Work toward health equity and establishment of programmes fully inclusive of the (social) determinants of health perspectives requires policymakers and practitioners engaging in processes for intersectoral action for health (IAH) and health in all policies (HiAP), driven by signals of the efficiency and effectiveness of their approaches. Evaluation ought to be integral to this. This report reviews motivations and conditions for appropriate evaluation – the most important being a strong conceptual framework (i.e., ‘theory’). A key reading for intersectorality practitioners.

McDaid D, Park A-L. (2016) Evidence on financing and budgeting mechanisms to support intersectoral actions between health, education, social welfare and labour sectors. Copenhagen: World Health Organisation regional Office for Europe : Health evidence Network; 2016. Available from: [http://eprints.lse.ac.uk/67725/1/McDaid\\_Evidence%20on%20financing\\_2016.pdf](http://eprints.lse.ac.uk/67725/1/McDaid_Evidence%20on%20financing_2016.pdf)

Resourcing intersectorality can be an important incentive for its success. This report reviews 51 cases. Successful models include discretionary earmarked funding, recurring delegated financing allocated to independent bodies and mechanisms for joint budgeting between two or more sectors. Successful models tend to be located at regional and local jurisdictions rather than nation-states. For these models, organizational structures, management, culture and trust are key parameters.

McDaid, David. (2018). Institutionalising intersectoral action: a time for leaping and pole-vaulting. *Eurohealth*, 24 (1), 13 - 15. World Health Organization. Regional Office for Europe. <https://apps.who.int/iris/handle/10665/332586>

Builds on \*McDaid & Park\* and provides practical and tactical advice for establishing intersectoral action and policy. Argues that engaging in sectoral warfare may not yield any result. Rather, one could transcend nitty-gritty and pole-vault over the issue by engaging in governance discourse.

McQueen, David V, Wismar, Matthias, Lin, Vivian. et al. (2012). *Intersectoral governance for Health in All Policies: structures, actions and experiences*. European Observatory on Health Systems and Policies, World Health Organization. Observatory Studies Series: 26. Regional Office for Europe. Copenhagen <https://apps.who.int/iris/handle/10665/326430>

Serious tome by a collection of experts in health promotion and Health in All Policy showing the range of models available for establishing and maintaining Health in All Policy. Shows how governments and ministries can initiate action; and how intersectoral governance structures can be successfully established, used and sustained. Drawing on 20 case studies from Europe, the Americas, Asia and Australia it also identifies key intersectoral structures and how they facilitate intersectoral action: cabinet committees and secretariats; parliamentary committees; interdepartmental committees and units; mega-ministries and mergers; joint budgeting; delegated financing; and public, stakeholder and industry engagement.

Milio, N. (1981). *Promoting health through structural change: analysis of the origins and implementation of Norway's farm-food-nutrition policy*. *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology*, 15(5), 721-734

One of the very first serious analyses, deploying a strong conceptual foundation, of the complex interaction and social, health and economic opportunities of a joined-up public sector policy initiative, in this case, Norway's programme of work to promote health through enhancing agricultural, food, and nutrition parameters in a comprehensive programme logic.

Sassi, F. & Belloni, F. (2014) *Fiscal incentives, behavior change and health promotion: what place in the health-in-all-policies toolkit?* *Health Promotion International*, 29(suppl\_1, 1) pp i103-i112, <https://doi.org/10.1093/heapro/dau050>

Evidence out of the OECD, and supported by its wealth of (statistical) data, that appropriate fiscal governance can generate conditions for intersectoral collaboration and sustained Health in All Policy. Published in connection with the 8<sup>th</sup> Global Health Promotion Conference (Helsinki, 2013) on Health in All Policies.

Schaefer, M. (1981). *Intersectoral cooperation and health in environmental management : an examination of national experience*. World Health Organization. Geneva <https://apps.who.int/iris/handle/10665/39446>

First substantial report, reviewing and summarising the needs and concerns in environmental health management, to systematically argue for added benefit of intersectoral cooperation.

von Schirnding, Y. (1997). *Intersectoral action for health: addressing health and environment concerns in sustainable development*. World Health Organization Office of Global and Integrated Environmental Health. <https://apps.who.int/iris/handle/10665/63359>

Pragmatic yet encyclopaedic report of attempts and successes in intersectorality around the world. Argues there is a need for further analysis of the particular underlying political, economic, development and administrative contexts in which various initiatives are situated, with an emphasis on obtaining a better understanding of the reasons for success or failure under varied conditions and contexts. Fails to frame a strong agenda for resolving this need.

WHO/EURO (2017). *Advocating intersectoral action for health equity and well-being: the importance of adapting communication to concept and audience*. World Health Organization. Regional Office for Europe. Copenhagen <https://apps.who.int/iris/handle/10665/329507>

WHO/EURO Slovenian Summer School report that starts with the correct premise that initiation, establishment, and sustainability of intersectoral action hinges on the appropriate communication and advocacy of evidence across different sector stakeholders. Although the work presents interesting case studies there are few strong analytical and strategic recommendations and the body of literature about the evidence-policy-practice nexus is ignored.

WHO/SEARO (2016). *Strengthening intersectoral collaboration for adolescent health*. World Health Organization Regional Office for South-East Asia. <https://apps.who.int/iris/handle/10665/204359>

The improvement of adolescent health and reduction of inequities between groups in the cohort is an important investment in a nation's future. In this report of a workshop WHO/SEARO claims a range of successes within health service delivery, and recognises that the involvement of other sectors is critical for further development. A series of case studies highlight gender and sexuality education, poverty reduction, and capacity building. Health services are called upon to reach out to other sectors.

## Health sector conceptualisations

The search for appropriate and operational approaches to intersectoral action gained momentum in the 1990s. An Australian review commissioned by the Federal government Harris et al 1995 has become in many ways a stable benchmark in thinking about intersectoral work. Authors describe intersectoral collaboration as "A recognised relationship between part or parts of the health sector and part or parts of another sector, that has been formed to take action on an issue or to achieve health outcomes, (or intermediate health outcomes) in a way which is more effective, efficient or sustainable than could be achieved by the health sector working alone" and list types of intersectoral action as "sharing relevant information on a particular issue; networking to share information and undertake advocacy work; jointly managing cases; co-locating services and providing resources; providing sponsorship or endorsement of activities; providing technical support, information and training; co-ordinating the delivery of services and programmes; providing funds for activities undertaken in other sectors; jointly sponsoring projects; forming coalitions to promote a particular issue; developing joint policies; creating formalised agreements; and developing legislation that applies within other sectors."

Their definition and proto-theoretical typology of intersectoral collaboration was adopted by a WHO conference three years later Kreisel & Von Schirnding 1998, and is still seen as the most authoritative among a range of conceptualisations cf Dubois St-Pierre & Veras 2015, Baldwin et al 2005. Aveling & Jovchelovitch 2014 complement this definition with social psychological insights why individuals, groups and communities are driven to collaborate rather than going it alone – but Synnevåg, Amdam & Fosse 2019 warn that professional identities may be challenged in partnership relations.

Aveling, E.-L., & Jovchelovitch, S. (2014). *Partnerships as knowledge encounters: A psychosocial theory of partnerships for health and community development*. *Journal of Health Psychology*, 19, 34-45.

Partnerships are conceptualised as encounters with the knowledge of self and others, entailing processes of representation and communication between all stakeholders involved, and shaped by institutional and sociocultural contexts. We argue that partnership is an evolving practice that requires critical reflection and the creation of enabling institutional contexts. As such, it must be understood not as a tool for intervention, but as part of the intervention. In a – hitherto lacking - transdisciplinary perspective, authors could have embraced the notion of epistemic communities to embrace divergent sectoral world views.

Baldwin, L., Abernethy, P., Roberts, L., & Egan, H. (2005). *Forming, managing and sustaining alliances for health promotion*. *Health Promotion Journal of Australia*, 16(2), 138-143

Builds on \*Harris et al. 1995\* in a piece of research carried out for the National Heart Foundation of Australia after it established a policy to work intersectorally in alliances. Based on a

small and focused literature review authors see three stages in alliance life cycles, elements of which they test with Heart Foundation staff who add practical and experiential insight. Elegant and brief 'how to' publication.

Dubois, A., St-Pierre, L., & Veras, M. (2015) A scoping review of definitions and frameworks of inter-sectoral action. *Ciencia & saude coletiva*, 20, 2933-2942.

Important scoping review of definitions, concepts, and meanings of different permutations of intersectorality across the literatures of four languages (English, French, Spanish and Portuguese). Proffers consolidated and consensual definitions; deserves an update of recent insights; worthy of global standardization and benchmarking.

Harris, E., Wise, M., Hawe, P., Finlay, P., & Nutbeam, D. (1995). *Working together: intersectoral action for health*. Canberra: Australian Government Publishing Service.

Federal policy report, the first to define intersectoral collaboration: "A recognised relationship between part or parts of the health sector and part or parts of another sector, that has been formed to take action on an issue or to achieve health outcomes, (or intermediate health outcomes) in a way which is more effective, efficient or sustainable than could be achieved by the health sector working alone." Followed by a list of 13 types of intersectoral action.

Kreisel, W., & von Schirnding, Y. (1998). *Intersectoral action for health: a cornerstone for health for all in the 21st century*. *World health statistics quarterly*. *Rapport trimestriel de statistiques sanitaires mondiales*, 51(1), 75-78.

Builds on and adopts the structure and outline of \*Harris et al. 1995\*. This paper is the 'readers' digest' of the official WHO conference report. Gives further legitimacy to the typology suggested.

Synnevåg ES, Amdam R, Fosse E. (2019) Legitimising Inter-Sectoral Public Health Policies: A Challenge for Professional Identities?. *International Journal of Integrated Care*. 2019;19(4):9. DOI: <http://doi.org/10.5334/ijic.4641>

Important empirical research in three Norwegian municipalities how intersectoral action and \*Health in All Policy\* takes shape. Integration in planning and management structures and in formal documents seems easier or less complicated to achieve than other types of legitimacy related to personal understanding, values and norms. For bureaucrats as key operators in establishing collaboration there is the possible risk of identity conflicts, which could potentially pose challenges to collaborations, and challenge the implementation of integrated care.

## Guidance documents and reviews

The review literature in the intersectoral space is characterised by a high degree of utilitarianism. Virtually every piece of work in this section aims to evidence and inspire collaborative work, sometimes diagnostically (*'how do I assess collaboration?'*), sometimes operationally (*'what is known about effective behaviours in collaboration?'*). We will discuss larger reviews first, followed by the available tools and methodological works.

### Reviews

A short digest of top readings in partnerships and intersectoral collaboration is provided by Corbin 2017. She references and analyses the other works that we list here, with some exceptions. De Leeuw 2017 reviews the need for (also cf Sindall 1997, FPTAC 1999, Kuruvilla 2018), and empirical as well as theoretical evidence of, intersectoral work. She concludes that affected communities and institutions should be the prime drivers of intersectorality, but also identifies a need for greater conceptual clarity around distinctions between intersectoral action (interventions), policy (mandated organisational resolutions to resolve problems in particular jurisdictions through the deployment of (re)distribution operations) and governance (higher level rule setting). This aligns with the findings of the classic Gillies 1998 work on

partnerships for health promotion as a function of social capital rather than health services, firmed up by Corbin, Jones & Barry 2016 and Jones & Barry 2011.

Bilodeau et al 2011 formulate and validate a diagnostic tool highlighting the inherent dynamic nature of building and operationalising intersectoral partnerships. This is complemented by earlier work by Rousos & Fawcett 2000 who document the inherent value of partnerships for public health as these are integral to community-based public health work.

Some authors question the functions and legitimacy of intersectoral work and action, often because they do not clarify the conceptual challenges that are identified by De Leeuw 2017, Corbin 2017 and Bilodeau et al 2011. Such critical reviews include Shankardass et al 2012, Graham Sibbald & Patel 2015 who study and critically appraise intersectoral policy (or its variants, Healthy Public Policy and Health in All Policy) from the unique vantage point of public sector action. True partnerships include other institutional arrangements, including civil society (industry, community) actors and actants (meaningful events in the shaping of networks, cf Latour 1999 naming such networks 'actant-rhizome ontologies').

An excellent review that incorporates all these dimensions and proposes hands-on ways forward is offered by Ministry of Health New Zealand 2001. Their stages for conceptualising, shaping, managing and evaluating intersectoral action include (1) agreements on the necessity of intersectoral action; (2) support for it exists in the wider community; (3) capacity exists for (a) partner organisations; (b) community participation; (c) resources; and (d) personal skills, all within a strong inclusive paradigm that in their case is driven by Māori world views; (4) relationships enabling action are defined and developed; (5) agreed actions are planned and implemented; and (6) outcomes are monitored. This detailed list is conceptually rigorous and an enhancement of the initial scope of the Harris et al 1995 work. Further operational strength is added by Canadian perspectives (FPTAC 1999 and Health Canada 1999) who both add an appreciation of the multi-layered nature of sectors (defined as 'fields of activity') and therefore the complex but often opportune connections between public, private and civil society elements of each sector.

Bilodeau, A., Galarneau, M., Fournier, M., & Potvin, L. (2011). Diagnostic tool for action in partnerships: foundation, development and validation. *Canadian Journal of Public Health Revue Canadienne de Sante Publique*, 102(4), 298-302.

The tool includes 18 items, with 3 answer choices provided for each item. It is sensitive to variations in judgement. It allows for good convergence among respondents from participating organizations within a partnership; it can also distinguish between partnerships that have difficulty meeting certain conditions and those that do not. The tool is suitable for self-evaluation of partnerships engaged in common projects that involve more than information exchange.

Canada's Federal Provincial-Territorial Advisory Committee on Population Health (FPTAC) 1999 report *Intersectoral Action Towards Population Health*. Ottawa.

Lists evidence and an inventory of steps toward intersectoral action in Canada

Corbin, J. H. (2017). Health promotion, partnership and intersectoral action. *Health promotion international*, 32(6), 923-929. <https://doi.org/10.1093/heapro/dax084>

Editorial to a virtual collection spanning twenty-five years of conceptual, theoretical, and empirical publishing in the journal *Health Promotion International*. Demonstrates a growing sophistication in thinking about the nature and depth of collaboration in health promotion.

Corbin, J. H., Jones, J., & Barry, M. M. (2016). What makes intersectoral partnerships for health promotion work? A review of the international literature. *Health Promotion International*, 33(1), 4-26. <https://doi.org/10.1093/heapro/daw061>

Scoping review of literature on partnership functioning provides a narrative synthesis of findings related to processes that support and inhibit health promotion partnership functioning. The review includes 26 studies employing quantitative (n = 8), qualitative (n = 10) and mixed

method (n = 8) designs. Nine core elements are identified that constitute positive partnership processes: (i) develop a shared mission aligned to the partners' individual or institutional goals; (ii) include a broad range of participation from diverse partners and a balance of human and financial resources; (iii) incorporate leadership that inspires trust, confidence and inclusiveness; (iv) monitor how communication is perceived by partners and adjust accordingly; (v) balance formal and informal roles/structures depending upon mission; (vi) build trust between partners from the beginning and for the duration of the partnership; (vii) ensure balance between maintenance and production activities; (viii) consider the impact of political, economic, cultural, social and organizational contexts; and (ix) evaluate partnerships for continuous improvement.

de Leeuw, E. (2017). Engagement of sectors other than health in integrated health governance, policy, and action. *Annual review of public health*, 38, 329-349

Review clarifying the conceptual foundations for integral health governance, policy, and action, delineates the different sectors and their possible engagement, and provides an overview of a continuum of methods of engagement with other sectors to secure integration. This continuum ranges from institutional (re)design to value-based narratives. Depending on the lens applied, different elements can be identified within the continuum.

Gillies, P. (1998). Effectiveness of alliances and partnerships for health promotion. *Health promotion international*, 13(2), 99-120

Alliance or partnership initiatives to promote health across sectors, across professional and lay boundaries and between public, private and non-government agencies, do work. They work in tackling the broader determinants of health and well-being in populations in a sustainable manner, as well as in promoting individual health-related behaviour change. The greater the level of local community involvement in setting agendas for action and in the practice of health promotion, the larger the impact.

Graham, R., Sibbald, S. L., & Patel, P. (2015). Public health partnerships: Does the evidence justify the enthusiasm? In *Healthcare management forum* (Vol. 28, No. 2, pp. 79-81). Sage CA: Los Angeles, CA: SAGE Publications.

Slightly technocratic semi-systematic appraisal of the literature on public health partnerships finds that they may not have impact on improvements of individual and population health. However, authors also note that (intersectoral) partnership engagement may have social effects that go beyond patient health. The mixed findings, they claim, make it harder for governments to stimulate collaboration.

Jones, J., & Barry, M. M. (2011a) Exploring the relationship between synergy and partnership functioning factors in health promotion partnerships. *Health Promotion International*, 26(4), 408-420.

This study aimed to identify key factors that influence health promotion partnership synergy. Data were collected from 337 partners in 40 health promotion partnerships. The questionnaire incorporated a number of multidimensional scales designed to assess the contribution of factors that influence partnership synergy. New validated scales were developed for synergy, trust, mistrust and power. Trust, leadership and efficiency were shown to be the most important predictors of partnership synergy. Synergy is predicated on trust and leadership. Trust-building mechanisms need to be built into the partnership forming stage and this trust needs to be sustained throughout the collaborative process.

Kuruville, S., Hinton, R., Boerma, T., Bunney, R., Casamitjana, N., Cortez, R., ... & Papp, S. (2018). Business not as usual: how multisectoral collaboration can promote transformative change for health and sustainable development. *bmj*, 363.

Editorial summarising and further conceptualising twelve country-level case studies from around the world, documenting how multisectoral action can positively affect health and sustainable development. Not inhibited by theoretical or historical awareness the authors propose 'new ways' of framing such effective multisectoral collaboration. Essential steps are – Drive change; - Define; - Design; - Relate; - Realise; - Capture success.

Latour, B. (1999). On recalling ANT. *The sociological review*, 47(1\_suppl), 15-25.

One of the fathers of Actor-Network Theory discusses the problematic nature of each of the elements of the theory: "Actor", "Network", "Theory", and "-" (the hyphen) and concludes it is more method than theory.

Ministry of Health New Zealand (2001) *Intersectoral Initiatives for Improving the Health of Local Communities – A Literature Review*, Wellington [https://www.moh.govt.nz/note-book/nbbooks.nsf/8b635a9881e8aed85256ca8006d4e51/f9foda13c86a067dcc256b1e007923b3/\\$FILE/IntersectoralReviewOctober2001.pdf](https://www.moh.govt.nz/note-book/nbbooks.nsf/8b635a9881e8aed85256ca8006d4e51/f9foda13c86a067dcc256b1e007923b3/$FILE/IntersectoralReviewOctober2001.pdf)

Very detailed review of theoretical, dogmatic and practical evidence in intersectorality, concluding with an extensive set of parameters that – if followed conscientiously and dynamically – guarantee success in collaborating for health.

Roussos ST, Fawcett SB. (2000) *A review of collaborative partnerships as a strategy for improving community health*. *Annu Rev Public Health* 2000; 21: 369–402

Classic text on collaborative partnerships and still a must-read in this space. Examines evidence about the effects of collaborative partnerships on (a) community and systems change (environmental changes), (b) community-wide behaviour change, and (c) more distant population-level health outcomes. We also consider the conditions and factors that may determine whether collaborative partnerships are effective. The review concludes with specific recommendations designed to enhance research and practice and to set conditions for promoting community health.

Shankardass, K., Solar, O., Murphy, K., Greaves, L., & O'Campo, P. (2012). *A scoping review of intersectoral action for health equity involving governments*. *International Journal of Public Health*, 57(1), 25-33

Empiricist review of intersectoral action for health *equity*. Found 128 unique articles describing intersectoral action across 43 countries. A majority of the cases appear to have initiated in the decade since the turn of the millennium. A variety of approaches were used to carry out intersectoral action, but articles varied in the richness of information included to describe different aspects of these initiatives. Authors find that the description of these complex, multi-actor processes was generally superficial and sometimes entirely absent and improvements in such documentation in future publications is warranted.

Sindall, C. (1997). *Intersectoral collaboration: the best of times, the worst of times*. *Health Promotion International*, 12(1), 5-7.

Editorial reflecting on the promise and possible failings of intersectorality if not applied conscientiously.

## Tools and methods

A number of guidance documents, scales, toolkits and checklists have been developed for making, running and evaluating intersectorality. VicHealth 2016 has formulated a popular checklist for the life stages of partnerships in health. It is a condensation of practical work published by, for instance, an overview of the shifts in intersectorality and public policy by Public Health Agency of Canada 2007, and the systematic appraisal of a large number of practical tools by Mahmood, Moreale & Barry 2015 which is unique in its wide scope. The Tamarack Institute nd toolkit addresses similar areas but more prominently from a community perspective and aimed at a North American audience (VicHealth 2016 is Australian, Mahmood,

Moreal & Barry 2015 European; we have not been able to identify toolkits from the Global South and non-OECD members states).

The scholarly community has proposed a number of tools and methods to appreciate and gauge intersectorality, too. Jones & Barry 2011 have developed a tool to measure synergy in health partnerships, building on initial work by Lasker, Weiss & Miller 2001. A specific challenge in appraising partnerships is addressed by Leurs et al 2008 who echo the systematic review work by Roe, Guinness & Rafferty 1999: how would you measure phenomena that are inherently dynamic, shape-shifting and possibly ephemeral? Their solution is to establish benchmark moments and opportunities; Bilodeau et al 2011, however, embrace the fluidity in these networks by adopting a more dynamic theoretical approach that enables the measurement of change over time and space.

Bilodeau, A., Galarneau, M., Fournier, M., & Potvin, L. (2011). Diagnostic tool for action in partnerships: foundation, development and validation. *Canadian Journal of Public Health Revue Canadienne de Sante Publique*, 102(4), 298-302.

Reports the development, validation and implementation of a tool that dynamically allows for the support of partnership arrangements. More narratively and qualitative focused but a great resource.

Delaney, F. G. (1994). Muddling through the middle ground: theoretical concerns in intersectoral collaboration and health promotion. *Health Promotion International*, 9(3), 217-225

Reviews concepts and perspectives within the 'interorganisational relations' literature. These are applied to health promotion, specifically the development of healthy public policy at local level. Accounts for the importance of collaboration and working together at practitioner level, but the main emphasis is on strategic level collaboration and policy coordination. The aim is to consolidate understanding of the concept, its features and its 'determinants'.

Public Health Agency of Canada (2007) *Crossing Sectors – Experiences in intersectoral action, public policy and health*. Prepared by the Public Health Agency of Canada in collaboration with the Health Systems Knowledge Network of the World Health Organisation's Commission on Social Determinants of Health and the Regional Network for Equity in Health in East and Southern Africa (EQUINET), Ottawa. [https://www.who.int/social\\_determinants/links/events/crossing\\_sectors\\_2007.pdf](https://www.who.int/social_determinants/links/events/crossing_sectors_2007.pdf)

Documents an overview of horizontal and vertical integration in Intersectoral Action (IA) and liberally confuses complexity thinking, policy processes, and governance within and between sectors. Yet a good account of the relationship between intersectorality and social determinants of health.

Jones, J., & Barry, M. M. (2011b). Developing a scale to measure synergy in health promotion partnerships. *Global Health Promotion*, 18(2), 36-44.

Practice oriented version of Jones & Barry 2011a reporting on the work undertaken and its operational opportunities for health promoters.

Lasker, R. D., Weiss, E. S., & Miller, R. (2001). Partnership synergy: A practical framework for studying and strengthening the collaborative advantage. *Milbank Quarterly*, 79(2), 179-205.

Lengthy and insightful review of the predominantly US literature on partnerships and interorganisational partnerships for health. Resolving that the concept of 'synergy' is key to their understanding and development. Operationalises a synergy measurement tool and validates it through panel research.

Leurs, M. T., Mur-Veeman, I. M., van der Sar, R., Schaalma, H. P., & de Vries, N. K. (2008). Diagnosis of sustainable collaboration in health promotion—a case study. *BMC public health*, 8(1), 382.

Developed the Diagnosis of Sustainable Collaboration (DISC) model to enable comprehensive monitoring of public health collaboratives. The model focuses on opportunities and impediments for collaborative change, based on evidence from interorganizational collaboration, organizational behaviour and planned organizational change. Empirical application shows that monitoring a collaboration based on the DISC-model yields insight into windows of opportunity and current impediments for collaborative change. DISC-based monitoring is a promising strategy enabling project managers and social entrepreneurs to plan change management strategies systematically.

Mahmood, S., Morreale, S., & Barry, M. M. (2015). Developing a checklist for intersectoral partnerships for health promotion. World Health Organization Collaborating Centre for Health Promotion Research, National University of Ireland Galway

Background study to \*Jones & Barry 2011a\* \*Jones & Barry 2011b\* \*Corbin Jones & Barry 2016\* with the full research protocol and complete data set. Excellent source material for replication.

Roe, B., Guinness, L., & Rafferty, A. M. (1999). A systematic search of the literature on effectiveness of alliances for health promotion: some methodological issues and their implications for research. *Health Education Journal*, 58(1), 78-90.

Behaviour-change focused study reviewing 19 'macro-alliances' and 91 'micro-alliances' for 'health promotion' (ie health education). Taking the randomised controlled trial as their search benchmark, authors find unsatisfactory results, then discuss methodological issues and framing challenges.

Tamarack Institute (nd) Collaboration Spectrum Tool. <https://www.tamarackcommunity.ca/library/collaboration-spectrum-tool> Tamarack Institute for Community Engagement, University of Waterloo, Ontario, Canada

Practical toolbox for guiding communities through their collaboration ambitions.

VicHealth, Victorian Health Promotion Foundation. (2016) The partnership analysis tool: A resource for establishing, developing and maintaining partnerships for health promotion. Resource document. Retrieved March 18, 2018, from, <https://www.vichealth.vic.gov.au/media-and-resources/publications/the-partnerships-analysis-tool>

Excellent resource for diagnosing and then developing opportunities for partnerships across a range of agencies and communities. Locally a gold standard.

## Domain specific work

Intersectoral action, policy and governance really comes into its own once it is driven by specific problematised (and politicised) areas of work. It is interesting to note that the emphasis of intersectoral arguments has shifted from infectious disease control and sanitation (as pointed out in earlier sections) to the prevention, control and management of non-communicable disease (NCDs), also framed as 'chronic' or 'lifestyle' health conditions. We take a look at a selection of these issues, including resource considerations, obesity, food and nutrition, global health and its determinants, community health, schools, equity, and a rest category that includes sport. It is further noteworthy that some of the main areas of world health concern, including tobacco control, have not to a meaningful degree published analyses around intersectoral paradigms.

## Resourcing intersectorality

McDaid D, Park A-L. (2006) Evidence on financing and budgeting mechanisms to support intersectoral actions between health, education, social welfare and labour sectors. Copenhagen: World Health

Organisation regional Office for Europe : Health evidence Network; 2016. Available from: [http://eprints.lse.ac.uk/67725/1/McDaid\\_Evidence%20on%20financing\\_2016.pdf](http://eprints.lse.ac.uk/67725/1/McDaid_Evidence%20on%20financing_2016.pdf)

Proactively resourcing intersectorality is one critical strategy for successful formation and maintenance of collaborative work. Authors review forms of financing (earmarked; delegated; joint); the architecture for getting it right; identification of ‘resourceable’ outcomes; creating ongoing financial routine. They identify trust, local level action, and incentives as critical determinants of intersectorality.

McGuire, F., Vijayasingham, L., Vassall, A., Small, R., Webb, D., Guthrie, T., & Remme, M. (2019). Financing intersectoral action for health: a systematic review of co-financing models. *Globalization and Health*, 15(1), 86. <https://doi.org/10.1186/s12992-019-0513-7>

Reports a review of incentivising intersectoral action on structural inequities and barriers to health interventions and finds that it contributes to more effective engagement of non-health sectors; to efficiency gains in the financing of universal health coverage; and to simultaneously achieving health and other well-being related sustainable development goals.

Watkins, D. A., Nugent, R., Saxenian, H., Danforth, K., González-Pier, E., Mock, C. N., ... & Jamison, D. T. (2017). *Intersectoral Policy Priorities for Health*. In *Disease Control Priorities: Improving Health and Reducing Poverty*. 3rd edition. The International Bank for Reconstruction and Development/The World Bank.

This chapter proposes 29 concrete early steps that countries with highly constrained resources can take to address the major modifiable behaviour and environmental risks while (1) touching on broader social policies addressing the consequences of ill health; (2) stressing that the need for such policies will increasingly place demands on public finance; (3) providing illustrative examples from Sri Lanka, Mexico, and Vietnam of successful health risk reduction through intersectoral policy; and (4) discussing various aspects of policy implementation.

## Obesity

Johnston, L. M., & Finegood, D. T. (2015). Cross-sector partnerships and public health: challenges and opportunities for addressing obesity and noncommunicable diseases through engagement with the private sector. *Annual review of public health*, 36, 255-271.

In the obesity space, partnering with businesses presents a means to acquire resources, as well as opportunities to influence the private sector toward more healthful practices. However, public-private or nonprofit-private partnerships present risks and challenges that warrant specific consideration. The review takes stock of the role of public health partnerships with the private sector, with a focus on efforts to address obesity and noncommunicable diseases in high-income settings. Authors identify key challenges—including goal alignment and conflict of interest—and consider how changes to partnership practice might address these.

## Food, nutrition, agriculture

Hawkes, C., & Buse, K. (2011). Public health sector and food industry interaction: it's time to clarify the term ‘partnership’ and be honest about underlying interests. *The European Journal of Public Health*, 21(4), 400-401.

Refreshing political view of the partnership rhetoric and an argument that any public health/health promotion practitioner and developer should be aware of stakes, interests and power issues behind the scenes of intersectoral action.

Milio, N. (1981). Promoting health through structural change: analysis of the origins and implementation of Norway's farm-food-nutrition policy. *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology*, 15(5), 721-734.

Documentary analysis of Norway's integrated policy – the basis of Milio's later landmark publication on \*Healthy Public Policy\* which was at the foundation of the \*Ottawa Charter\* (1986) and Adelaide Recommendations on Healthy Public Policy (1988).

WHO (2015) Addressing and managing conflicts of interest in the planning and delivery of nutrition programmes at country level. Report of a technical consultation convened in Geneva, Switzerland, on 8–9 October 2015. ISBN 978 92 4 151610 5.

[https://apps.who.int/iris/bitstream/handle/10665/206554/9789241510530\\_eng.pdf?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/206554/9789241510530_eng.pdf?sequence=1)

As \*Hawkes and Buse 2011\* argue, many health promotion concerns touch on industry influence and lobby. Report of WHO identifies conflicts of interest, their accountability and transparency, and pitfalls for health promotion action across this intersectoral space.

## Global determinants of health

Lencucha R, Thow AM (2020) Intersectoral policy on industries that produce unhealthy commodities: governing in a new era of the global economy? *BMJ Global Health* 2020;5:e002246.

Commercial determinants of (NCD related) global health could be regulated by national and global instruments. These necessarily need to be intersectoral, this piece argues. Possible policies include labelling, marketing and excise taxes, but are in the realm of sectors beyond health. In recent years, the status quo of a narrow economic rationality that places economic growth above health, environment or other social goals is being re-evaluated by some governments and key international economic agencies, authors argue. This seems the time for public health to (1) reimagine policy mandates, drawing on whole-of-government imperatives for sustainable development, and (2) closely examine the institutional structures and governance processes for synergy between agendas.

Lock, K. & McKee, M. 2005, 'Health impact assessment: assessing opportunities and barriers to intersectoral health improvement in an expanded European Union', *Journal of Epidemiology and Community Health*, vol. 59, pp. 356-360.

Dated but interesting argument that transnational collaboration must be driven by health impact assessment, which in itself necessarily is of an intersectoral nature. This paper argues for an intersectoral public health approach in an expanding European Union. It reviews the legal basis for assessing the health impacts of policy in the EU and, using health impact assessment as a case study, it examines how well the new member states may be prepared to tackle intersectoral public health action within the constraints imposed by EU policy.

Watkins, D. A., Nugent, R., Saxenian, H., Danforth, K., González-Pier, E., Mock, C. N., ... & Jamison, D. T. (2017). *Intersectoral Policy Priorities for Health*. In *Disease Control Priorities: Improving Health and Reducing Poverty*. 3rd edition. The International Bank for Reconstruction and Development/The World Bank.

World Bank argument for instruments and techniques to include intersectoral approaches for health within LICs and MICs (Lower; Middle Income Countries) and how these could be inspired by South-South exchanges and North-South assistance mechanisms. Many excellent intersectoral case studies.

Jamison, D. T., Alwan, A., Mock, C. N., Nugent, R., Watkins, D., Adeyi, O., ... & Binagwaho, A. (2018) Universal health coverage and intersectoral action for health: key messages from *Disease Control Priorities*. *The Lancet*, 391(10125), 1108-1120.

Message from a group of esteemed (former) bureaucrats and leaders of global NGOs, United Nations technical agencies and scholars that Universal Health Cover (UHC) can only be achieved through political will and intersectoral action.

## Communities

El Ansari, Ceri J. Phillips, W. (2001). Partnerships, community participation and intersectoral collaboration in South Africa. *Journal of Interprofessional care*, 15(2), 119-132.

Five community partnerships were initiated in South Africa as demonstration projects aimed at the re-orientation of health professionals' education to be more community responsive and interprofessional. The paper identifies potential impediments, and makes explicit how they impact on partnership fostering. Includes mechanisms for their early detection and possible solutions. The lessons are that wide representation, commitment and a sense of ownership, sound leadership skills, regular and effective communication, reliable member expertise and capabilities and attention to power issues are crucial elements in the partnership equation.

Goodman, R. M., Wandersman, A., Chinman, M., Imm, P., & Morrissey, E. (1996). An ecological assessment of community-based intervention for prevention and health promotion: Approaches to measuring coalitions. *American Journal of Community Psychology*, 24(1), 33-61

American health education and public health literature often speaks of 'coalitions' rather than partnerships or collaborations. This paper claims to present an ecological assessment of a community coalition to prevent alcohol, tobacco, and other drug abuse, and related risks. Ecological assessment is defined as occurring at multiple social levels and along a continuum of stages of coalition readiness. Measures used to assess the coalition's formation, implementation of community initiatives, and production of community impacts are described, along with the triangulation strategies used to enhance the assessment findings.

Cicognani, E., Albanesi, C., Valletta, L., & Prati, G. (2020). Quality of collaboration within health promotion partnerships: Impact on sense of community, empowerment, and perceived projects' outcomes. *Journal of Community Psychology*, 48(2), 323-336.

Study assessed the quality of the functioning of health promotion partnerships created within a large community health promotion program implemented by the Emilia-Romagna region located in the north-east of Italy. Measures effectiveness of partnership working in empowerment, sense of community and the outcomes of a well-functioning partnership. Uniquely, uses Bayesian structural equation modelling to establish that higher perceived quality of collaboration within the partnership enhances the outcomes of a well-functioning partnership, by strengthening their sense of a health-promoting community and empowerment.

## Schools

Bergeron, D. A., Talbot, L. R., & Gaboury, I. (2019). Intersectoral oral health promotion interventions for schoolchildren living in remote rural Andean communities: a realist evaluation. *Global Health Promotion*, 1757975919870160.

Previous positive experiences of collaboration, a focus on communication, feelings of being respected and considered, and development of leadership and trust among stakeholders involved in intersectoral oral health promotion were elements of configurations that positively influence intersectoral oral health promotion. On the other hand, unfavorable physical, social and political environments, previous negative health experiences, feelings of not being respected or considered, demotivation, development of mistrust and insufficient leadership were shown to negatively influence outcomes.

Pucher KK, Candel MJJM, Krumeich A, Boot NMWM, de Vries NK. (2015a) Effectiveness of a systematic approach to promote intersectoral collaboration in comprehensive school health promotion: a multiple-case study using quantitative and qualitative data. *BMC Public Health*. ;15:613.

Applies the DISC model \*Pucher et al. 2015b\* to demonstrate that major improvements in change management and project management occurs in intersectoral school action. There were also improvements in consensus development, commitment formation, formalization of the CSHP, and alignment of policies, although organizational problems within the collaboration increased. Content analyses of qualitative data identified five main management styles, including (1) facilitating active involvement of relevant parties; (2) informing collaborating parties; (3) controlling and (4) supporting their task accomplishment; and (5) coordinating the collaborative processes.

Pucher KK, Candel MJJM, Boot NMWM, van Raak AJA, de Vries NK. (2015b) A multiple case study of intersectoral collaboration in comprehensive school health promotion using the Diagnosis of Sustainable Collaboration (DISC) model. *Health Educ*. 2015;115:301–21.

Case of 'slicing the salami thin' for peer-reviewed publication, replicates \*Pucher et al 2015a\* but adds more information on the actual development of the DISC model.

## Equity

Ndumbe-Eyoh, S., & Moffatt, H. (2013). *Intersectoral action for health equity: a rapid systematic review*. *BMC public health*, 13(1), 1056

Found 1 systematic review, 14 quantitative studies, and 2 qualitative studies, 10 of which classified as 'strong'. The body of literature on intersectoral action as a public health practice for advancing health equity is mixed, revealing moderate to no effect on the social determinants of health. Much of the available literature is descriptive and programs are not rigorously evaluated. Creating an interdisciplinary body of knowledge about how to evaluate intersectoral action, along with supporting tools, will help strengthen the evidence base for intersectoral action on health equity and the social determinants of health. Collaborations between public health and other sectors show promise in creating supportive environments and enhancing access to services for marginalized populations.

Shankardass, K., Solar, O., Murphy, K., Greaves, L., & O'Campo, P. (2012). *A scoping review of intersectoral action for health equity involving governments*. *International Journal of Public Health*, 57(1), 25-33

Using different search parameters from \*Ndumbe-Eyoh & Moffatt 2013\* this study found 128 unique articles describing intersectoral action across 43 countries. A variety of approaches were used to carry out intersectoral action, but articles varied in the richness of information included to describe different aspects of these initiatives. The description of these complex, multi-actor processes in the published documents was generally superficial and sometimes entirely absent and improvements in such documentation in future publications is warranted.

Chircop, A., Bassett, R., & Taylor, E. (2015). *Evidence on how to practice intersectoral collaboration for health equity: a scoping review*. *Critical Public Health*, 25(2), 178-191

Authors set out to systematically document how to do intersectoral policy making. Out of 227 articles, 64 articles described intersectoral collaboration specifically in relation to public policy. Of those articles with a policy topic, 10 had a focus on broad public policy areas, while 51 publications articulated specific policies relevant to the determinants of health and only three articles examined effective practices of intersectoral collaboration in public policy through phenomenology, literature review and case study research. The majority of policy-focused

publications described that collaboration was used as a strategy to address intersectoral public policy issues, but failed to report how the process of collaboration unfolded.

Scheele, C. E., Little, I., & Diderichsen, F. (2018). Governing health equity in Scandinavian municipalities: The inter-sectorial challenge. *Scandinavian journal of public health*, 46(1), 57-67.

Excellent research situated within the Scandinavian type welfare states. Identifies 24 intersecting factors across seven themes that fall into three categories: political processes, evidence and concerted administrative action. The identified factors intersect and operate at multiple government levels that involve complex interdependencies and coordination issues. Getting health equity and intersectorality on municipal agendas is also a matter of careful policy/evidence framing that may need to include sustainability and 'HEiAP' (Health Equity in All Policies) references.

### Physical activity and sport

Kang, E. (2015). Intersectoral collaboration for physical activity in Korean Healthy Cities. *Health promotion international*, 31(3), 551-561.

Narrative comparative account of intersectoral efforts in physical activity programmes looking at Healthy Cities and non-Healthy Cities. There were no statistical differences between the two groups. Collaboration activities were mostly supportive, such as providing a venue, recruiting participants and publicizing, and other kinds of administrative support. To strengthen intersectorality in Korean Healthy Cities, various actions including providing a legal basis, specific and substantive supports, financial incentives, and organizational recognitions will be helpful as well as the development of partnerships with other departments in urban planning, transport, urban design, and communication.

Hermens, N., Verkooijen, K. T., & Koelen, M. A. (2019). Associations between partnership characteristics and perceived success in Dutch sport-for-health partnerships. *Sport Management Review*, 22(1), 142-152.

Working in sport-for-health partnerships is challenging and little is known about how to manage such partnerships. This paper reports on a questionnaire among 86 participants in Dutch sport-for-health partnerships. It includes measures pertaining to three indicators of successful inter-sectoral partnership (i.e., partnership synergy, partnership sustainability, and community outcomes) and nine partnership elements that may predict its success. Multivariate results suggest that (a) partnership synergy may be best predicted by communication structure and building on the partnership participants' capacities, (b) community partnership outcomes may be best predicted by partnership visibility and task management, and (c) partnership sustainability may be best predicted by partnership visibility.