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REDUCING HEALTH INEQUITIES THROUGH INTERSECTORAL ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

Report of the Secretariat

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BACKGROUND

1. Health inequities are unjust and avoidable.[1] Population health and health inequalities are influenced by the conditions in which people are born, live, grow and age. They are also influenced by the broader determinants of health which are predicated on policies, governance structure, political and economic factors, as well as the environmental and developmental issues in countries. Reducing health inequities requires addressing wider socioeconomic and structural factors and tackling the underlying causes of disease, inaccessibility to health care services and shortage of quality services.

2. Since 2008, WHO has launched the Commission on Social Determinants of Health report,[2] adopted a series of international social determinants of health, and issued several health promotion declarations.[3,4,5,6,7,8] Resolutions WHA67.12 of 2014 and WHA69.24 of 2016 highlight the need for WHO and Member States to recognize and address the social determinants of health. These commitments underscore the need for sustainable actions across sectors, the whole-of-government approach, the health-in-all-policies approach, and integrated people-centred health services[9] to improve population health and health equity.

3. The 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs) provide a development framework that requires intersectoral collaboration, greater efforts and coordination across sectors. They constitute an opportunity for the health sector to address the determinants of health while promoting health in all goals. The recent Executive Board paper[10] (EB140/32) clearly stated that "a strength of the 2030 Agenda is that opportunities to improve health can be found across the entire set of Sustainable Development Goals. The drivers of good health are neither linear nor unidirectional; rather, good health outcomes depend on multiple inputs that are shared across work towards other goals, and the outcomes often feedback to reinforce the inputs". On the other hand, health is a precondition for and an outcome of policies to promote sustainable development.

4. Ensuring food security is one of the SDGs that plays a major role in population health outcomes, particularly for children. In 2016, for instance, over 40% of under-five children in 19 out of 41 countries had a low socioeconomic status (poorest quintile), and thus suffered from chronic malnutrition compared to the richest quintile, while most of the other countries had less than 20% (see Annex 1). These disparities stem from the unavailability, inaccessibility and unaffordability of nutritious food for the entire population. Intersectoral actions involving the finance, health, agriculture and other economic sectors are required to address poverty, food insecurity, and malnutrition as highlighted in the case of Ghana and Kenya (see Annex 5) which show desirable results.

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1 Whitehead M. (1992). The concepts and principles of equity and health. *International Journal of Health Services* 22: 429-445.

2 Definition: Social determinants of health (SDOH) are the economic and social conditions (in which people are born, grow, live, work and age) and their distribution among the population that influence individual and group differences in health status.

3 WHO (1986). Ottawa Charter for Health Promotion. First International Conference on Health Promotion, Ottawa, Canada. 21 Nov 1986.

4 WHO (2005). The Bangkok Charter for Health Promotion in a globalized world.

5 WHO (2011). Rio Political Declaration on Social Determinants of Health. World Conference on Social Determinants of Health, Rio de Janeiro, Brazil: 19-21 October, 2011.

6 WHO (2011). UN Political Declaration on Non-Communicable Diseases.

7 WHO (2013). Helsinki Health in All Polices.

8 WHO (2016). Shanghai Declaration on the role of Health Promotion.

9 WHO (2016). WHO Framework on Integrated people centered health service.

10 WHO (2017) Progress in the implementation of the 2030 Agenda for Sustainable Development Report by the Secretariat (EB140/32). Geneva, January, 2017.

5. Education and place of residence also contribute to inequalities. For example, in 2016 uneducated mothers were less likely to have their children immunized. Annex 2 illustrates measles immunization coverage among one-year-olds based on mothers' level of education. Disparities between urban (70%) and rural (50%) communities that have access to safely-managed sources of drinking water are also visible in most countries (see Annex 3). The richest quintile in most countries had over 50% access to improved sanitation facilities while the poorest population had less than 30% access (see Annex 4). Inequitable distribution of water has huge implications on sanitation and hygiene, often resulting in a high burden of diseases like cholera, typhoid, malaria and yellow fever which can spread to epidemic proportions.[11]

6. Commercial determinants, including unhealthy diets, industrialization of manufacturing of food and sugar-added beverages, harmful use of alcohol, tobacco use and exposure to tobacco smoke and unsafe food; violence and injuries, and the advertising of unhealthy products have contributed to the rising burden of noncommunicable diseases (NCDs) in Africa. The burden of NCDs is related to cardiovascular diseases (heart attacks and stroke), cancers, chronic respiratory diseases (chronic obstructed pulmonary disease and asthma) and diabetes. WHO estimates that approximately 62% of adults aged over 45 years die from NCDs and by 2020, NCD-related morbidity and mortality are projected to rise to 60% and 65% respectively.[12]

7. Nevertheless, some countries in the WHO African Region, show positive intersectoral experiences and contribute to health and the outcomes of other sectors. For example, the Gambia and South Africa have instituted successful tobacco control through political leadership and multisectoral actions with broad-based participation and strategic partnerships from the national to the subnational levels, including civil society. The community-based insurance initiative in Rwanda is another example of successful intersectoral action under which the health sector engages with the Office of the President, the Ministry of Finance and the Economy, as well as local government bodies to increase the health budget and seek health financing support (see Annex 5).

8. Member States in the WHO African Region are increasingly aware of the importance of the determinants of health and the need for strategic alignment with policies across sectors to enhance actions that address health inequities in the long term (see Annex 5).

9. The WHO African Region highlights challenges and proposes key actions under the WHO agenda on intersectoral action for health, which can be undertaken by multiple stakeholders to advance the SDGs (EB140/32).

ISSUES AND CHALLENGES

Provision of policy, legislation and regulatory frameworks to promote intersectoral collaboration

10. Addressing the upstream determinants of health such as the policies of other sectors is a challenge in most countries that have no policy, legislation and regulatory frameworks that promote intersectoral collaboration. Intersectoral programmes such as tobacco control,

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[11] WHO (2017). Financing Universal Water, Sanitation and Hygiene under the Sustainable Development Goals. UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) 2017 report. Geneva: World Health Organization; 2017.

[12] http://www.aho.afro.who.int/profiles_information/index.php/AFRO:Disease_burden -_Non-communicable_diseases_and_conditions

HIV/AIDS, nutrition and healthy products, road safety, health and social security regulation, require legislative and regulatory frameworks to engage with other sectors with a view to delivering desirable health outcomes and tackling the impact of trade agreements, tobacco advertisement, cross-border migration, traffic regulation, etc. The sustainability of intersectoral actions becomes a challenge when there is no high-level support from the governance system.

11. The health sector needs an integrated approach to engage with other sectors in addressing health inequities and the determinants of health, while leveraging the new framework of Sustainable Development Goals. The major development stakeholders such as local government structures, civil society, the private sector and other non-health sectors need to be engaged to provide social amenities and infrastructure for health. Pooling resources for technical and financial support through intersectoral alignment and coordination will address issues of duplication of efforts, fragmented impact and dispersed resources.

Leadership and political commitments needed to identify, monitor and build evidence on health and inequities

12. The health sector often plays a responsive role in providing needed services on the health conditions of the population. However, the challenge resides in how to address the underlying causes of illness that lie outside the health sector. The SDGs platform provides a new opportunity for the heath sector to draw attention to health as an outcome and prerequisite to development, thus championing the cause of sustainable development in which everyone counts.

13. To provide effective leadership for health and development, the ministry responsible for public health needs to strengthen its data systems to provide scientific evidence on health disparities across population groups, including the vulnerable and hard-to-reach populations. National population survey and census statistics need to be routinely updated to monitor progress and assess the impact of policies and programmes on population health, using sufficient disaggregated data coming from the subnational to the national health information systems. Reliable data sets and shared information across sectors would ensure effective planning and decision-making for the whole-of-government approach to addressing health inequities and the determinants of health.

14. Investment in health information systems, innovative research, research capacity, infrastructure and tools is critical to understanding the underlying determinants of health and for enabling countries to move forward and close the knowledge gaps in public health research. Research to formulate the economic rationale that backs up the case for social determinants of health and health inequality interventions will be crucial in enabling Member States to strengthen systematic dialogue and collaboration with other sectors and to facilitate understanding of the various sectoral agendas and policy approaches.

Changing landscape that needs collaborative efforts, resources, and capacities

15. The African Region faces unique challenges that include a rapidly changing demographic profile, changing environmental conditions, a growing youthful and elderly population, rural-urban migration, climate change and governance challenges. These factors contribute to food insecurity, social unrest and climate-related disease outbreaks due in part to inadequate water supply, poor sanitation and lack of other essential amenities necessary for a healthy life. There is a disproportionate distribution of these social amenities between the rich and the poor, men and women, rural and urban dwellers, leading to a widening of the inequalities and inequities gap within countries due to limited preparedness to respond to these rapid changes. This changing

landscape will need collaborative efforts, high-level political commitment, adequate resources and capacities to address the critical determinants of health.

ACTIONS PROPOSED

Provide policy, legislation and regulatory frameworks to strengthen intersectoral coordination and collaboration in addressing social determinants

16. Member States should establish sustainable coordination mechanisms at the national and subnational levels to ensure that the private sector, civil society and other sectors mainstream health into their policies. A coordinated multisectoral approach will help to address the determinants of health effectively and to ensure that a "whole-of-government" approach is adopted to reducing health inequities in the African Region.

17. Member States should adopt and implement an intersectoral approach to facilitate actions that address the social and environmental determinants of health and promote an inclusive, equitable, economically-productive and healthy society through engagement with multisectoral partners, civil society groups, the private sector and communities.

18. Member States should develop or utilize existing policies, legislation and regulatory frameworks to strengthen effective intersectoral collaboration among various sectors and to foster good governance for health and development across sectors. Local government structures and authorities (i.e. municipalities) play crucial roles in implementing intersectoral actions that address the factors influencing health, including reaching diverse population groups with services.

19. Member States should take action to strengthen systematic dialogue and collaboration with other sectors and to understand the various sectoral agendas and policy approaches to timely interventions that promote the positive impact of public policies on population health.

20. Member States are encouraged to strengthen the primary health care system through a paradigm shift and prioritizing health promotion with sufficient financial resources. Countries are urged to engage local communities in the planning process, including identifying health needs and finding context-specific solutions to meet their needs.

Strengthen leadership in health and development

21. Member States, particularly the ministry in charge of health, should use their leadership in health to advocate for health in all Sustainable Development Goals, while recognizing the major contributions that policies and programmes from other sectors make towards addressing the determinants of health for all population groups including indurialization and commercialization of unhealthy products that contribute to the rising burden of noncommunicable diseases.

22. Member States should strengthen health leadership at all levels, advocate for the reduction of health inequities through all programme functions, and foster the co-design of programme implementation with other sectors, bearing in mind that the various constituencies would mutually benefit from tackling the determinants of health through a health-in-all-policies approach.

23. Member States should invest in capacity development to strengthen leadership and partnership skills, as well as resources for collaborative actions with multisectoral partners.

Building evidence, innovation and scientific research

24. Member States are urged to strengthen or build national and subnational data collection systems to ensure the routine collection of accurate disaggregated data to monitor health inequalities and inequities, particularly those generated by social, economic and environmental factors. Institutional structures should enhance the monitoring of progress and support information-sharing to strengthen intersectoral actions that address the determinants of health and leverage innovation and scientific research across sectors and departments.

25. Member States should develop a culture of evidence-based research to inform decision-making at all levels, giving consideration to the underlying causes of health issues within health systems and across programmatic areas, and to develop tools for communicating with partners and stakeholders in tackling the determinants of health and inequities.

26. Member states should use impact assessment for policy-making, or tools developed by WHO such as the urban health impact assessment and response tool (Urban HEART),[13] the health inequality monitoring tool,[14] the policy brief series on intersectoral actions for health,[15] or the checklist for evaluating the function of intersectoral partnerships to effectively influence the development agenda and address the determinants of health.

International cooperation for knowledge and skills sharing

27. Member States should embrace South-South and international cooperation through bilateral, regional, subregional or interregional agreements to create and strengthen existing technological capacity, share knowledge and skills through capacity-building, and pool their expertise and resources to address the social determinants of health while moving forward to achieve the Sustainable Development Goals. Such concerted efforts require active commitment and participation from all partners to ensure that health issues are considered through whole-of-government and whole-of-society approaches.

Address the changing landscape

28. Member States should collaborate across sectors to seek opportunities for tackling the determinants of health particularly those relating to urbanization, rapid demographic changes and the new landscape of interconnectedness in social, economic and health development. They should build partnerships with local authorities, social protection entities and legislative authorities to combat existing inequalities and inequities across population groups, and also promote the active participation of multi-stakeholders to create an enabling environment for the population to enjoy healthy and sustainable lives.

29. WHO, as the secretariat to this agenda, will provide technical support, guidance and development of tools to facilitate the intersectoral actions that address the social determinants of health, using the "health in all policies" or "one-health" approach (that recognizes the interrelationships between human, animal, and environmental health and applies interdisciplinary tools and intersectoral efforts to solve complex health risks). WHO plays a key role in creating the platform for political dialogue and engagement with partners across sectors to support intersectoral actions at country level. Such partners are the private sector, civil society including the UN country teams, development partners and relevant experts. As part of global actions on

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[13] http://www.who.int/kobe_centre/measuring/urbanheart/en/.
[14] http://apps.who.int/iris/bitstream/10665/85345/1/9789241548632_eng.pdf.
[15] http://www.who.int/social_determinants/publications/SDH6.pdf.

the determinants of health to address health inequities, WHO will collaborate within the United Nations system and intergovernmental organizations on advocacy, research, capacity-building and direct technical support on social determinants of health and inequities.

30. The Regional Committee examined the document and endorsed the actions proposed.

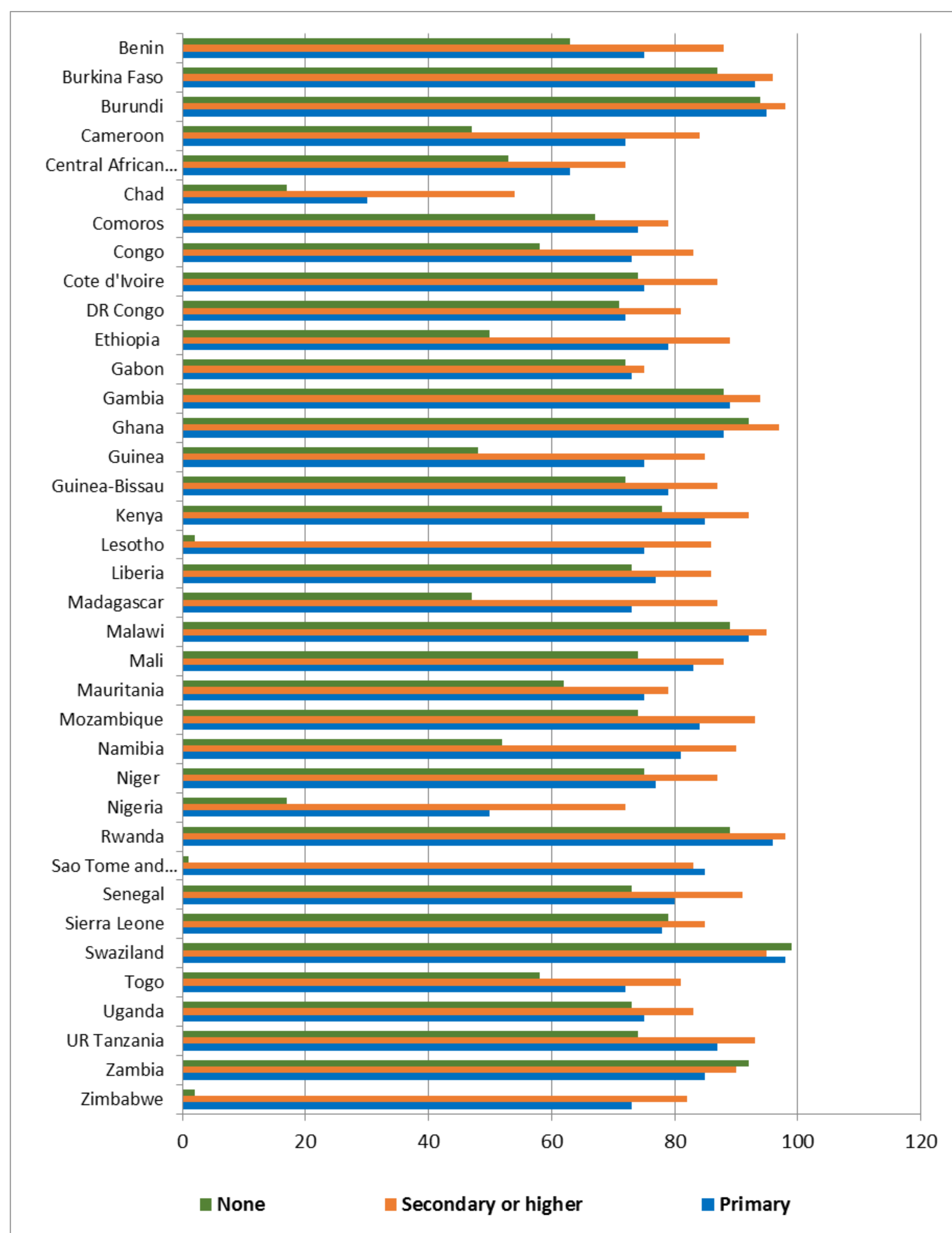
ANNEX 1: Prevalence of chronic malnutrition among under-five children by the poorest and richest quintiles in 41 Countries

Prevalence of chronic malnutrition – under-five children	Poorest quintile	Second quintile	Middle quintile	Fourth quintile	Richest quintile
Algeria (2012)	12.6	12.1	11.0	11.7	10.6
Benin (2006)	49.5	48.3	47.2	39.2	28.8
Burkina Faso (2010)	41.9	37.0	37.6	33.2	18.6
Burundi (2010)	70.0	59.1	59.8	56.5	41.4
Cameroon (2011)	26.1	18.0	11.6	8.8	2.8
Central African Republic (2010)	45.3	44.7	41.4	39.4	30.3
Chad (2010)	38.3	42.7	41.3	40.8	29.7
Comoros (2012)	38.2	32.5	25.9	27.0	21.9
Congo (2012)	34.5	27.6	26.9	17.0	9.3
Côte d'Ivoire (2011)	38.5	35.5	27.7	24.2	15.5
DR Congo (2013)	49.7	48.3	45.8	41.4	22.9
Equatorial Guinea (2011)	28.4	28.7	35.2	26.5	19.0
Eritrea (2010)	56.6	57.2	59.0	46.9	26.5
Ethiopia (2011)	49.2	47.7	45.6	45.0	29.7
Gabon (2012)	29.9	18.8	12.3	11.9	5.8
Gambia (2013)	29.5	27.2	25.2	22.4	15.2
Ghana (2014)	24.8	25.5	17.9	14.4	8.5
Guinea (2012)	33.8	41.1	33.8	25.0	15.4
Guinea-Bissau (2010)	41.9	36.7	31.1	23.6	18.0
Kenya (2014)	36.9	30.2	25.4	20.7	13.8
Lesotho (2014)	45.6	38.1	34.8	28.2	13.4
Liberia (2013)	35.3	35.2	35.3	27.7	19.9
Madagascar (2009)	47.6	54.0	52.5	51.0	43.6
Malawi (2013)	48.7	43.9	43.6	39.1	33.6
Mali (2013)	46.4	44.4	42.4	33.9	21.2
Mauritania (2011)	33.8	29.5	25.4	19.7	13.7
Mozambique (2011)	51.1	48.0	46.4	37.4	24.1
Namibia (2013)	31.3	28.8	24.2	16.8	8.7
Niger (2012)	46.9	48.0	41.8	46.7	34.5
Nigeria (2013)	53.8	46.1	35.1	26.3	18.0
Rwanda (2014)	48.6	44.7	37.5	30.2	20.9
Sao Tome and Principe (2009)	38.2	34.9	32.2	20.5	17.6
Senegal (2014)	28.8	21.7	15.5	13.4	8.4
Sierra Leone (2013)	42.6	40.4	38.1	35.0	28.1
South Sudan (2010)	31.3	34.1	32.0	31.7	26.5
Swaziland (2010)	41.9	32.3	33.4	26.3	14.0
Togo (2013)	33.4	37.5	32.5	19.4	10.6
Uganda (2011)	37.3	30.9	45.0	30.5	20.8
United Republic of Tanzania (2010)	20.4	19.5	16.5	13.7	8.9
Zambia (2013)	47.3	41.7	40.2	37.6	28.4

Zimbabwe (2014)	33.4	31.3	28.3	27.0	15.0

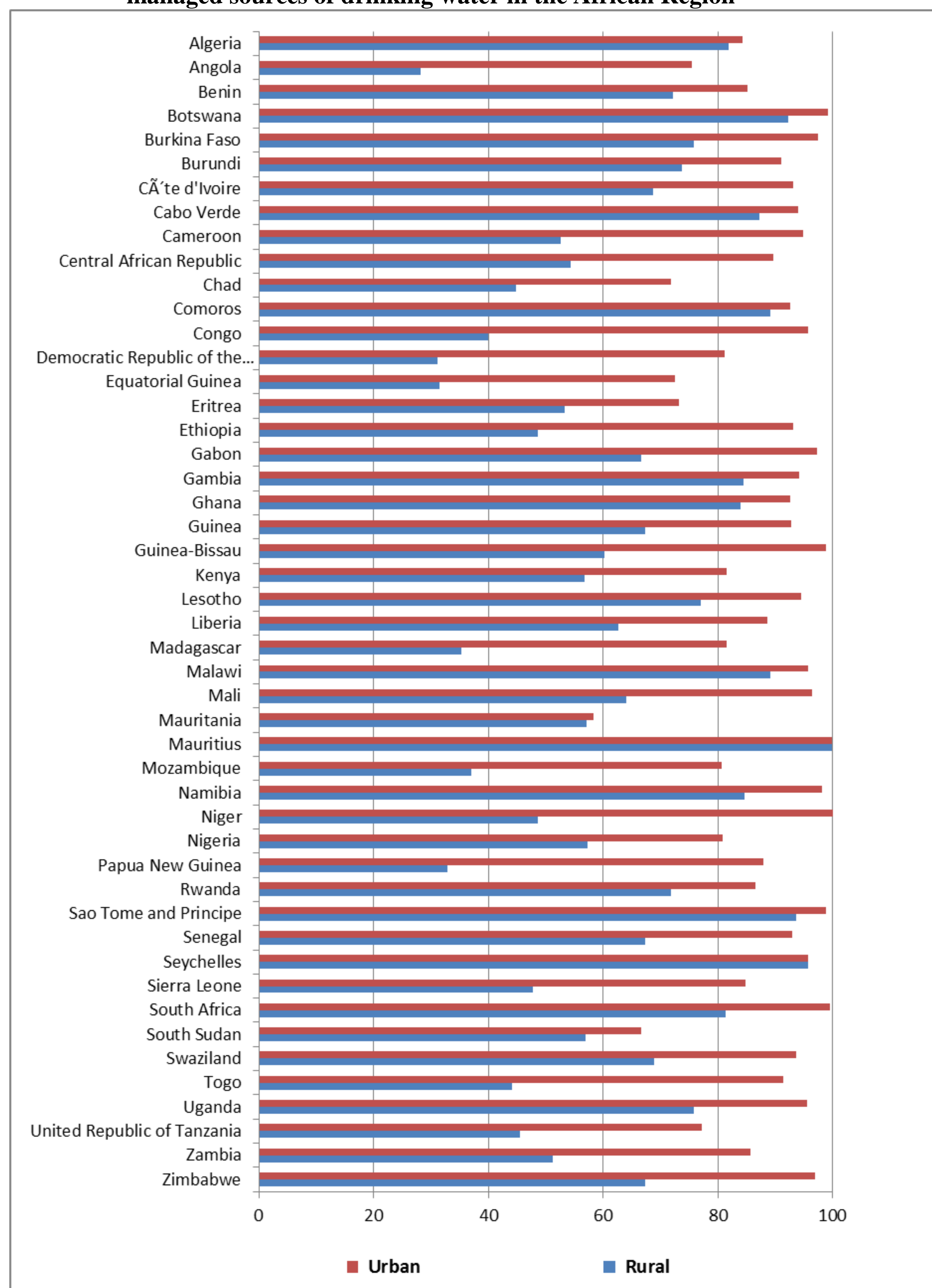
Data source: *Data from latest population survey (MICS, DHS). The databases of population-based surveys such as DHS or MICS have disaggregated data and 41 countries had data fully disaggregated by wealth quintiles. Wealth quintiles are developed using social and economic indicators. Countries without disaggregated data/socioeconomic indicators data were excluded from the analysis.*

ANNEX 2: Measles (MCV) immunization coverage among one-year-olds (%) by educational level in the African Region, 2000–2013



Data source: *Data from the latest Atlas of African Health Statistics 2016 consisting of population survey (MICS, DHS) data. Countries without the relevant indicator/data were excluded from the analysis.*

ANNEX 3: Percentage of the population residing in urban and rural with access to safely managed sources of drinking water in the African Region



Data Sources: *WHO World Health Statistics report, 2017 – link: http://who.int/gho/publications/world_health_statistics/2017/en/*

ANNEX 4: Percentage of population with access to improved sanitation facilities by quintile in the African Region

Access to improved sanitation facilities	Poorest	Second	Middle	Fourth	Richest
Algeria (2012)	61.4	60.1	65.7	72.2	62.3
Benin (2011)	9.3	23.2	22.7	36.4	38.7
Burkina Faso (2015)	33.5	16.5	32.2	28.3	22.1
Burundi (2010)	36.5	39.7	49	40.6	49.4
Cameroon (2011)	28.6	52.1	57.7	40.6	55.7
Central African Republic (2010)	16.4	23.4	30.2	44.5	52.2
Chad (2010)	18.8	15.2	25.2	36.5	63.3
Congo (2012)	71.5	65.7	63.4	34.3	49.2
Côte d'Ivoire (2011)	14.3	20.8	26.4	46.3	36.3
DR Congo (2013)	31.2	39	34.6	48.8	51.2
Ethiopia (2011)	3	7.8	5.7	11.7	6.1
Gabon (2012)	40.6	47.8	54.8	52	58.1
Gambia (2013)	47.7	51.2	61.9	27	55.4
Ghana (2011)	53.1	44.7	61.7	..	..
Guinea (2012)	12.1	36.8	32.5	56.3	68.6
Guinea-Bissau (2010)	27.9	26.2	31.2	53.7	
Kenya (2014)	47.9	49.3	51.7	61.6	59.3
Liberia (2013)	37	60.8	55	58.4	85.4
Madagascar (2009)	32.5	29.5	39.4	51.8	68
Malawi (2013)	38.7	39.4	51	48.9	59.3
Mali (2013)	9.9	32.8	22.7	54.8	33.3
Mauritania (2011)	16.5	28.4	33.1	43.3	42.7
Mozambique (2011)	17.1	12		12.7	11
Niger (2012)	5.5	8.1	3.8	5	34.8
Nigeria (2013)	36.5	25.2	42.5	49.9	45.9
Sao Tome and Principe (2009)	72	18.5	81	57.9	..
Sierra Leone (2013)	37.9	50.3	34.2	53	63.9
South Sudan (2010)	17.5	28.9	23.5	41.3	53.3
Swaziland (2010)	57	49.9	58	69	75.8
Togo (2013)	27.8	46	36.8	43	49.1
Uganda (2011)	40.3	42.7	55	45.2	62.6
Zambia (2013)	46.2	39.7	48.1	59.9	72.4
Zimbabwe (2014)	27.4	32.5	34.5	42.3	46.2

Data Source: *Population survey data (MICS, DHS). Countries without data disaggregated by social parameters were excluded from analysis*

ANNEX 5: Table highlighting examples of successful intersectoral actions in the African Region

Exposure/health determinant	Intersectoral action: Examples of key actions beyond the health sector	Key Impact
Poverty, food insecurity and nutrition (**Ghana, Kenya**[16])	• Intersectoral action involving finance, health, agriculture and other economic sectors, showcasing an example of embedding health into a wider economic policy and economic activity • Intersectoral collaboration on child nutrition in informal settlements in Mombasa, Kenya. Intersectoral actions involving health, agriculture • Government introduced the intersectoral Economic Stimulus Programme – fish farming/ aquaculture to address food insecurity, spur economic growth through the leadership of the ministries of finance, agriculture, fisheries	✓ In Kenya the findings showed increased food security and improved nutrition. For example 42.4% reported increased food availability and 57.6% improved household nutrition ✓ Fish farming project created employment opportunities (56.1%) and generated income (43.9%) ✓ In Mombasa there was reduction in child malnutrition among poor families in informal settlements and slum communities ✓ Strengthened intersectoral collaboration and enhanced public private partnership in food security initiatives ✓ Increased political willingness
Tobacco (**Gambia**[17] **and South Africa**[18])	• The National Tobacco Control Act 2016 is a comprehensive FCTC- compliant legislation, developed through broad-based participation and strategic partnership between the Ministry of Health and Social Welfare and other sectors (i.e. environment and climate change, water resources, foreign affairs, agriculture and finance and economic affairs, civil society and other key stakeholders) under the technical leadership and guidance of WHO • Strong leadership and political commitment led to a multisectoral action initiated in 2012 to control the growing tobacco epidemic in The Gambia and South Africa • Three-year tobacco taxation policy introduced between 2013 and 2015 and is being replicated in 2017-2019 • Development of a national tobacco control policy, a strategy and an action plan for 2013-2018 • Capacity-building in tobacco taxation in 2012 and 2013 • Enacted tobacco legislation – Tobacco Control Act 2016 • Developed tobacco cessation clinical guidelines followed by capacity-building for implementation in 2016 • Ratification of the Protocol on Illicit Trade in Tobacco Products in 2016	✓ Prevention of different NCDs attributable to tobacco products ✓ Tobacco taxation policy led to decline in importation volume of tobacco products from 1.12 million kilograms to 0.44 million kilograms (estimated 60% decrease) however revenues grew from D155.32 million to D420.06 million (a nominal growth rate of 170%) between 2012 and 2016 ✓ Development of two tobacco control legislations – Prohibition of Smoking (public places) Act of 1998 and Prohibition of Tobacco Advertisement Bill 2003 ✓ Production of a network of tobacco control champions ✓ Ratification of the WHO FCTC by Gambia in 2007 ✓ Establishment of technical working group to monitor the tobacco industry interference with public policy ✓ Establishment of multisectoral working group to tobacco and NCD prevention and control in 2012

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[16] WHO 2013. Addressing determinants of health through intersectoral collaboration: Fish farming project in South Imenti constituency in Meru County, Kenya.

[17] http://www.afro.who.int/sites/defaults/files/2017-07.

[18] WHO 2013. Intersectoral case study: successful tobacco legislation in South Africa. WHO Regional Office for Africa, 2013.

Salt intake reduction (**Mauritius, Nigeria and South Africa**)[19]	• Government working with food producers and distributors and communities to increase awareness and create an enabling environment • Mauritius developed national strategy centred on food labelling and working with bakery and supermarket distributors to monitor salt content in bread • South Africa produced national strategy to reduce the salt intake through mandatory reformulation to impact salt in processed food • Nigeria developed guidelines on salt intake and is working with communities to build awareness	✓ Reduced hypertension (i.e. evidence shows that high salt diets are linked to raised blood pressure—a major risk factor for cardiovascular diseases and a range of other illnesses)
School-based deworming (**Kenya**)[20]	• Strong links between children's health and social and educational outcomes including accessibility to quality education on the individual and family health status. This was achieved through intersectoral action involving the ministries of health and of education. Teachers (16 000) were trained to administer the deworming tablets and to provide health education to parents and pupils in their respective schools • In Kenya 70% of school-going children aged 13-14 years exhibited the highest prevalence of worm infection, usually soil-transmitted helminths (STH).	✓ School based mass deworming reduces school absenteeism by 25% including improved health status leading to increased productivity, educational performance, life expectancy, savings and investments and decreased debts and expenditure on health care. ✓ 3.5 million children from 8000 schools were dewormed, thus achieving 70% in terms of scope and cost effectiveness. The deworming programme cost approximately US$ 0.3 per child per year.
Health-promoting schools (**South Africa**)	• Intersectoral work between education, health and other sectors to prevent factors that place learners at risk, such as poverty, violence, road safety, personal hygiene, substance abuse, HIV and nutrition	✓ Health promotion ✓ Increased school attendance
Health financing and social protection safety net (**Rwanda**)[21]	• Intersectoral action through community-based health insurance initiative. Sectors involved - the President's Office, the Ministry of Local Government, and the Ministry of Finance and Economic Planning including district mayors • Other intersectoral initiatives are: the "Girinka Munyarwanda" (One Cow per Poor Family), the Ministry of Agriculture and its Rural Sector Support Project, subsidized subscriptions for community-based health insurance (CBHI) and in-kind social care services run by the Ministry of Gender and Family Promotion and the Ministry of Health	✓ Health and well-being ✓ Reduce poverty ✓ Increased social protection safety net
Many of the determinants of health and health inequities within the populations have social and economic origins that are beyond the direct influence of the health sector and health policies.		

[19] Muthuri SK, Oti SO, Lilford RJ, Oyebode O (2016) Salt Reduction Interventions in Sub-Saharan Africa: A Systematic Review. PLoS ONE 11(3): e0149680. https://doi.org/10.1371/journal.pone.0149680.

[20] WHO 2013. Improved school-based deworming coverage through intersectoral coordination: the Kenya experience. WHO Regional Office for Africa, 2013.

[21] WHO 2013. Improving health through inter-sectoral actions: lessons from health financing in Rwanda. WHO Regional Office for Africa 2013.