BUILDING THE FOUNDATION FOR HEALTHY SOCIETIES: INFLUENCING MULTISECTORAL ACTION FOR HEALTH. PHASE ONE.

VOLUME ONE: MULTISECTORAL OPPORTUNITIES AND CONSTRAINTS ASSESSMENT TOOL

DISCUSSION PAPER

JUNE 2014

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Influencing Multisectoral Action for Health

Phase One

VOLUME ONE

Multisectoral Opportunities and Constraints Assessment Tool

Anne M. Pierre-Louis, Neesha Harnam, Montserrat Meiro-Lorenzo, Martin Lutalo, Brian Pascual, and Maggie Davies

June 2014
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Abstract: Improving the health of whole populations through action across sectors is at the heart of goals set by the World Bank Group to eradicate extreme poverty and to promote shared prosperity by fostering the income growth of the poorest 40 percent of the population in every country. The Bank’s 2007 HNP Strategy called for the need to leverage investments and actions in other sectors as an imperative given the shifts in the global landscape (rapid urbanization, rise in non-communicable diseases as the leading cause of death in almost every region, worrying trends in road traffic injuries, pandemic threats, climate change to name a few), which heighten the importance of coordination between multiple sectors. The knowledge product (KP) Building Healthy Societies: Influencing Multisectoral Action for Health addresses a demand from the World Bank’s Health Nutrition and Population (HNP) Global Practice staff and management and is the first of a series aimed at inducing a paradigm shift that places the responsibility for delivering health outcomes across multiple sectors. The audience for this KP includes not only World Bank task teams but also country policy makers and stakeholders.

The objective of this KP is to equip task teams with the tools and best practices to engage more effectively across sectors to improve health outcomes. The main products of the KP are (i) the development of the Multisectoral Opportunity and Constraints Assessment Tool (MOCAT) and (ii) four high level case studies.

This first volume provides an overview of the KP and focuses on the description of the MOCAT, its possible uses and the process of developing and testing it in two states of India. It also offers some thoughts and recommendations for its refinement going forward.

Keywords: Multisectoral action, public health, health policy, development effectiveness

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“...The World Bank Group will continue to step up our work on improving health through action in other sectors, because we know that policies in areas such as agriculture, clean energy, education, sanitation, and women’s empowerment all greatly affect whether people lead healthy lives...”

Excerpt from WBG President Dr. Jim Yong Kim’s speech at the World Health Assembly, Geneva, May 21, 2013
Table of Contents

RIGHTS AND PERMISSIONS ........................................................................................................... II

ACKNOWLEDGMENTS .................................................................................................................. VIII

ACRONYMS ................................................................................................................................... IX

PART 1: SYNOPSIS OF THE KNOWLEDGE PRODUCT ................................................................ 2

  Introduction .............................................................................................................................. 2
  Case Studies ............................................................................................................................ 4
    Summaries of the Case Studies ............................................................................................. 4
  Multisectoral Opportunities and Constraints Assessment Tool (MOCAT) ......................... 6
    Introduction .......................................................................................................................... 6
    Framework and Tool Development ..................................................................................... 7
    Consultation to develop the concept and turn it into practice ............................................ 8
    Literature review ................................................................................................................... 9
    Pilot testing ............................................................................................................................. 9
    The process of pilot testing .................................................................................................. 12
  Dissemination Strategy ......................................................................................................... 13
  Next Steps for the KP .............................................................................................................. 15

PART 2: THE MOCAT TOOLKIT ................................................................................................. 16

  Background ............................................................................................................................. 16
  Rationale ................................................................................................................................. 16
  Purpose .................................................................................................................................. 17
  MOCAT Framework ............................................................................................................... 18
  MOCAT Frequently Asked Questions ................................................................................... 20
  THE MOCAT ............................................................................................................................ 24
  Determine Priority Health Results ............................................................................................ 24
    Data Analysis ....................................................................................................................... 24
    Benchmarking ....................................................................................................................... 25
    Identification of Major Health Equity Outcomes ................................................................. 25
  Identify Drivers, Opportunities, and Constraints to Multisectoral Action ......................... 25
  Identify Proven Solutions ........................................................................................................ 26
  Engage Across Relevant Practices/Sectors ............................................................................. 27
  Determine Optimal Multisectoral Action ............................................................................... 27
    Political Analysis .................................................................................................................. 28
    Stakeholder Analysis and Assessment of Multisectoral Forums .......................................... 28
    Quick Wins ............................................................................................................................ 28
    Medium Term ....................................................................................................................... 28
    Long Term ............................................................................................................................. 29
  Review Opportunities for WBG Involvement in Light of Comparative Advantage ................ 29
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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACU</td>
<td>AIDS Control Unit</td>
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<tr>
<td>AER</td>
<td>Action for Economic Reform</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ANSV</td>
<td>Agencia Nacional de Seguridad Vial</td>
</tr>
<tr>
<td>APL</td>
<td>Adaptable Programmatic Loan</td>
</tr>
<tr>
<td>APS</td>
<td>AIDS Program Secretariat</td>
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<tr>
<td>ARSP</td>
<td>Argentina Road Safety Project</td>
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<tr>
<td>ARV</td>
<td>Antiviral</td>
</tr>
<tr>
<td>BAT</td>
<td>British American Tobacco</td>
</tr>
<tr>
<td>CARE</td>
<td>Cooperative for Assistance and Relief Everywhere</td>
</tr>
<tr>
<td>CACC</td>
<td>Constituency AIDS Control Committee</td>
</tr>
<tr>
<td>CACOC</td>
<td>Constituency AIDS Coordinating Committee</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organization</td>
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<tr>
<td>CCM</td>
<td>Country Coordination Mechanism</td>
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<tr>
<td>CCT</td>
<td>Conditional Cash Transfer</td>
</tr>
<tr>
<td>CoP</td>
<td>Community of Practice</td>
</tr>
<tr>
<td>CMIS</td>
<td>Computerized Management Information System</td>
</tr>
<tr>
<td>CNSSS</td>
<td>National Social Security Council</td>
</tr>
<tr>
<td>CPF</td>
<td>Country Partnership Framework</td>
</tr>
<tr>
<td>CRECER</td>
<td>National Strategy for Poverty Reduction and Economic Opportunities</td>
</tr>
<tr>
<td>CSDH</td>
<td>Commission on Social Determinants of Health</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
</tr>
<tr>
<td>DALYs</td>
<td>Disability-Adjusted Life Years</td>
</tr>
<tr>
<td>DDC</td>
<td>Department of Disease Control</td>
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<tr>
<td>DOF</td>
<td>Department of Finance</td>
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<tr>
<td>DTC</td>
<td>District Technical Committee</td>
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<tr>
<td>EBRD</td>
<td>European Bank for Reconstruction and Development</td>
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<tr>
<td>JAPR</td>
<td>Joint HIV and AIDS Program Review Process</td>
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<tr>
<td>JSY</td>
<td>Janani Suraksha Yojana</td>
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<tr>
<td>KNASP</td>
<td>Kenya National HIV/AIDS Strategic</td>
</tr>
<tr>
<td>EFNEP</td>
<td>Expanded Food and Nutrition Education Program</td>
</tr>
<tr>
<td>FCAP</td>
<td>FCTC Alliance – The Philippines</td>
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<tr>
<td>FCTC</td>
<td>Framework Convention on Tobacco Control</td>
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<tr>
<td>GBD</td>
<td>Global Burden of Disease, Injuries, and Risk Factors Study</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GP</td>
<td>Global Practice</td>
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<tr>
<td>GRSF</td>
<td>World Bank Global Road Safety Facility</td>
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<tr>
<td>HEART</td>
<td>Health Equity Assessment and Response Tool</td>
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<tr>
<td>HIA</td>
<td>Health Impact Assessment</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HIV/AIDS-ICC</td>
<td>Interagency Coordinating Committee for HIV/AIDS</td>
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<tr>
<td>HNP</td>
<td>Health, Nutrition, and Population</td>
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<tr>
<td>HNPFAM</td>
<td>Health, Nutrition, and Population Family</td>
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<tr>
<td>HPV</td>
<td>Human Papillomavirus</td>
</tr>
<tr>
<td>IAS</td>
<td>Indian Administrative Services</td>
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<tr>
<td>IBRD</td>
<td>International Bank for Reconstruction and Development</td>
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<tr>
<td>ICT</td>
<td>Information and Communications Technology</td>
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<tr>
<td>IDA</td>
<td>International Development Assistance</td>
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<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
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<tr>
<td>IEC</td>
<td>Information, Education, and Communication</td>
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<tr>
<td>IHME</td>
<td>Institute of Health Metrics and Evaluation</td>
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<tr>
<td>IMSS</td>
<td>Mexican Institute of Social Security</td>
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<tr>
<td>IRAP</td>
<td>International Road Assessment Program</td>
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<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
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<tr>
<td>NCD</td>
<td>Noncommunicable Disease</td>
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<td>NGO</td>
<td>Nongovernmental Organization</td>
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<td>NMHP</td>
<td>Nagaland Multisectoral Health Project</td>
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<tr>
<td>NSF</td>
<td>National Strategic Framework</td>
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</tbody>
</table>
Plan

KP Knowledge Product
LIC Low-Income Country
LMICs Low- and Middle-Income Countries
MAP Multicountry AIDS Program
MOCAT Multisectoral Opportunities and Constraints Assessment Tool
MCH Maternal and Child Health
MDG Millennium Development Goal
MDR Multidrug Resistant
MOH Ministry of Health
MOPH Ministry of Public Health
MOHSS Ministry of Health and Social Services
MOU Memorandum of Understanding
MSM Men who have sex with men
MTP Medium-Term Plan
NABCOA Namibian Business Coalition on HIV/AIDS
NAC National AIDS Council
NAPC National AIDS and Prevention Control Committee
NACM National HIV/AIDS Coordinating Mechanism
NACC National AIDS Control Council
NACO National AIDS Control Organization
NACP Indian National AIDS Control Program
NAEC National AIDS Executive Committee
NAMACOC National Multisectoral AIDS Coordination Committee
NANOSO Namibia Network of AIDS Service Organizations
NASCOP National AIDS and STI Control Program
UKHSDP-II Uttarakhand Health Systems Development Project-II
UN United Nations
UNAIDS Joint United Nations Program on AIDS
UNDP United Nations Development Program
UNESCO United Nations Educational, Scientific and Cultural Organization
UNFPA United Nations Population Fund
NVP New Voice Association of the Philippines
OECD Organization for Economic Co-Operation and Development
OPM Office of the Prime Minister
PAHO Pan-American Health Organization
PBGS Paquete Basico Garantizado de Salud
PhP Philippine Peso
PH Public Health
PLWH People Living with HIV/AIDS
PPP Public-Private Partnership
PREM Poverty Reduction and Economic Management
RACOC Regional AIDS Coordinating Committees
REDESA Sustainable Supply Chains for Food Security
RSBY Rashtriya Swasthya Bima Yojna
RTA Road Traffic Accident
SABER System Assessment and Benchmarking for Education Results
SACS State AIDS Control Societies
SCD Systematic Country Diagnostic
SDH Social Determinants of Health
SDIP Safe Delivery Incentive Program
SEARO South-East Asia Region of the World Health Organization
SEATCA Southeast Asia Tobacco Control Alliance
SEDESOL Secretaria de Desarrollo Social
SUS Family Health Program
TB Tuberculosis
TFK Campaign for Tobacco-Free Kids
TTC Transnational Tobacco Companies
TTL Task Team Leader
UHC Universal Health Coverage
UNICEF United Nations Children’s Fund
USAID United States Agency for International Development
USDA United States Department of
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
<th>Organization</th>
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<tbody>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
<td>Agriculture</td>
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<tr>
<td>TOR</td>
<td>Terms of Reference</td>
<td>WBG</td>
</tr>
<tr>
<td>TOWA</td>
<td>Total War against HIV and AIDS</td>
<td>WHO</td>
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<td></td>
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<td>WTO</td>
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<td>World Bank Group</td>
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<td>World Trade Organization</td>
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PART 1: SYNOPSIS OF THE KNOWLEDGE PRODUCT

Introduction

Improving the health of whole populations through action across all relevant sectors is at the heart of the goals set out by the World Bank Group — namely, to eradicate extreme poverty by reducing the number of people living on less than US$1.25 a day to 3 percent by 2030, and to promote shared prosperity by fostering the income growth of the poorest 40 percent in every country. To achieve these outcomes, the World Bank Group’s strategy has three components: (1) maximize development impact by engaging country clients in identifying and tackling the most difficult development challenges; (2) promote scaled-up partnerships that are strategically aligned with the goals; and (3) crowd in public and private resources, expertise, and ideas.

The Bank’s 2007 Health, Nutrition, and Population (HNP) Sector Strategy called for interventions in other sectors to be leveraged to deliver health results, recognizing that it takes more than health services to improve HNP outcomes. The 2009 HNP Strategy implementation report identified strengthened multisectoral action as one of the areas where significant work remained to be done. The 2012 Public Health Policy Note, Connecting Sectors and Systems for Health Results, sets out the vision for the Bank’s approach to public health over the next few years. The note called for a strong focus on multisectoral action and investments to address the upstream determinants of health — an imperative given the shifts in the global landscape, which heighten the importance of coordination between multiple sectors.

The Bank today has the best opportunity in decades to engage in multisectoral action — an agenda to which its leadership is strongly committed. It is a “win-win” to leverage investments in sectors beyond health that are the foundation of healthy societies, including education, water and sanitation, agriculture, social protection, transport, gender equity, and environment. One example of such win-wins where leveraging investments is concerned is in the field of early childhood development — not only are healthier children more engaged in learning, but higher levels of education are important for the achievement of better health outcomes in the long term, making investments in education beneficial for the health sector and vice versa.

Multisectoral action is also a key tenet in achieving universal health coverage (UHC), the main vehicle in HNP for the Bank to reach its twin goals in the fight against poverty by 2030. Building Healthy Societies is a key pillar of the UHC framework: taking an upstream approach to addressing health issues is critical to the successful and sustainable achievement of the two other pillars of UHC, namely financial protection and health service–delivery coverage. For example, the availability of safe roads, reliable power, and clean water will improve access to health facilities for the population and ultimately improve health outcomes.

The overall goal of this Knowledge Product (KP) is to assist HNP task teams in assuming the transformational role they will have to play within the HNP Global Practice (GP) — and by extension with Ministries of Health — to promote a paradigm shift that places the responsibility for delivering health outcomes across multiple sectors. Building on more than two decades of World Bank experience in working across sectors, this KP seeks to make such efforts more systematic and pragmatic — and thus create greater impact in improved health outcomes in different country contexts. The KP examines concrete examples of how multisector collaboration has been used to optimize health and development outcomes. These examples will provide support for task team leaders (TTLs) and task teams as the HNP GP starts rolling out on July 1, 2014 — helping them engage effectively across sectors internally within the Bank and at country level.

Nested in the overall vision for healthy societies mentioned above, this KP is the first in a series aimed at catalyzing multisectoral action within the HNP GP, and bringing other sectors together to achieve health and development outcomes. The specific objectives of the series are the following:
Equip task teams — and through them our client countries — with useful, practical tools and concrete “how-to” examples of relevant best practices in engaging more effectively across sectors to improve health and development outcomes.

Increase learning and collaboration across Global Practices for health results.

Addressing demand: This KP meets a demand expressed by the HNP Sector Board during meetings held in December 2012 and April 2013. At these meetings, the Sector Board concluded that the HNP Anchor would lead in launching the work to promote the multisectoral agenda in line with the 2007 HNP strategy. The KP also aims to address requests made by a cross-section of HNP task team leaders (TTLs) during a focus group discussion. These requests included support for upstream engagement in multisectoral work in the Country Partnership Strategy (now Country Partnership Framework, or CPF) process, and for making the case to other sectors on the rationale for their involvement in health outcomes. In addition, the TTLs identified specific products that would assist them in engaging with countries, partners, and other sectors — including an information template, fact sheets, burden of disease analyses, and review of country portfolios. This demand from the regions is now especially relevant, as the Bank’s new CPF approach will call for a cadre of staff that is well equipped to work in coordination across sectors.

Main products of the KP: The main products for this KP include a Multisectoral Opportunities and Constraints Assessment Tool (MOCAT) and four illustrative case studies highlighting concrete examples of successful engagement across sectors.

The KP responds to the demands of the HNP Sector Board to develop a concrete package of products that is of practical use to TTLs and country teams and that meets their needs both in terms of a process for engaging other practices and sectors, and in terms of content in relation to key issues and proven solutions. The set of interrelated products include the following:

1. The MOCAT: In line with the agreed framework, the tool walks through a process that identifies specific data on the burden of disease in the context of the upstream determinants of health, engages other practices and sectors in addressing these, translates proven solutions into optimal action in the immediate and longer term, and relates these back to the achievement of the Bank’s twin goals. In this context, it important to note that the MOCAT is not meant to be in competition with other existing tools; it is meant to be complementary to those tools. Indeed, the resource sheets (described below) are intended to serve as a conduit, by providing pointers to additional content relating to upstream determinants of health.

2. Case studies: The suite of case studies on (i) Road Safety Management in Argentina; (ii) Social Protection and Conditional Cash Transfers (CCTs) in Mexico; (iii) Multisectoral HIV and AIDS Responses; and (iv) Tobacco Tax Reform in the Philippines are intimately related to the MOCAT process in that they offer examples of proven solutions. They are intended not only to be examples of best practice, but also to offer key learning points that could be transferred to other countries and settings.

3. Resource sheets: Indoor air pollution, tobacco use, undernutrition, and road traffic accidents and transport have been identified as key issues where HNP practice will become more involved going forward, and these are areas where the Bank has extensive examples of best practice from its own work. Therefore, they have been selected as the areas on which to develop the first batch of resource sheets that point the TTL and team members to existing practice, relate the process of engagement to a specific topic area and add content to it. The resource sheets do not attempt to reinvent the knowledge base that exists in the Bank; rather, they are intended to provide pointers to that base.

4. Background paper: A background paper provides further content and examples of good practice in terms of multisectoral work to address the social determinants of health, and it includes examples on the double burden of obesity and undernutrition and, more broadly, on NCDs.

In conclusion, the four elements of the KP package are not intended to be stand-alone products. Rather, they should be viewed together as a whole where the overarching process is populated with content on specific key topics through live examples and by reference to the Bank’s ongoing work and knowledge base in key areas.
Audience: The primary audience for the KP is World Bank Group TTLs and task teams. The secondary audience includes country directors and program leaders, and through them, stakeholders across practices and sectors.

Case Studies

Selection of the four case studies took into account a combination of factors, including sectors involved, risk factors addressed, country income, targeting of the poor, lessons learned or successes and failures in working across sectors, and the extent to which the cases addressed areas of priority focus for the Bank. The selection process paid particular attention to identifying case studies that would provide insight to TTLs on the process to follow to work effectively across sectors. To ensure the quality of the final product and in response to a request by sector managers, each case study was written by a senior consultant with a good knowledge of the Bank and the subject matter. The terms of reference (TOR) template for the case studies was based on an adapted version of the Harvard Business School model for case studies, with the intention that the end products would serve both for overall knowledge purposes and for teaching applications.

In briefings to the consultants, it was stressed that the case studies needed to provide solid examples of multisectoral action in health — aimed at increasing understanding of the constraints to working effectively across sectors, and how some of those constraints have been overcome — while drawing on best practices in project management and evidence-based policy dialogue.

Summaries of the Case Studies

<table>
<thead>
<tr>
<th>Case Study 2.1a</th>
<th>Institutionalizing Road Safety Management in Argentina</th>
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<tr>
<td>Road traffic accidents are a growing concern for health and development in most low-and middle-income countries. Recently, Argentina established a national road safety agency with sustained funding and a mandate to regulate road safety across the country. The government approached the World Bank for a loan to strengthen the capacity of the agency to effectively coordinate national road safety programs. This resulted in the Argentina Road Safety Project (ARSP), a stand-alone road safety loan aimed at implementing the Safe System approach. This study traces the history of the Bank’s engagement in road safety in Argentina to illustrate how Bank staff can encourage similar developments in other countries.</td>
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</table>

Key lessons:

- Prioritizing the development of institutional capacity over fragmented, one-off interventions is crucial for sustainable improvements in national road safety performance.
- Creating country demand for the Safe System approach should be the ongoing work of road safety advocates until focusing events create opportunities for rapid implementation.
- Understanding the relative role of different sectors can support effective cross-sectoral action. While health sector leadership is essential for positioning road safety as a developmental priority, most activities in a balanced program require leadership from other sectors, primarily transport, infrastructure, and enforcement.
Case Study 2.1b  Conditional Cash Transfers (CCTs) and Health

Conditional cash transfer programs, mainly safety net programs that transfer cash to beneficiaries in exchange for school attendance and health service utilization, are a type of multisectoral program that has an impact on health and nutrition outcomes in a variety of settings. This case study takes a closer look at one of the world’s largest and longest-lasting CCT initiatives, Mexico’s *Oportunidades* program, reviewing its effects on health and nutrition, exploring how multisectoral collaboration was undertaken, and highlighting two intrasectoral collaboration challenges that have emerged over the life of the program. Finally, opportunities to enhance the health and nutrition impact of the program are discussed in a way that will be relevant to CCTs in other settings.

**Key lessons:**

- Formal collaborative structures at different levels of government and complementary supply-side strengthening are two key “how-to” lessons learned that emerge from more than a decade of the *Oportunidades* program.
- Challenges in multisectoral collaboration will emerge in any context. Lessons learned from the highlighted challenges in *Oportunidades* suggest the importance of aligning budget, fiscal transfer, and payment policies with technical policies, as well as going further to target supply-side strengthening in those areas where CCT beneficiaries are concentrated.
- Finally, a broad lesson learned has to do with the centrality and scope of the *Oportunidades* evaluation. The evaluation’s rigorous design, permanence in time, and efforts to measure on both the supply and demand sides represents a best practice in CCT and in social policy in general. These allow us to use the case of *Oportunidades* to learn lessons both for Mexico and elsewhere.

Case Study 2.1c  Multisectoral HIV and AIDS Responses

Responses to HIV and AIDS at the global, national, and subnational levels have undergone substantial evolution and expansion since the HIV virus was first identified in the 1980s. While early interventions were confined to medical and public health approaches to curtail the epidemic, today a wide group of stakeholders plan, implement, and evaluate multisectoral responses in countries. Important lessons can be drawn from the three decades of these multisectoral experiences. This case study examines how four countries — India, Kenya, Namibia, and Thailand — developed, implemented, and sustained multisectoral responses to HIV and AIDS. The case study then identifies lessons learned for TTLs about how to engage effectively across sectors.

**Key lessons:**

- Ensure that national strategic plans (and their accompanying action plans) involve multisectoral participation in plan formulation, are results-oriented and costed, include frameworks for sectoral leadership and coordination, and are integrated within longer-term vision and planning frameworks.
- Understand the priorities and perspectives of all sectors and identify mutual benefits before proceeding with multisectoral action.
- Plan activities multisectorally, but implement sector-by-sector. Each implementing sector should be able to articulate what outcomes they are contributing to.
- Ensure that communities and the private sector have incentives for collaboration, such as subsidies and contracts.
- Develop frameworks and tools for systematic data sharing among sectors to facilitate reporting against multisectoral indicators.
- Institute the multisectoral response at decentralized levels through structures with some autonomy to successfully partner with multiple sectors, particularly civil society and people living with HIV.
Case Study 2.1d  Best Supporting Actor: The World Bank and Tobacco Tax Reform in the Philippines

What can the World Bank do to help countries control tobacco, a man-made scourge of health and development? This case study presents and analyzes evidence from the 2012 Philippine tobacco tax reform. It discusses why tobacco control is so challenging, and describes how the Philippines’ reform actually unfolded, with an emphasis on the World Bank’s role.

The goal of the reform was to raise taxes on tobacco products to achieve three objectives: increase tax revenues, reduce smoking and related costs by discouraging tobacco consumption through price increases, and provide funding for expanding the government’s pro-poor UHC scheme. The reform succeeded by increasing taxes immediately — in 2013 the excise tax on cheaper cigarettes more than tripled versus prereform levels — and taxes will continue to rise as they take full effect in 2016. Already in 2013 tobacco taxes provided approximately ₱70 billion (about US$1.65 billion) in revenues.

Key lessons:
- Tobacco is the world’s leading cause of preventable death. Yet while tobacco control policies are well known, implementing them is extremely challenging because the political economy of reform is very difficult.
- The World Bank can play a key role in supporting these reforms if staff understand the following:
  - The multisectoral nature of tobacco production, sale, and consumption
  - The types, capacities, and roles of domestic actors
  - How to leverage the Bank’s comparative advantages in economic and technical analyses to counter tobacco industry arguments and contribute effectively to domestic political processes

Requests for assistance with tobacco tax reform are likely to become common because most countries are party to the WHO Framework Convention on Tobacco Control, which requires them to legislate, implement, and enforce wide-ranging measures to discourage consumption and reduce production.

Multisectoral Opportunities and Constraints Assessment Tool (MOCAT)

Introduction

The MOCAT is intended to contribute to meeting the Bank’s goals by providing guidance to task teams working in countries to support a multisectoral approach in addressing health and its upstream determinants. This tool aims to (i) propose a systematic process for HNP to close the gap between knowledge and action for multisectoral engagement; (ii) provide evidence to task teams to make the case for multisectoral action; and (iii) help to improve health equity outcomes. The tool recognizes the complexities of policy dialogue, and the need to build partnerships and negotiate with stakeholders to address drivers and opportunities for change. It reflects the iterative nature of the process of identifying and agreeing to optimal solutions to address major health problems. Although the tool is being developed within the Bank’s Country Partnership Framework (CPF) process, it is expected that it will also be of use during midterm reviews, project preparation, and in guiding policy dialogue. The HNP GP will provide support to HNP task teams to use the MOCAT, as outlined in the MOCAT Development Plan (part 3 of this KP).

The launch of the GPs has put the spotlight on the need to work across sectors. Multisectoral action has been included in the TORs of the newly appointed senior directors of the GPs and there is renewed emphasis on the cross-cutting agenda. In health, it should be emphasized that a multisectoral approach does not necessarily mean multisectoral projects, though it may be that projects across sectors take place in parallel or in a phased approach while addressing the major social determinants of health.
The MOCAT provides added value through its provision of a systematic approach to improve health outcomes in the context of multisectoral action. Users of the MOCAT will be able to identify priority sectors to improve a specific health outcome, and eventually to determine which investments and opportunities (both within and beyond the health sector) provide the biggest returns. In addition, this approach will provide strong rationale to key stakeholders within governments, partners, and donors to mobilize other sectors for health results.

**Framework and Tool Development**

The toolkit consists of the following:

- A review of selected literature and tools
- Background on social determinants of health (SDH)
- The MOCAT
- Selected topic-based guidance (tobacco, road safety, nutrition, household air pollution)

The MOCAT is based on the conceptual framework provided below, using the CPF cycle as an example. An expanded version of this flowchart, outlining the purpose and expected outcome at each level, is provided in the MOCAT (see part 2 of this document). Use of the tool will facilitate situational analysis, identification of opportunities, and the iterative development of solutions. When using the MOCAT, consideration of factors such as the social and political environment, transactions and negotiations as well as transferability of best practices is essential, given that no “one size fits all” where solutions are concerned.

**Figure 1. Refining the Science of Delivery: An Example of Using the MOCAT Within the CPF Cycle**
The MOCAT is meant to assist task teams in assessing new opportunities to achieve health results in various contexts: (i) during the Systematic Country Diagnostic (SCD)/ Country Partnership Framework (CPF) or project/product preparation; (ii) when assessing the portfolio of a country to identify quick wins; (iii) at the midterm evaluation of a CPF or a project/product; and (iv) during overall policy dialogue.

A high-caliber consultant with the right experience and expertise was hired to assist in developing the MOCAT. The development process included consultations, concept development, advisory and focus groups, a literature review, pilot testing, and production of the MOCAT toolkit (see part 2).

Consultation to develop the concept and turn it into practice

The MOCAT was developed through an inclusive process that involved senior staff from diverse sectors and regions, including the following:

- **HNP staff dialogue on multisectoral experience.** Senior HNP staff met for a dialogue to build on their experience of working multisectorally and to pool their knowledge of related tools to refine the MOCAT concept and to clarify its aims, scope, audience, added value, and timing.

- **Dialogue with TTLs and sector managers.** HNP staff and TTLs from other sectors met to discuss the new CPF, with the goal of understanding how the MOCAT may fit into this framework. Sector managers of AFR, SAS, and MENA, and the director of HNP then met with the task team to help shape the development of the MOCAT concept and consider the best way to translate it into practice.

- **Advisory group.** The KP concept review meeting proposed the formation of an advisory group to assist with the development of the MOCAT. This group comprised sector managers, senior HNP staff across regions, and staff from other sectors, (transport, water and sanitation, environment), and was chaired by the HNP sector manager for the MENA Region. The initial meeting of the group concluded that the structure of the MOCAT was overly complicated and came across as a questionnaire designed for the purpose of data collection. A simplified version presented during the second meeting was well received, and it was acknowledged that significant progress had been made. The following observations helped to refine the tool:
  - The branding focused on the negative constraints, whereas this tool should convince country directors that opportunities will be identified.
  - Given the limited time available to country directors, coupled with resource constraints, compelling reasons need to be given on the benefits of the MOCAT approach.
  - The role of the team in the country and their input could be clearer, and more emphasis could be placed on how local knowledge is brought in.
  - It was recognized that there will be some important structural drivers to the burden of disease that the MOCAT will not be equipped to address (such as change of government).
  - In the future, it would be helpful to develop an electronic version of the MOCAT.

- **Focus group:** To canvass a broad range of views, a focus group discussion and consultations with team leaders were convened. The comments regarding the purpose of the tool, adoption of a systematic approach, and general feedback have been taken into account in the redesign of the tool. Specifically, the group suggested the following:
  - The format of the framework was too “busy,” and the links between the different MOCAT domains could be better articulated.
  - The purpose of collecting different types of data and the relationship between the burden of disease and upstream drivers could be clearer.
  - More clarity was needed as to how the MOCAT would add value to the stakeholder analysis that Bank teams are expected to do as a matter of course.
Consultation with the Capacity Development and Results Unit of the World Bank Institute (WBI) (soon to become the Science of Delivery Unit). This unit has recently carried out, with support from Deloitte, a thorough inventory of tools in HNP. There are valuable links that will be useful for the TTLs to consult; these will be included in the final version of the MOCAT. The unit believes that the MOCAT is different from all the tools reviewed and is a very good example of science delivery focused on the "how to." They have offered support to develop a fact sheet on the MOCAT to be included in their revised inventory, which will support the dissemination process.

Literature review

The team conducted a literature review of over 200 articles, consulted leaders in the field of the social determinants of health, and used networks to confirm that a tool equivalent to the proposed MOCAT did not exist and to import best practice into its development. The strengths and weaknesses of the tools were assessed as to their usefulness to the MOCAT process, not in terms of the purpose for which they were developed. Much of the literature identified focused on theory and emphasized the need for a practical tool. A short descriptive framework of the documents and tools that were reviewed and were considered to have the potential to complement the MOCAT are included in the toolkit.

The paper, Research on Project Cycle Tools and Approaches in Health, Nutrition and Population, which has been published as a result of a need identified during the Science of Delivery stocktake (FY2014), proved to be a valuable resource in mapping the broad landscape of tools. Particularly rich areas are health financing and HIV; these have been given due consideration in refining the MOCAT.

A background paper that highlights specific issues of multisectoral action to address the social determinants of health and the topics of NCDs and nutrition was developed from the literature review and is included in the MOCAT toolkit (see part 2 of this document).

Pilot testing

The MOCAT has been tested in two states in India, and initial consultations have taken place with the HNP team leader in Madagascar, where subsequent testing of the tool is planned. In India, Nagaland and Uttarakhand were selected as test sites as there was an opportunity to build on the multisectoral efforts already underway there through the Uttarakhand Health Systems Development Project-II (UKHSDP-II) and the Nagaland Multisectoral Health Project (NMHP). Preparation for pilot testing involved communication with the project teams, review and preparation of background materials and presentations, and the completion of the MOCAT prior to the mission. The Country Management Unit (CMU) of India is solidly committed to the concept of multisectoral action to achieve HD outcomes. Plans are in place to refine the tool based on user experience, including in Nagaland and Uttarakhand (see the MOCAT Development Plan in part 2). In the case of India, more detailed data collection will be conducted by the Institute of Health Metrics and Evaluation (IHME) in the targeted states in the near future; it will be interesting to compare the findings of the pilot testing to those of the IHME analyses.
**World Bank projects in the pilot sites:**

**The Nagaland Multisectoral Health Project (US$60 million)**

**Summary description:** The main project objective is to improve the availability and utilization by targeted communities in Nagaland of services in several sectors that have a potential impact on health and nutrition. Main components include the following:

**Component 1: Multisectoral interventions for improving health**
- Innovation to improve electricity, water supply, and sanitation systems in targeted health facilities
- Community empowerment to improve health and nutrition

**Component 2: Health systems capacity development**
- Technical assistance and project management
- Supply chain management and infrastructure/equipment maintenance systems
- Human resource development and management
- Information and communication technology (ICT)
- Filling gaps in health service delivery

**The MOCAT pilot testing**

**A. Main findings:**
- Through their specific remit, the MOCAT team was able to reinforce the nature and importance of a multisectoral approach with senior government officials from across sectors and to help focus their thinking on the opportunities for joint work. Feedback received from a senior health official illustrated this point.
- The engagement of the MOCAT team with stakeholders from across sectors in the margins of formal meetings and negotiations brought another perspective to the Bank’s work.
- By gathering and analyzing additional data from across sectors and highlighting gaps in knowledge, alternative data sources could be identified.
- Discussion around specific issues in the states could be informed using experience in other countries.
- Opportunities for multisectoral work were identified beyond the scope of the project.

**B. Main conclusions:**
- Ensure that the first stage of the framework reflected the need to consult the TTL.
- Include further steps to ensure that local voices and expertise are considered at every stage.
- Highlight the gap between published data and the situation in the state. For example, as a “dry state” the significant issue of overconsumption of alcohol was not identified at the desk-search stage.
- Suggest that solutions from international literature should only be considered once the full picture based on both desk review and a mission has been identified.

By its nature, a fact-finding mission in the context of the MOCAT process will also start to build relationships, and this initial pilot visit demonstrated this. It reinforced that the MOCAT process should be for the long term and built on sustainable relationships; further work to develop and maintain the process is recommended.

**Full details of the mission are provided in part 3. The process and recommendations are highlighted below.**
The Uttarakhand Health Systems Development Project-II (US$125 million)

Summary description: The main project objective is to improve access to and quality of health services and to expand health financial risk protection for the entire state of Uttarakhand. Main components include the following:

- Nutrition
- Road safety
- Disaster preparedness and disaster resilience

Other activities include:

- Stewardship and systems improvement
- Innovations in engaging the private sector

MOCAT pilot testing

A. Main findings:
Support to the multisectoral aspect of the project by bringing international knowledge and examples of relevant approaches to the table was well appreciated. This helped articulate the links between areas such as disaster preparedness and road traffic accidents, for example, in relation to identifying potential sites for trauma centers.

In Uttarakhand, the desk review provided a better understanding of the burden of disease and its upstream determinants than in Nagaland. However, the field mission helped develop a better understanding of priority areas, underlining the importance of field work.

The possibility of direct interactions with key stakeholders on the MOCAT was more limited in Uttarakhand compared to Nagaland given the fact that discussions about the tool took place in the context of several ongoing project meetings with government officials.

Feedback from the Bank’s project team suggested that the MOCAT process had helped to clarify how to systematically translate the concept of multisectoral working into action. It also provided insight on collecting data from sources other than the health sector, for example, in relation to road traffic accidents where the police and criminal justice system have very good information.

B. Main conclusions:
- Place greater emphasis on in-country work, and for ongoing dialogue with TTLs, team members, and stakeholders.
- Given the symbiotic nature of the MOCAT process and the Bank’s project, which is under development in Uttarakhand, it is recommended that further work on the MOCAT is carried out in the state to both add value to the existing project and to provide foresight as to possible multisectoral operations beyond its scope.

Full details of the mission are provided in part 2 of this document. The process and recommendations are highlighted below.
The process of pilot testing

The HNP GP team responsible for pilot testing the tool worked to ensure that the process added value to, and supported the work of TTLs. They also acknowledged from the outset that the knowledge and expertise on the state’s priorities and possible solutions largely reside within that state. While considerable attention was paid to ensuring as much data and background information was gathered and analyzed before the mission, the importance of the work in the country was never underestimated. Through dialogue with Bank task teams and key stakeholders from across sectors, a picture of priorities that could be amenable to multisectoral action was developed. While this has produced a snapshot of the opportunities and constraints, the iterative nature of the MOCAT process means that it will lend itself to support the ongoing development of multisectoral relationships and joint work.

The process outlined in the MOCAT was followed:

- Discuss the relevance and appropriateness of systematic multisectoral action (such as that outlined in the MOCAT) with the TTLs, team members and stakeholders.
- Conduct a desk search of grey and published literature and identify data on the burden of disease, upstream determinants, and related factors.
- Consider who the key stakeholders would be and what could help or constrain their actions toward positive health outcomes.
- Consider examples from international best practice that might be relevant to the situation.
- Check data with the TTLs and task teams.
- Develop a program for engaging key stakeholders from across sectors (for example, water and sanitation, transport, employment, and education) and from government, NGO, and service provision in liaison with the TTLs.
- Undertake the MOCAT mission (this was arranged to coincide with a visit by the wider WB project team).
- Attend meetings with policy makers from across the sectors and conduct individual interviews to fill in gaps in the data and to understand the information in the cultural and political context.
- Refine the data and identify potential priority areas for action.
- Share findings with the TTLs and discuss possible next steps.

See part 2 of this document for details of the process.

3.3v. Main findings from the pilot testing in relation to the MOCAT format

Dialogue with TTLs and stakeholders

- As the MOCAT task team anticipated, the early dialogue with the TTLs is of crucial importance in understanding the relevance of the MOCAT to their country, its appropriate use, and how it could support their wider agenda.

Data collection

- The TTL is an important first informant on data sources. It is expected that there will be differences in how much good quality data is available, and this needs to be taken into account in planning the mission to ensure that the right stakeholders capable of filling the knowledge gaps are involved.
- The initial search of published and grey literature is the starting point of building a broad picture of health and its upstream drivers in a country, and it is a good basis for early discussions with the TTL. However, this data will often be incomplete, and work in the country is essential to understand the context of the data, identify priority issues that do not appear in the literature, and match what is known from international evidence of best practice to local need.

Identification of drivers

- The MOCAT is intended to be a tool used by task teams with support from the HNP GP. While there are benefits in an MOCAT team being integrated into a larger mission, including their
contribution to it, this has to be balanced with the heavy demands on the TTLs’ time during periods of intense activity on the ground.

Identification of proven solutions

- In preparing for the mission, international examples of good practice can be considered in broad terms, but specific solutions are best arrived at in dialogue with stakeholders.

Engagement across practices

- The MOCAT is closely related to the Country Partnership Framework (CPF) process, and this could present the best entry point for the tool.
- The mission is research in action; it not only serves to develop a fuller understanding of the burden of disease, upstream drivers, and potential solutions, but it can trigger a shift in the mindset of key stakeholders who become part of the process.
- The initial audience for the MOCAT is the task team. However, the in-country process involves stakeholders from across sectors, and a second stage of the process could usefully focus on articulating the value of the MOCAT to government.
- The importance of the MOCAT as part of the long-term relationship–building process across sectors, rather than a discrete activity, was illustrated by the mission.

Determining optimal multisectoral action

- The MOCAT team was able to share a broad range of experience and knowledge with stakeholders as issues emerged, and this was well appreciated.

In conclusion, the pilot testing to date has demonstrated that the MOCAT is a useful tool and an effective way of highlighting multisectoral approaches to address specific priority issues in countries. The pilot test also confirmed that the MOCAT needs to be a live process that involves the TTL and key stakeholders from the outset, that a flexible approach is needed to fully respond to country needs, and that the MOCAT should form part of a longer-term process of relationship building and engagement.

Dissemination Strategy

The dissemination strategy for this KP will focus primarily on an internal audience. The MOCAT and case studies will be disseminated to allow early sharing of knowledge as well as feedback from TTLs, practitioners, and country partners. Given the timing and nature of the subproducts for this KP, dissemination activities are expected to continue during the next fiscal year. The team has developed dissemination and utilization strategies with clear communication objectives and metrics.
<table>
<thead>
<tr>
<th>Desired objectives</th>
<th>Audience</th>
<th>Dissemination channel</th>
<th>Actions needed</th>
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</thead>
<tbody>
<tr>
<td>• Educate/convey key messages of the MOCAT</td>
<td>TTLs from different GPs</td>
<td>Training/coaching sessions</td>
<td>• Develop PPT slides</td>
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<tr>
<td>• In-depth understanding of the rationale behind MOCAT</td>
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<td>• 1–2 page summary of findings from the MOCAT pilot testing</td>
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<td>• TTL mastery of applying the MOCAT</td>
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<td>• Identify good coaches/trainers</td>
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<td>• One-on-one coaching sessions</td>
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<td>• Small-group training on use of the MOCAT</td>
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<td>• Webinars and videos</td>
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<tr>
<td>• Educate/convey key messages</td>
<td>Country directors</td>
<td>Fact sheets/one pager</td>
<td>• Develop short, easy-to-read fact sheets for the MOCAT with key messages and lessons learned</td>
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<tr>
<td>• In-depth understanding of, and demonstrate benefits of MOCAT and studies</td>
<td>Program leaders</td>
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<tr>
<td>• Create awareness and encourage use of the MOCAT</td>
<td>TTLs from different sectors WB staff, especially TTLs</td>
<td>Web</td>
<td>• Utilize HNP internal newsletter</td>
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<tr>
<td>• Make the MOCAT easily accessible</td>
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<td>• Utilize HNP GP knowledge management (KM) portal</td>
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<td>• Utilize HNP Spark site</td>
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<td>• Blogs</td>
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**CASE STUDIES**

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<th>Desired objectives</th>
<th>Audience</th>
<th>Activities</th>
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</thead>
<tbody>
<tr>
<td>• Increase awareness of and utilization of the case studies</td>
<td>World Bank staff, especially TTLs</td>
<td>Push e-mails</td>
<td>• E-mails to HNPFAM</td>
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<tr>
<td>• Create awareness of how-to’s of successful multisectoral initiatives</td>
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<td>• Targeted e-mails to Public Health Community of Practice; TTLs from other GPs, e.g., Water, Transport, Agriculture, Social Protection</td>
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<td>• Develop 1–2 pagers with main messages</td>
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<td>• Educate/convey key messages on the “how-to” of engaging across GPs/sectors</td>
<td>Country directors</td>
<td>Fact sheets</td>
<td>• Develop short, easy-to-read fact sheets for capturing the how-to of effective multisectoral action, key messages, and lessons learned</td>
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<td>Program leaders</td>
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<td>• Create awareness of how-to’s of successful multisectoral initiatives</td>
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<td>• Utilize HNP internal newsletter</td>
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<td>WB staff</td>
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<td>• Post content on HNP KM portal</td>
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<td>• Utilize HNP Spark site</td>
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**CASE STUDIES AND MOCAT (Joint action)**

<table>
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<th>Desired objectives</th>
<th>Audience</th>
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<th>Actions needed</th>
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</thead>
<tbody>
<tr>
<td>• Create awareness</td>
<td>TTLs from</td>
<td>Events</td>
<td>Disseminate fact sheets</td>
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and encourage use of the MOCAT beyond the HNP GP
different sectors
• WB staff
Examples. Half-day event to disseminate MOCAT and case studies; plus other events involving other GPs
for the MOCAT with key messages
• Disseminate fact sheets for capturing the how-to of effective multisectoral action
• Presentations on the MOCAT

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<th>METRICS</th>
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<td>• Surveys to gather feedback on the KP products (including during training for the MOCAT)</td>
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<td>• Anectodal feedback</td>
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<td>• Case Study downloads</td>
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<tr>
<td>• Requests for the MOCAT</td>
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**Next Steps for the KP**

As stated in the introduction, this is the first phase of development of the KP: *Building the Foundation for Healthy Societies: Influencing Multisectoral Action for Health*. Indeed, bringing about a change in mindset to embrace action beyond the health sector, both within the Bank and at country level, requires a long-term engagement and sustained momentum. To this end, proposed steps for Phase Two of the KP include the following:

- Refining the MOCAT based on the pilot testing and further assistance to the TTLs in Nagaland and Uttarakhand.
- Testing in different country contexts, including Madagascar, taking into account the CPFs schedule for fiscal year 2015 and beyond. This, over time, will create a critical mass and help institutionalize the MOCAT.
- Preparing more case studies to continue to provide TTLs with the “how to” to help them develop more intersectoral collaboration and action.
- Embedding, as needed, HNP staff in other sectors to help make the case for these sectors’ roles in promoting health.
- Developing a training curriculum on the social determinants of health with the Institute of Health Equity based at the University of London.
- Carrying out analytical work on attributable risk modeling of the social determinants of health, which could build on the World Bank’s multisectoral work on nutrition,\(^1\) as well as on return on investment to determine the potential impact of investments in other sectors to improving health outcomes. This will help determine priority actions in other sectors to maximize impact for health results.

Subsequent phases of the KP will require that staff time be set aside to assist task teams with data collection, analysis, and testing of the MOCAT. In addition, some incremental variable resources will be needed for (i) the preparation of additional case studies to highlight knowledge in multisectoral action; (ii) use and refinement of the MOCAT in countries with upcoming CPFs; (iii) conducting attributable risk modeling and return on investment analysis; and (iv) app development. Further details are provided in part 2 of this document, under the MOCAT Development Plan.

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PART 2: THE MOCAT TOOLKIT

Background

Working with other sectors for economic development and health improvement within countries is not new to the World Bank, which has a track record of working with partners on investments that have a positive impact on health. However, despite the rationale for a systematic approach to multisectoral working — as was outlined in the 2007 HNP strategy — this has not materialized, and the evaluation of the strategy carried out in 2009 flags such work as one key area where progress was not accomplished.

Effort on this front took a significant shift forward in 2012 with the publication of the Public Health Policy Note, Connecting Sectors and Systems for Health Results. This sets out a five-year vision for the Bank’s approach to public health, and calls for a strong focus on multisectoral action and investments to address the upstream factors that are the foundation of healthy societies. This represents a significant shift away from approaching work in individual sectors and toward a principal of coordinated engagement across several sectors, which better reflects the complex interplay of social and economic factors as determinants of health.

The importance of multisectoral work is given greater prominence in the Bank as it is an explicit requirement in the terms of reference of newly appointed Global Practice directors.

The Multisectoral Opportunities and Constraints Assessment Tool (MOCAT) is being developed to help task teams better understand the drivers and constraints of a systematic approach to multisectoral work in countries, and to identify opportunities to underscore the importance of work across sectors, which is central in developing health improvement programs. The MOCAT will help task teams and other Bank staff (and ultimately policy makers at the country level) to think differently about their approach to improved health outcomes.

All consultations carried out to date in the process of developing this tool (with TTLs, sector managers, the HNP director, and peer reviewers) underscore the need to develop a simple, easy-to-use tool at this first stage of the work. The MOCAT, along with four case studies on multisectoral action in health (Institutionalizing Road Safety Management in Argentina; Conditional Cash Transfers and Health with a focus on Mexico; Multisectoral HIV and AIDS Responses: Lessons for Task Team Leaders; and Best Supporting Actor: The World Bank and Tobacco Tax Reform in the Philippines), will be the main deliverables of the first phase of the KP: Influencing Multisectoral Actions in Health. Management wants to make this available to task teams when the new HNP Global Practice is launched, starting July 2014. The development of the MOCAT will be an iterative approach: the first two pilots in India (in two states) take place before the end of the 2014 fiscal year, while the full process of refinement will continue with its use over the next three years.

Rationale

- If the World Bank succeeds in achieving its goal of eradicating extreme poverty by reducing the number of people living on less than US$1.25 a day to 3 percent by 2030, it will have made a significant contribution to global health because actions to reduce poverty de facto address the major social determinants of health.
- In meeting its goal of promoting shared prosperity by fostering the income growth of the bottom 40 percent in every country, the World Bank will also significantly contribute to addressing the persistent issue of health inequalities.
- Improving people’s health will also significantly contribute to the Bank’s goal of poverty reduction. Economic, physical, and mental health and well-being are inextricably linked, and evidence demonstrates that multisectoral action is an effective way of achieving positive health and development outcomes. The process of multisectoral working is not separate or additional to the Bank’s core business of poverty reduction, but it is a way of sharing effort and resources and of marshaling those efforts to maximize impact. The overarching reason to adopt this approach is that only a limited amount can be achieved in
developing health equity by one sector acting on its own. Moreover, multisectoral action has other practical advantages, including the following:

- Sharing tasks and resources with other funding bodies is time saving and maximizes resource use.
- Working across sectors offers opportunities for consensus building and effective advocacy, and potentially to provide support for achieving the Bank’s goals.
- Dialogue and consensus building across sectors can remove barriers or objections to work on the Bank’s priority areas.
- Working with the people that a project is intended to benefit helps ensure that it is based on real need, and that there is ownership of solutions.
- As most of the determinants of health do not reside in the health sector, multisectoral working is needed to effect positive outcomes by, for example, action on education, the environment, transport, employment, and housing.

Multisectoral work recognizes that key factors will require action beyond the health sector. These factors include global shifts in the upstream determinants of health such as trade, the environment, and migration; the epidemiological transition (while communicable diseases and the achievement of the Millennium Development Goals [MDGs] are still major issues in many LMICs, noncommunicable diseases are rapidly becoming a major cause of death); the double burden of undernutrition and obesity in countries; the disability transition; the significant rise in road traffic injuries; air quality; rapid urbanization; changes in weather patterns; and the impact on agriculture and water supplies.

**Purpose**

The MOCAT process is intended to do the following:

- Assist in identifying opportunities for and constraints to multisectoral work in pursuit of better health equity outcomes in countries; and
- Support multisectoral action and work across practices in the Bank to achieve positive health equity outcomes in countries through joint work.

The following diagrams present an overview of the MOCAT framework and the plan for development of the tool.
Figure 2. Refining the Science of Delivery: An Example of Using the MOCAT Within the CPF Cycle

A new, upstream focus on health outcomes

Dialogue with country leads to assess the appropriate use of the MCAT

Determine priority health results to address

Identify drivers, opportunities, and constraints to multisectoral action

Identify proven solutions

WHAT DO OUR CLIENTS NEED/WANT?
HOW CAN WE GET IT TO THEM COST-EFFECTIVELY?

Assess success of multisectoral action; learn from failure

Knowledge sharing; process refinement

Implement action plan

Course-correct and course-adjust

Develop an action plan with interventions and intermediate outcomes (with client and country teams)

Promote dialogue and engage relevant practices/sectors

Review opportunities for WBG involvement in light of comparative advantage

Determine optimal multisectoral actions (agreement with government, stakeholders, and other sectors on opportunities for actions to address identified priorities)

CPF: Country Partnership Framework
IP: Implementation Plan
SCD: Systematic Country Diagnostic

Source: MOCAT Development Team
**Figure 3. The MOCAT Development Plan**

**Table 2. MOCAT Development Plan Budget**

<table>
<thead>
<tr>
<th><strong>MOCAT</strong></th>
<th>FY 15</th>
<th>FY 16</th>
<th>FY 17</th>
</tr>
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<tr>
<td>Consultant for the MOCAT</td>
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<tr>
<td>Consultant to assist with analytical work (attributable risk modeling)</td>
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<td>Refining of the tool (3 missions in 3 countries)</td>
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<td>App development</td>
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<td>App testing and refinement</td>
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<td>30,000</td>
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<tr>
<td>Dissemination</td>
<td>12,000</td>
<td>12,000</td>
<td>12,000</td>
</tr>
<tr>
<td><strong>Case studies</strong></td>
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<td>90,000</td>
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<td><strong>TOTAL VARIABLE COSTS</strong></td>
<td><strong>279,000</strong></td>
<td><strong>132,000</strong></td>
<td><strong>132,000</strong></td>
</tr>
</tbody>
</table>

**Source:** MOCAT Development Team
1. **Who is the MOCAT for?**
The MOCAT is intended for use by the in-country TTL and other members of the Bank’s task team with support of the HNP GP.

2. **What is the purpose of the MOCAT?**
The purpose of the MOCAT is to assist in identifying opportunities for and constraints to multisectoral work in countries and to facilitate engagement across relevant Bank practices and sectors to achieve positive health outcomes.

3. **What is the added value of the MOCAT?**
The MOCAT is a guidance tool that aims to (i) provide a systematic process to close the gap between knowledge and action for multisectoral engagement; (ii) provide evidence to task teams to make the case for multisectoral action; (iii) provide support to country task teams from HNP; (iv) promote shared resources and effort across sectors whose work impacts health but where health care delivery plays a relatively small part; and (v) improve health equity outcomes.

4. **How do I use the MOCAT?**
The MOCAT should be used as a guidance document, but not all sections will be relevant in all contexts. The HNP GP will provide support to task teams for specific sections of the MOCAT (see MOCAT Phase One: Process Outline below).

5. **When do I use the MOCAT?**
The MOCAT is meant to assist task teams during preparation of the Systematic Country Diagnostic (SCD)/ Country Partnership Framework (CPF), but may also be used opportunistically when assessing the project portfolio of a country to identify quick wins, for the midterm evaluation of a CPF or a project, or to assess new opportunities through which health outcomes may be addressed by multisectoral action.

6. **Is the MOCAT a questionnaire?**
No, the MOCAT is a guidance tool. It is designed to encourage reflection on best practice in the context of identified need, and to raise key issues for consideration in relation to assets, opportunities, constraints, and barriers to multisectoral work toward positive health outcomes.

7. **How is the MOCAT related to the CPF?**
The MOCAT is intended to assist during preparation of the SCD/CPF. This first phase of the MOCAT covers the SCD and the steps of the CPF framework, not the third step (the Implementation Plan).

8. **Does the MOCAT mean more work for me?**
The MOCAT suggests a consensual way of working with other sectors that will potentially reduce both the workload and resource needs of each.

9. **What are the different products in the toolkit?**
The toolkit will contain the following:

   i. The MOCAT
   ii. A background paper on the social determinants of health
   iii. Summary of complementary documents and tools.
THE MOCAT PROCESS OUTLINE (SCD AND CPF)

PREPARATORY WORK: DIALOGUE WITH COUNTRY TEAM TO ASSESS THE APPROPRIATE USE OF THE MOCAT

- Identify how the MOCAT process can support the Bank's team in a country to improve health through multisectoral work on the upstream determinants of health.
- Gain insight into the current situation, both in terms of health challenges and existing interventions, by discussion with the TTL and other members of the Bank's team.

OUTCOME: An agreed plan of action for implementing the MOCAT within a country with the support of the HNP GP.

A. DETERMINE PRIORITY HEALTH RESULTS

Process:
- Identify which actions across sectors could help to achieve the Bank's twin goals with a particular focus on equity in health.
- Gather data and knowledge through a range of sources in discussion with the TTL and task teams.
- Assess the current situation to identify the major issues that impact health, the current burden of disease, health trends, and potential risks to set priorities.

Actions:
- Data analysis
- Benchmarking
- Prioritization of major health issues in the country

OUTCOME: Identification of the three to five major health issues that are amenable to multisectoral action.

HNP GP will provide assistance with data analysis and benchmarking and the identification of priority health issues to be addressed.

B. IDENTIFY DRIVERS, OPPORTUNITIES, AND CONSTRAINTS TO MULTISECTORAL ACTION

Process: In the context of the priority issues from box A, identify the upstream drivers from across sectors that impact these, and consider the opportunities and constraints to feasible action.

Actions:
1. Literature review of upstream factors
2. Consult TTL
3. Interview key stakeholders
**OUTCOME:** List of key drivers (that is, what is behind the issue) and identification of key opportunities and constraints.

**HNP GP** will provide assistance by helping task teams identify possible relevant drivers, carry out data analysis and review of the literature, and identify preliminary challenges to achieving positive results in the priority areas.

**C. IDENTIFY PROVEN SOLUTIONS**

Process: Consider examples of international evidence-based best practice in meeting similar priorities to those identified in boxes A and B, taking full account of the issue of transferability and of opportunities for local innovation.

Actions:

1. Review grey and published literature and consult networks to identify proven solutions.
2. Consult TTL and stakeholders on cultural appropriateness and transferability.

**OUTCOME:** Identification of proven solutions and best practice applicable in the specific country context.

**HNP GP** will provide support by identifying proven solutions to address the priority issues in the country and by helping to analyze these for transferable learning and to test their appropriateness.

**D. ENGAGEMENT ACROSS RELEVANT PRACTICES/SECTORS**

Process: Identify the key sectors whose work will impact the identified health priorities, and develop an understanding of opportunities and constraints on them to act in a health supporting way.

Actions: Identify incentives, mutual benefits, and win/wins in joint working for stakeholders from across sectors.

1. Map existing joint work, fora, and networks for multisectoral work within the country.
3. Help TTLs make the case for other sectors’ involvement.
4. Identify and open dialogue with stakeholders from across sectors whose work could impact the identified health priorities.

**OUTCOME:** A plan to develop a mechanism to maintain the engagement of multisectoral partners. Multisector partners are engaged and mutually agree on necessary action.

**HNP GP** will provide support to task teams to make the case to the sectors about their role in addressing the issues identified, and to emphasize what other sectors have to win from such involvement. This will highlight previous efforts of multisectoral collaboration.
E. DETERMINE OPTIMAL MULTISECTORAL ACTION (AGREEMENT WITH GOVERNMENTS, STAKEHOLDERS, AND OTHER SECTORS ON OPPORTUNITIES FOR ACTION TO ADDRESS IDENTIFIED PRIORITIES)

Process: In the context of priorities identified in box A, and the opportunities and constraints on multisectoral action on the upstream determinants, identify the optimal actions that can be taken in the short, medium, and long-term.

Actions:

1. Political analysis
2. Stakeholder analysis and assessment of multisectoral forums
3. Identification of quick wins, and medium-term and long-term possibilities

OUTCOME: A concrete set of actions to be taken to address the upstream determinants of health that have been agreed with stakeholders from across sectors.

HNP GP will provide support to identify and connect stakeholders and develop multisectoral forums and networks.

F. REVIEW OPPORTUNITIES FOR WBG INVOLVEMENT IN LIGHT OF COMPARATIVE ADVANTAGE

Process: Evaluate portfolio of WBG in country of interest, and connect with TTLs.

Actions: Taking into account discussions under box E, assess opportunities for WBG incorporation into current activities or for pursuit of new activities. Consider the following:

1. What is the comparative advantage of WBG?
2. What opportunities are there for strategic partnerships?

OUTCOME: A summary of the country’s portfolio, highlighting potential areas of interest and gaps in WBG activity.

HNP GP will provide support by conducting an analysis of the country’s current portfolio and helping task teams reach out as needed to TTLs in relevant sectors.
THE MOCAT

Determine Priority Health Results

- Identify which actions across sectors could help to achieve the Bank’s twin goals with a particular focus on equity in health.
- Gather data and knowledge through a range of sources in discussion with the TTL.
- Assess the current situation to identify the major issues that impact health, the current burden of disease, health trends, and potential risks to set priorities.

Data Analysis

It is acknowledged that different levels of data will be available in each country at national, regional, and local levels and that a desk review needs to be supplemented with work in the country to get the fullest possible picture. This will include both identifying grey literature and additional information from key informants to not only add to the data, but to locate it in the context of other forms of local knowledge and political realities.

- Analysis of data from a range of sources is carried out to provide clarity on the burden of disease and trends in it. Sources could include the following:
  i. Household surveys
  ii. Global Burden of Disease, Injuries and Risk Factors Study (GBD 2010)
  iii. Health impact assessment processes
  iv. Health system attendances

- Analysis of data from a range of sources is carried out to understand the impacts of the upstream determinants on health, for example, trade, education, employment, the environment, transport, and housing. Sources could include the following:
  i. UNDP Human Development reports
  ii. Environmental health reports
  iii. Survey of educational achievement
  iv. WHO water and sanitation report

- Analysis of data is carried out to understand the differing impacts of action across sectors on population health. For example, in the context of the following:
  i. Quintiles of society
  ii. Ethnicity, race, or religion
  iii. Gender
  iv. Urban and rural settings

- If data on health and its determinants is not disaggregated in such a way as to demonstrate inequities in the distribution of health, an understanding of the situation may be developed by looking at proxy markers or a basket of indicators on what is known to impact health.

- Analysis of risk within your country is carried out, by looking at, for example:
  i. Risky behaviors (for example, type of health-harming behavior and most affected groups)
  ii. Natural disasters (for example, fire, volcanic eruption, and earthquakes)
  iii. Pandemics
  iv. Weather shocks (for example, droughts, floods, and hurricanes)
  v. Man-made disaster and political stability

(Please see note 1 below for opportunities for data collection)
Benchmarking

- Comparisons are carried out to define where the country is disproportionately experiencing specific, health-related issues. Sources will be from different levels; for example:
  i. WHO global disease and benchmarking between countries
  iii. The Bank and other donor country reports
  iv. State-level comparisons
  v. National averages and regional variations
  vi. Differences between local communities

- Comparisons are carried out to identify a previous time when the country had better health outcomes — if such existed — and the learning from that period is identified.

- Trends in other countries are identified to provide foresight into possible future scenarios in the country.

(Please see note 2 below for opportunities for benchmarking)

Identification of Major Health Equity Outcomes

- As a result of the data analysis and benchmarking processes, three to five health issues that disproportionately impact 40 percent of the population with the lowest income are identified for priority action. This will clarify the relevant key actors and stakeholders.

Identify Drivers, Opportunities, and Constraints to Multisectoral Action

Identify upstream drivers across sectors that impact the priority issues (identified pursuant to section A above), and consider any opportunities and constraints to feasible action.

The upstream factors that may be responsible for the major health issues (identified in section A above) are considered, and their relative importance and likely impact on the health issues being prioritized is determined. Dialogue with stakeholders will be key to refining this process as stakeholders will be aware of specific drivers and constraints in their sector (see section D below). Analysis could include a consideration of the status of the following key services along with an assessment of their effectiveness and accessibility to 40 percent of the population with the lowest income regardless of religion, ethnicity, sexuality, or gender:

i. Health systems:
   - Fully functioning and accessible prevention, primary and acute health systems.
   - Adequate facilities to support pregnant women, new mothers and their babies, including vaccination, nutrition, financial support, delivery, and postnatal care.
   - Providing adequate information on services, health risks, and behaviors to those who most need them.

ii. Education system:
   - Fully functioning primary to adult
   - Accessible to girls

iii. Housing:
   - Access to clean water and sanitation
   - Well ventilated with adequate space

2. Benchmarking can be used at the national, state, region, or local area levels or between villages.
iv. Employment and social protection:
- No child labor
- Appropriate opportunities for good quality employment
- Adequate social protection systems

v. Nutrition:
- Access to adequate nutritious food
- Disrupted food production due to, for example, crop failure or trade agreements
- Food safety issues, such as the storage, transport, and handling of food to avoid contamination

vi. Transportation:
- Access to transport links to economic centers and to health facilities
- Road traffic safety issues

vii. Energy
- Access to a reliable source of electricity for the home and industry
- Access to clean cooking facilities

viii. Social environment:
- Social constructs or religious objection to effective work to address key drivers in relation to, for example, education for girls, sex between men, or vaccination programs

ix. Regulatory environment:
- Health promotion taxation, for example on tobacco and alcohol
- Commitment to international treaties and frameworks, such as the Framework Convention on Tobacco and the MDGs
- Compliance with international health regulation
- Safety and protection laws, such as health at work and road safety
- International trade agreements, for example, which support local markets and prohibit health-harming imports

x. Political3 and policy environment:
- The impact of fragility at the state level, and of the potential for a change of government on the economy and on opportunities for inward investment
- Political instability resulting in the lack of a negotiated position on health that will hold
- Short-term political cycles that do not support medium- or long-term strategic approaches or the development of new legislation
- Lack of political will or limited interest in addressing inequalities and the health needs of the bottom 40 percent of society, who may fall outside democratic processes
- Philosophical or political positions that inhibit willingness of stakeholders to sit at the table together

Specific opportunities and barriers to action to address the major health issues (flagged in box A) within the relevant sectors are identified through dialogue with leaders in the areas corresponding to the identified burden of disease and upstream drivers.

Identify Proven Solutions

Consider examples of international evidence–based best practice in meeting similar priorities to those identified in boxes A and B, taking full account of the issue of transferability and of opportunities for local innovation.

3. While the MOCAT process is not going to change the political environment, it may help to identify the best ways to work within it.
Given the health priorities in section A and the opportunities, constraints, and drivers identified in section B:

- Examples within the country, region, or in the international literature of good practice in addressing similar issues to those identified in sections A and B above are considered. In particular, consideration is given to the proven impact on health of work in other sectors. Sources might include case studies on multisectoral action within the Bank, WHO Best Buys, reports from international and national aid agencies and charities, and other analyses carried out by academics and those at the country level.
- Possible transferable learning from any highly culturally specific or local issues along with the lessons learned, and how best practices could be relevant to the country are drawn out.
- Evaluation of the best practice examples suggests that they would have a significant impact on the identified issues in your country.

(Please see note 3 below on constraints to identifying appropriate solutions.)

**Engage Across Relevant Practices/Sectors**

**Identify the key sectors whose work will impact identified health priorities, and develop an understanding of opportunities and constraints to acting in a health-supporting way.**

Making the case to other sectors within the Bank, use the proven multisectoral solutions identified in section C above, approach other practices in the Bank, and discuss the relative importance of their roles in addressing the key health issues identified.

Additional sources that may be helpful in this process include the following:
- Annex 6 of the HNP Policy Note, *Connecting Sectors and Systems for Health Results* (presents illustrative roles of different sectors in strengthening public health programs and results)
- Data analyses conducted in completing section C above
- Slide set showing that multisectoral work has been conducted successfully within the Bank for the improvement in health outcomes
- Selected case studies (nutrition, tobacco, road safety, CCTs)

In approaching others, consider the following:
- Whether there is sufficient well-evaluated evidence of what works in order to act
- Whether there is willingness to translate international learning into local actions
- Whether there is willingness to draw on international evidence on the need for multisectoral work to change upstream determinants
- Whether there are joint bridges and win/win actions to be identified by consensus

The broad range of stakeholders and key actors at country level will emerge from the process of identifying priority areas and solutions (sections A, B, and C above). The action that is possible and specific constraints to it will be clarified through dialogue. The stakeholder and political analysis will facilitate this process by promoting a better understanding of the language and point of view of other sectors.

**Determine Optimal Multisectoral Action**

**Identify optimal actions that can be taken in the short-, medium-, and long-term concerning the priorities identified in section A above, and the opportunities and constraints on multisectoral action on the upstream determinants.**
**Political Analysis**

The political analysis will include a consideration of the following:

- The political will from the top to work across policy areas
- The degree of flexibility to work across policy and delivery areas in a matrix approach to joint work as opposed to a system rigidly organized in silos
- Whether decision makers operate in a culture of competition for resources or to raise their profile, which may be counter to developing agreement on priority areas
- Whether political or financial cycles align with the proposed milestones of the multisectoral work being considered
- Whether prioritization of the agenda is not influenced by vested interests or lobby groups

**Stakeholder Analysis and Assessment of Multisectoral Forums**

A comprehensive analysis by the Bank, or others working for improved health outcomes, to understand stakeholder priorities and what drives their work, might include a consideration of the following:

- The overall strategic aims of organizations
- The target groups that are a priority for them to work with
- Political or religious agenda that will impact their approach
- Funding source and any restrictions on the type of work they can fund
- The capacity and capability that exists in the organization
- Criteria for assessing their successes

Mechanisms in place to support the contribution of sectors on positive health drivers. For example:

- Health-supporting legislation and national policies, including on poverty reduction
- Coherence between the aims of donors and a willingness to work together
- Transparency, communication, and a shared agenda between sectors
- Clear links between top-down donor policy and bottom-up community interests

In identifying where multisectoral engagement can realistically make a difference and add value to work already taking place in the country, quick wins, medium-term action, and long-term actions are all considered.

**Quick Wins**

- **Existing pieces of work by partners as well as other government initiatives** where the health benefits could be made more explicit — for example, water and sanitation infrastructure development, which has benefits not only in disease prevention, but in the safer delivery of health care services.
- **Proposed large-scale investments** in other areas where health components could be added — for example, looking at infrastructure development in terms of transport to consider access to care and economic centers, or taking the school as a center for better nutrition and vaccination programs.
- **Opportunities for the Bank to help draw out the health aspects of work across sectors by government** and by other donors. The Bank may be able not only to add value to the work of other organizations, but also to be the glue between them by identifying the possible inputs across sectors and facilitating joint work.

**Medium Term**

- Action to mitigate and reduce the impacts of upstream determinants based on international evidence (which may be translated in the form of local pilots and innovation).
**Long Term**

- Evidence-based work on poverty reduction to break the health — and poverty — cycle. For example, on economic growth, employment, trade, urban and rural development, and support for civil society.

**Review Opportunities for WBG Involvement in Light of Comparative Advantage**

Taking into account discussions under box E, assess opportunities for WBG incorporation into current activities or for pursuit of new activities. Consider the following:

1. What is the World Bank’s comparative advantage?
2. What opportunities are there for strategic partnerships?

**Process:** Evaluate portfolio of WBG in country of interest, and connect with TTLs.

**Outcome:**

A summary of the country’s portfolio, highlighting potential areas of interest and gaps in WBG activity.

As the Bank’s twin goals address the key upstream determinants of health by focusing on poverty reduction, the Bank will have a role in health improvement within countries.

Other international and donor organizations operating in the same country may have similar or complementary goals and strategic aims; consideration is needed as to where a symbiotic relationship or added value can be identified in joint work.

After the burden of disease and upstream determinants are established and the possible actions identified:

1. Consider if planned or existing Bank projects within the country will address the burden of disease and upstream determinants identified through multisectoral working.
2. Map the strategic aims of other donor agencies, including:
   - UN family, including WHO
   - Country donors such as DFID, CIDA, and AusAID
   - International NGOs such as the Robert Wood Foundation, the Welcome Trust, and the Bill and Melinda Gates Foundation

Directories and sources of information include the following:

- [http://www.fic.nih.gov/Global/Pages/NGOs.aspx](http://www.fic.nih.gov/Global/Pages/NGOs.aspx)
- [http://guides.lib.umich.edu/content.php?pid=19349&sid=282924](http://guides.lib.umich.edu/content.php?pid=19349&sid=282924)

3. Consider their criteria for funding, for example, the countries that they work in and the topics that they will work on.
4. Consider if there are areas where the Bank is in a unique position to fill a gap or convene work with other donors.
5. Consider where the signal given by a strategic partnership working on a key issue can help to focus attention and draw in further resources. For example, work taking place on female genital mutilation (FGM) in Africa.
Conclusion

The reflection process, of working through the MOCAT with the support of the HNP GP, is intended to lead to the development, through an equity lens, of a concrete action plan that involves other sectors to obtain positive health outcomes. It is not intended to be a questionnaire to be completed once at the beginning of developing a strategy or program of work. Rather, it is a tool to return to when considering the multisectoral aspects of implementing and evaluating the work on an ongoing basis. The importance of building long-term relationships is key to the success of multisectoral working, and the MOCAT process should not be seen as a discrete activity but as part of a sustainable strategy for stakeholder engagement.

NOTE 1. Opportunities for Data Analysis

- Data is systematically collected across sectors on health or related factors.
- Ownership or data protection issues do not inhibit the sharing of information.
- Sufficient capacity or skills exist in the country to analyze or interpret data.
- Health impact methodologies are employed and are not seen as a barrier to work by leads in other areas (for example, in citing new factories or airports).
- Data are disaggregated to show the relationship between health and social and economic factors (for example, poverty, education, employment, transport, and housing).
- Findings from the data analysis are related to the achievement of the Bank’s twin goals.
- Health impacts are understood and seen as important by other sectors.

NOTE 2. Opportunities for Benchmarking

- Data from different countries collected in compatible formats.
- Culturally specificities are understood and comparisons are valid.
- There is political will to share data in a way to show success as well as to highlight areas that need greater attention.

NOTE 3. Opportunities to Identify Appropriate Solutions

- There is a long-term national strategic plan for health and development that provides a framework for specific actions.
- The benefits of holistic top-down and bottom-up approaches are recognized in national planning and funding allocations.
- National strategy and resource allocation reflect identified need.
- There is sufficient information on relative costs and pricing structures, and economic implications of an approach and cost effectiveness can be attributed to it.
- Examples of practice have effective evaluation.
- Publication bias does not inhibit opportunities to learn from failure.
- The causal links between health, poverty, and the broad determinants and attributable risks are fully understood and causal pathways can be established.
- Interventions have been developed through an equity lens, and the impact on the health gap between the best and the worst off members of society is clear.
- Cost-effective arguments are understood in informing intervention planning. For example, the relative cost of the downstream treatment of people injured in road traffic accidents, as opposed to the upstream development of a safer transport infrastructure.
- Pilots are scalable across geographic variations, and local champions can be identified.
- Work on downstream determinants and behavior change does not dominate the agenda and limit opportunities to work on upstream issues.
- Immediate needs do not overwhelm finances and capacity for long-term planning, and catastrophic events are effectively planned for.
NOTE 4. Opportunities in Engaging Other Practices and Sectors

- **The Bank** topic leads in other areas are willing to negotiate joint work and are able to see the benefit of adding health outcomes to their agenda.
- **Politicians** are not only interested in short-term wins, but value the need for long-term gains.
- **Policy makers** from across sectors, such as education, transport, rural development, environment, housing, and employment understand the health impact of their work and are willing to address it.
- **Donors** work in a coordinated way to maximize resources and reduce duplication, and they are willing to share recognition for work well done.
- **Private sector** partners recognize the importance of corporate social responsibility and/or have positive health outcomes as an overall objective.
- Members of the beneficiary **community** and the **NGOs** that represent them have an opportunity to be part of the priority-setting process and recognize the issues highlighted as being of importance to them.
- Opportunities exist to support **communities** with the greatest burden of inequality in health to find their own solutions and thereby achieve their buy-in.
- **Academics** are able to support the developing evidence base for multisectoral action.
- **Stakeholders from across sectors and levels** have the capacity to participate fully and see this as a way of delivering their core business.
- Sufficient opportunities exist for partners from **across sectors** to achieve the public profile or professional recognition they need.
- **Stakeholders** see the added value of working together, and win/wins have been identified.
- The need to address the upstream determinants is acknowledged as key to a positive health impact.
- There is agreement on the issues identified as priorities by other sectors and donors.
- There is an understanding by the Bank of the meta “language” other sectors speak, and the Bank terminology is clear to other sectors.
LITERATURE REVIEW

A desk review identified over 200 papers that dealt with the issue of tools for multisectoral working for positive health outcomes. However, most of these were general descriptions of a process, or were highly academic. Key stakeholders and colleagues were, therefore, consulted, and LinkedIn (a web-based platform) was used to supplement published information; however this identified little new material. Areas of interest were topic-based examples relating to noncommunicable diseases and road traffic accidents; a topic that proved to be particularly fruitful was the health impact assessment (HIA). While HIA is neither a direct part of the MOCAT nor a replacement for it, it does provide a complementary approach as a mechanism for deep diving into the impact that action across sectors has on health, and it can provide insights into the drivers outlined in the MOCAT process.

Following the literature search, it was concluded that the MOCAT could fill a gap in being a practical tool to support the development of multisectoral action in countries to produce positive health outcomes by action on upstream determinants.

A table of the most relevant tools, including HIA, their appropriate use, and where to find them was developed following the literature review; it is included in the MOCAT toolkit. This table highlights key strengths and weaknesses of the tools, but only in relation to their relevance to the MOCAT process, and does not reflect on their appropriateness to the function for which they were developed.

While none of the tools here are either essential to or or substitutes for the MOCAT, they do provide background information and complementary approaches; for example, several practical tools for health impact assessment have been included here. Although these have most often been used in higher-income countries, they could provide a useful approach for demonstrating the impact on health of action across policy sectors. In this way, they could support the MOCAT process of looking at the constraints and opportunities in relation to the upstream drivers of the burden of disease. Other tools are highly specific to a topic or disease: these will be pertinent to particular countries, but their approach could also be used to inform the MOCAT process, specifically on engaging stakeholders from across sectors.

4. The search strategy focused on publications in the last 15 years, although some older documents were considered as they related to the WHO Ottawa Charter and Lalonde report of 1974. The search strategy included multiple search terms:

- Determinant and multisectoral; upstream and multisectoral; health and multisectoral; tools and multisectoral
- Determinant and intersectoral; upstream and intersectoral; health and intersectoral; intersectoral and tools
- Policy development across sectors; action across sectors; intergovernmental action and health; health in all policies
- Determinant and multisectoral; upstream and multisectoral; health and multisectoral; tools and multisectoral
- Determinant and intersectoral; upstream and intersectoral; health and intersectoral; intersectoral and tools
- Policy development across sectors; action across sectors; intergovernmental action and health; health in all policies

The database search included Pubmed and Cochrane. UN and other international agency sites were interrogated, and a broader search of literature from across sectors was undertaken. Networks were used to identify grey literature.
Useful Tools and Documents

Table 3. Tools and Documents Relevant for the Development of the MOCAT

<table>
<thead>
<tr>
<th>Title</th>
<th>Who produced it and when</th>
<th>What it is used for/content</th>
<th>Where to find it</th>
</tr>
</thead>
<tbody>
<tr>
<td>---</td>
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</tbody>
</table>
**Weakness:** Its focus is on humanitarian needs in emergencies; it may be difficult to adapt for use in other development situations. | http://www.unicefinemergencies.com/downloads/eresources/docs/Health/MIRA_dec11.pdf |
| Tool: *Equity Action* | EU March 2014. | **Strength:** Provides a range of examples of work within and between countries.  
**Weakness:** Its focus is on high-income countries in the EU. | http://www.apho.org.uk/resource/item.aspx?RID=44257 |
| **Title:** *Improving Information Systems for Planning and Policy Dialogue: The SABER EMIS Assessment Tool.*  
**Tool:** SABER (System Assessment and Benchmarking for) | World Bank 2011. | **Strength:** Tool for assessing and monitoring the quality of education statistics. This tool is a key component of the Information System for Planning and Policy Dialogue and was developed under System Assessment and Benchmarking for Education Results.  
<table>
<thead>
<tr>
<th>Education Results</th>
<th>Weakness: It is highly sector-specific and has a focus on data and information.</th>
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<tbody>
<tr>
<td><strong>Title: Non-communicable Disease in the Developing World</strong></td>
<td>The book has suggestions for multisectoral approaches in low-income countries, with input from George Allyene and Sanita Nishtar on multisectoral action on NCDs by governments.</td>
</tr>
<tr>
<td>I. Galambos, J. L. Sturchio (US) 2014.</td>
<td><strong>Strength:</strong> Provides examples of multisectoral approaches in low- and middle-income countries based on sound theory.</td>
</tr>
<tr>
<td><strong>Weakness:</strong> It is rather theoretical in places, and has a strong NCD focus.</td>
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<thead>
<tr>
<th><strong>Tool: Multisectoral Collaboration</strong></th>
<th>Training unit on adopting a multisectoral approach to address road traffic accidents.</th>
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</thead>
<tbody>
<tr>
<td>The Indian Institute of Technology and WHO December 2006.</td>
<td><strong>Strength:</strong> A good example from a middle-income setting with a strong introduction on the issues, and a supportive practical tool.</td>
</tr>
<tr>
<td><strong>Weakness:</strong> It is culture- and sector-specific.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Tool: Multisectoral Action Framework for Malaria</strong></th>
<th>This makes the case for multisectoral structures, and presents a menu of concrete, implementable processes and actions. It is a guide for policy makers and practitioners.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roll Back Malaria Partnership/UND P 2013.</td>
<td><strong>Strength:</strong> A practical and evidence-based guide for addressing a health issue across sectors.</td>
</tr>
<tr>
<td><strong>Weakness:</strong></td>
<td></td>
</tr>
</tbody>
</table>

http://books.google.co.uk/books?id=AG8nAgAAQBAJ&pg=PA142&lpg=PA142&dq=HIATools+multisectoral+action&source=bl&ots=0_S7fvGEu4&sig=ctLaGgcCSQUGSi2ThIQMFtkQiE&hl=en&sa=X&ei=omgDU8PuO8qUhQe5IDgCw&ved=0CDgQ6AEwAg#v=onepage&q=HIA%20tools%20multisectoral%20action&f=false


| **Tool: Multisectoral Approach to Women’s Rights in Africa** | UN Women 2010. | This manual is a methodological tool to promote a multisectoral approach to women’s rights. Through practical guidance, the manual aims to support the African Union and its member states to fast track delivery on commitments to women’s rights and empowerment. It introduces an implementation framework that promotes the integration of women’s rights into all sectors of government and development endeavors.  
**Strength:** A practical and usable guide with a good background on the issues.  
**Weakness:** It is topic-specific; thus it is difficult to transfer learning from it. | http://www.unwomen.org/en/digital-library/publications/2010/6/manual-multisectoral-approach-to-women-s-rights-in-africa |
| **Tool: Urban Heart: Urban Health Equity Assessment and Response Tool** | WHO 2010. | This is a decision-support tool to identify and reduce health inequities in cities. The tool enables local communities, program managers, and municipal and national authorities to better understand the unequal health determinants and outcomes, and to use evidence when advocating and planning health equity interventions.  
**Strength:** A practical and usable tool for work at the subnational level.  
**Weakness:** The example is from an urban setting in a high-income country and may not be transferable. Its focus is on assessment of issues, rather than solutions. | http://www.who.int/kobe_centre/publications/ueart/en/ |
| **Tool: Community Tool Box** | Community Tool Box, US. 2013, chapter 24. | A guide to multisectoral work at the community level with case studies.  
**Strength:** A good introductory guide to multisectoral work at the community level.  
**Weakness:** It is more a basic training than a how-to, and is not a tool as such. | http://ctb.ku.edu/en/table-of-contents/implement/improving-services/multisector-collaboration/main |
| **Proposal: Pilot of Multisectoral Approaches to Improving Child** | World Bank 2008. | This is a draft proposal with a focus on improving child health and development, which includes a helpful overview of the role of other sectors and findings on key | Internal working document |
**Health and Development**

determinants. It provides an analysis of the situation in Mexico.

**Strength:**
The country analysis format could provide a model for other countries. The relationship of sectors to an array of upstream issues could be transferable. It provides a clear example of the need for and benefits of multisectoral working.

**Weakness:**
It is issue-specific.

*Source: MOCAT Development Team*
BACKGROUND PAPER ON ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH THROUGH MULTISECTORAL ACTION

Introduction

This background paper is part of the MOCAT toolkit. It considers how multisectoral action is an important mechanism in addressing the upstream social determinants of health (SDH) as well as specific issues, such as NCDs and undernutrition.

Background

If the World Bank succeeds in achieving its twin goals of eradicating extreme poverty by reducing the number of people living on less than US$1.25 a day to 3 percent by 2030, and promoting shared prosperity by fostering the income growth of the bottom 40 percent in every country, it will have made a significant contribution to global health and to the reduction of health inequalities in low-income countries, as any action to reduce poverty will de facto be addressing the major social determinants of health.

The places in which we live, work, and grow old impact both directly on our health and indirectly through their influence on the lifestyle choices we make. This is not a new concept; the need for systematic action across sectors to act on them has gained prominence over the last 20 years, since it was articulated in the Ottawa Charter in 1986.

The launch of the report by the WHO Commission on the Social Determinants of Health in October 2008 marked a significant step forward in evidence-based approaches to address the “causes of the causes” of health issues. This was the culmination of four years’ work by a team led by Professor Sir Michael Marmot, who developed an innovative hub and network approach that collected evidence from across the world on the key determinants that impact health, and considered what action could be taken to address them.

This highlighted the fact that while access to good quality care is an important part of maintaining health, most of the factors that influence health lie outside the health sector. Key overarching features that are highlighted in the report are the following: the importance of effective poverty-reduction strategies and the need for mechanisms that support people in gaining control over their own lives and health.

The upstream social determinants of health are closely related to the issue of health inequalities; note that the WHO report is called Closing the Gap in a Generation. Inequalities in health are observable in all countries in the world and can be characterized as the avoidable differences in health that run in a gradient through society due to the unfair distribution of power and resources.

These disparities exist both within and between counties. For example, in low-income countries the average life expectancy is 57, while in high-income countries it is 80. A child born in Malawi can expect to live 47 years, while a child born in Japan can expect to live 83 years (WHO 2011). In Madagascar the average age is 66 years, in India it is 70 years, while in the United Kingdom it is 80 years.5

Unsurprisingly, those most adversely affected are the poorest people in low-income countries, and in all countries the lowest quintiles of the population are disproportionately impacted. For example:

- Maternal mortality is up to four-times higher among poor Indonesian women than for high-income women in Indonesia (Graham et al. 2014)
- Indigenous Australians have a life expectancy that is 20 years lower than that of other Australians (Social Justice Commissioner 2005)

In India in 2012, 1.5 million under-five child deaths were reported in 597 districts, of which 71 percent were in the nine poorer states, which accounts for half of the population.\(^6\)

It is clear from the pattern of health distribution within and between countries that are working on development, poverty reduction, and health improvement, that these are all part of an integrated whole that requires a concerted effort across sectors.

**Defining the Scope of the SDH That Is Amenable to Multisectoral Action**

The WHO Commission on SDH noted that “every aspect of government and the economy has the potential to affect health and health equity — finance, education, housing, employment, transport, and health, just to name six” (WHO, CSDH 2008) and that “while highest-level government oversight is needed to push and coordinate intersectoral action and to ensure sustainability, local-level government and community ownership is a prerequisite to sustained results” (Ibid.).

The Systematic Country Diagnostic (SCD) will have helped to define the parameters of possible action designed to reduce poverty and inequalities within the specific country context, and these actions will implicitly or explicitly address the broad social determinants of health. To articulate the benefits in terms of positive impacts on health and inequalities, the situational analysis needs to encompass data that not only reflect the burden of disease but also consider proxy markers across a range of domains. Taking the recommendations of the WHO Commission on the Social Determinants of Health (CSDH) as a starting point, areas that might be considered are highlighted in the following paragraphs.

The role of education in health is well understood and is of the utmost importance in ensuring the health of the next generation. For example, in the United States an additional four years of education lowers five-year mortality by 1.8 percentage points; it also reduces the risk of heart disease by 2.16 percentage points, and the risk of diabetes by 1.3 percentage points. This translates into 0.03 to 0.10 years of additional life (depending on discounting), roughly a cost of US$2,250 to US$7,200 in present value (Picker 2014). The CSDH recommends that “compulsory primary and secondary education for all boys and girls should be available regardless of their ability to pay” (WHO, CSDH 2008, p. 4.). This reflects the UNESCO goals, which also include eliminating gender disparities in primary and secondary education by 2015, achieving a 50 percent improvement in adult literacy rates, and ensuring equitable access to learning and life skills programs (UNESCO 2006).

Access to quality housing and shelter and clean water and sanitation are human rights and basic needs for healthy living. The shift of populations from rural to urban areas is a worldwide challenge with both global and local implications. For the past 17 years, more people have lived in urban than in rural settings, and over a million people worldwide live in slums (Worldwatch Institute 2007). This demonstrates a need for better urban planning that is equity centered, as well as for investment in rural development.

Meeting MDG 10, target 7 on safe water and basic sanitation would avert 470,000 deaths and result in an extra 320 million productive working days every year. Economic analyses show that the benefits of investment to achieve the target would be considerable, and depending on the region of the world, economic benefits have been estimated to range from US$3 to US$34 for each dollar invested.\(^7\)

Some issues can have very different implications for health between urban and rural settings. For example, in the case of transport infrastructure and roads, while a rural community might find a lack of all-weather roads a barrier to economic opportunities and access to care, an urban dweller may be at increased risk of road traffic accidents as well as of respiratory disease due to pollution. The most obvious impact of roads on health is in terms of injuries. About 1.24 million people die each year as a result of road traffic crashes, and 91 percent of the world’s fatalities on the roads occur in low-income and middle-income countries, even though these countries have approximately only half of the world’s vehicles. Only 28 countries, representing 416 million people (7 percent of the world’s population), have adequate laws

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that address all five risk factors (speed, drunk driving, helmets, seat-belts, and child restraints). For this reason, the Bank has developed a framework for addressing these issues.

However, injuries and pollution are by no means the only health impacts of transport and road infrastructure. Other issues that can be considered in the multisectoral context are the following:

- Access to markets
- Access for business and industry to attract inward investment
- Access for tourism

In turn, these issues will impact another important SDH: namely, employment. Even in low-income households, access to good-quality employment is not only a means of meeting immediate economic needs, but also related to physical and psychological health, social relations, self-esteem, and personal development. Conversely, in both rural and urban settings, the place of work can involve health hazards, whether that is machete wounds from harvesting cocoa in west and central Africa, or injuries from the collapse of a building in Dhaka.

WHO, therefore, suggested that "achieving equity requires safe, secure, and fully paid work, (and) year-round work opportunities," as well as "improved working conditions to reduce exposure to material hazards, work-related stress, and health-damaging behaviors" (WHO, CSDH 2008, p. 6).

In some low-income countries, the issue of employment in rural areas is intrinsically linked to agriculture. As mentioned, this is also linked to the issue of transport infrastructure, which connects people to markets. While agriculture may be affected by catastrophic events and infestations, it is also subject to issues that are highly amenable to multisectoral action, such as trade agreements and water rights. Agriculture clearly links with other key upstream issues, such as food security and food miles.

In addition to employment, it is clear that there need to be effective social protection measures in place to support the unwaged or those with insufficient income to meet their needs. This can include mechanisms to help people avoid the health/poverty trap associated with unaffordable care services. Examples of these range from the Rashtriya Swasthya Bima Yojna (RSBY), which provides medical insurance cover to below-poverty line families in India, to the fully integrated welfare system in Scandinavian countries, which is in line with CSDH recommendations.

While it is acknowledged that most determinants of health lie outside the health sector, access to affordable and appropriate health care is a key determinant. Where this is not available, the effects on individuals, families, and communities can be catastrophic, with people falling into the well-recognized health/poverty trap. In its global strategy Horizon 2020, WHO outlines the key functions of the health sector, as shown in the following exhibit.
In carrying out its core functions, the health service can also be a beacon for other sectors in, for example, its employment practice, the food it buys, and its procurement policies.

In addition, the health service can play a key role in helping others understand the impact of their work on health, provide evidence, take on a stewardship role, and coordinate action across sectors. In some countries, the stewardship role for multisectoral work on the SDH resides in the Ministry of Health; this may require a transition from a focus on health care to the broader health perspectives.

Some of the data, which help in identifying specific health issues and trends within a country and which can provide a baseline against which to measure the success of interventions, reside in the health sector. However, epidemiology and the burden of disease will only be a part of the picture when dealing with the SDH; thus, it may be necessary to develop a basket of indicators. Depending on local factors, such indicators could contain information on the following:

- Percentage of school-age children in full-time education, and within that, the percentage of girls
- Literacy rates in children of school-leaving age
- Percentage of households with sufficient income
- Percentage of adults with employment
- Percentage of children who have been fully vaccinated
- Percentage of deaths associated with childbirth
- Prevalence of children experiencing undernutrition
- Prevalence of road traffic accidents in urban settings
- Number of households that have access to clean water and functioning sewage systems
- Access to community, primary, and care services, taking account of out-of-pocket costs and location
- Variations in health between ethnic groups, gender groups, or locations

Within countries, the relative importance and range of factors that impact health will vary; the MOCAT framework creates a pathway to look at the burden of disease and the underlying factors that have a significant impact on it.
Defining Multisectoral Working

Given the range of sectors whose work impacts health, there are clear advantages in taking a multisectoral approach. These include the following:

- Sharing human and financial resources
- Avoiding duplication and competition
- Providing support for the achievement of the Bank’s twin goals through consensus
- Providing a louder advocacy voice
- Providing a pool of skills, expertise, and knowledge

There is good evidence to demonstrate the importance of having a whole-systems approach to promoting and maintaining health. That is one where legislation and policy support local evidence-based action. In this context, the term multisectoral working often suggests different meanings. These include the following:

- **Health in all policies**, namely, environment, education, housing, employment, social protection, welfare, finance, criminal justice, and health
- **Top down and bottom up**, between international, national, regional/state, and community levels
- **Across organizations**, namely national and subnational government, academia, professionals and their bodies, private enterprise, NGOs, and civil society/communities

It is not necessary for all sectors to be involved in all aspects of work. Sometimes a bilateral arrangement between sectors, such as between health and education, or between health and sanitation, is considered a multisectoral partnership — this can be an effective arrangement, particularly if it is embedded in a wider strategic approach.

A model that attempts to bring these elements together was developed by WHO and tested within their European region. This calls for a cross-government steering group to be formed to set strategic directions and develop targets. This group is responsible for commissioning research and generating evidence and interventions to address health inequalities, as well as for the development and governance of coalitions of organizations and representatives from across sectors with specific expertise. These coalitions form a link between the end beneficiaries and policy makers, and are key components of the delivery mechanism. Ideally, the group is accountable to parliament and has clear indicators of success, though reporting mechanisms differ between countries.

Learning from experience, this type of group or forum is most effective if the following hold true:

- The group arrived at its priorities by consensus without one participant driving the agenda
- The group has clear aims and objectives for its joint work, which add value to the core activities of all the participants
- The group has a joint activity plan and is clear about roles: Who is expected to do what, and what constitutes success
- There is transparency over funding in terms of the budget that will be needed and who can contribute
- There is a recognition of the right of a sector or individual to convene or coordinate work with others
- The group is results-orientated and has a record of achievement
- The achievements of the group are ones on which the performance of participants will be managed within their own organizations
- There are criteria for inclusion in the group, which has the right skills mix to meet its stated aims
- The group is adequately resourced
- The group meets regularly, and its meetings are not often postponed
- Participation is not regularly delegated to more junior members of a team
- The group has appropriate secretariat support

42
Action on the SDH needs to be on several levels, including by the national or regional government in favor of the community. These levels need to be joined up so that policy and funding help to meet the felt and perceived needs of people. Ensuring full engagement with the community offers many challenges but has to be worthwhile, as the people who are burdened with health inequalities often are most knowledgeable about the solutions to their situation but have no voice to express these or the power to make change happen. In developing multisectoral action the interaction between other stakeholders and community members or end beneficiaries is, therefore, an important step to success.

On the most basic level, the community may be consulted on a policy or program that is already fully developed by professionals before their view is sought. This is often perceived as a “rubber stamping” exercise, which does not encourage buy in. Such a situation usually does not instill much ownership in community members, and unless radical change to a proposal is genuinely possible, it can be seen as tokenistic. In terms of mechanisms, this approach often involves one person being asked to represent a community at a meeting of multisectoral professionals.

At the other end of the spectrum, a strategy utilizing community development methodologies is possible. This involves the community defining the issues that it wants to work on and professionals providing technical support to help them reach their own solutions. Through this process, community members may acquire new skills or self-confidence, which can add an element of sustainability. However, this is not wholly achievable when professionals go to the community with a specific agenda or the topics they wish to address.

**Conclusion**

A key factor in successful multisectoral working is mutual understanding and inclusivity — understanding the language of other sectors and giving the community a voice. As an agent for multisectoral working, providing the connection between top-down policy making and bottom-up community empowerment is an important role, and the value of an honest broker in this situation should not be underestimated.

While the nuances of the partnerships and coalitions will vary between countries, the Bank has embraced this philosophy as a way of implementing SCDs and achieving its overall aims. This is in line with international best practice. The Bank’s work will also add to the evidence base for innovative multisectoral approaches that address the broad spectrum of social determinants of health in the future.
PART TWO: IMPLEMENTATION ON THE BROAD SDH

Introduction

The country priorities to meet the Bank’s overall goals will be identified through the SCD process, which will include factors relating to the broad SDH. In considering how to build on assets and opportunities and how to overcome barriers to a multisectoral response to the identified issues, it can be helpful to consider two factors: (1) the perpetual cycle of health and its social determinants, and (2) the life course.

1. There is a perpetual cycle of health and its social determinants, where poor health has a negative impact on its social determinants, as shown in the following exhibit. This is important in terms of locating an appropriate entry point for an intervention and in recognizing that while people have differing abilities and aspirations, few of the determinants are not responsive to action. For example, while one may not wish to change gender or ethnicity, interventions to remove or mitigate prejudice can be effective in terms of health outcomes and cost. Interventions in that context may include, for example, the provision of adequate lavatories and sanitary wear to increase the number of girls who are able to attend school, or ensuring religious diversity is reflected in lesson planning.

Figure 5. Relationship between the Cycle of Health and Social Determinants

2. Life course is another factor to be considered. This recognizes the impact of the entire span of life experiences on every stage of our lives, influencing our ability to maximize opportunities, and shaping our resilience in facing less-than-favorable conditions or crises. The determinants may have relatively different importance to us as we move through life, and the key players who need to take a role may vary, but the link between policy and practice retains its importance, as shown in the following table.
Table 4. Determinants on Different Stages of the Life Course

<table>
<thead>
<tr>
<th></th>
<th>Infant</th>
<th>Child</th>
<th>Adult</th>
<th>Older person</th>
<th>Sectors involved</th>
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<tr>
<td>Maternal and child services</td>
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<td>• Ministries of Health and Finance</td>
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<td>• NGOs</td>
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<td>• Community health workers</td>
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<td>• Mothers and community members</td>
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<td>Nutrition</td>
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<td>• Ministries of Health and Agriculture</td>
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<td>• Farmers</td>
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<td>• Processed food and drink manufacturers</td>
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<td>• Schools</td>
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<td>• Health professionals</td>
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<td>• World Trade Organization (WTO)</td>
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<td>• Community members</td>
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<td>5200Education and stimulation</td>
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<td>• Ministry of Education</td>
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<td>• Local policy makers</td>
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<td>• Health care professionals</td>
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<td>• Community midwives</td>
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<td>• Mothers and caregivers</td>
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<td>• Teachers</td>
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<td>• School boards</td>
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<td>• Planners</td>
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<td>• NGOs</td>
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<td>• Business and employers</td>
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<td></td>
<td>Community members</td>
<td>Ministry of Labor</td>
<td>Local policy makers</td>
<td>Unions and worker representatives</td>
<td>Business and employers</td>
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<td>Employment</td>
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<td>Social protection</td>
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<td>Housing</td>
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<td>Sanitation</td>
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<td>Transport infrastructure</td>
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<td>Health care services</td>
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</table>

*Source: MOCAT Development Team*
Each of these factors or ways of thinking about how the broad social determinants relate to individual behavior, health, and well-being suggest that an integrated approach that fully involves all stakeholders and includes the end beneficiaries is most likely to have a positive impact.

This approach dates back to the Ottawa Charter,9 which advocated targeting the places where people live, work, and play, and was the basis of the WHO Healthy Settings movement, which included the following:

- **Healthy schools** — clean environment, access to water and sanitation, provision of healthy meals, community use of school facilities, adult literacy classes for community members, lessons on health topics, and child-centered learning
- **Healthy villages** — improved housing, access to water/sanitation, microbusinesses and shared enterprise, community health programs, and trained community health workers
- **Healthy workplaces** — smoking policies, anti-bullying policies, safe and clean environment, opportunities to exercise, healthy options in canteens, adequate rest periods, and working time

**Case Study from the United Kingdom**

Tackling Health Inequalities

An example of an integrated approach that set out to explicitly address health inequalities through multisectoral action on the SDH came from England in 1997. Although the country’s health, life expectancy, and well-being indications compared well to the EU averages (with some notable exceptions), disaggregation of the data quickly revealed a persistent problem of a significant health gap between the upper and lower quintiles of society.

Whereas the Black Report of 1980, which highlighted the issue of health inequalities had been largely suppressed by the conservative government of the day, a report by Donald Acheson in 1998 on the same topic fitted exactly with the agenda of the New Labor government, which had recently been elected on an equity agenda.

As a result of this political will, cross-government mechanisms to take action were put into place or their role in addressing inequalities was articulated. These included the following:

- Appointment of a minister for public health
- Inquiry/Royal Commission Independent Inquiry into Inequalities in Health
- Taskforce Inequalities and Public Health Taskforce
- Children’s Taskforce
- Policy action teams developed
- Dedicated cross-departmental unit
- Children and Young People’s Unit
- Neighborhood Renewal Unit
- Social Exclusion Unit
- Inter-Departmental and Cross-Government Group on Public Health and Inequalities
- Cross-cutting Review on Health Inequalities led by Ministry of Finance
- Advisory Committee on Resource Allocation
- National health inequalities targets set
- National Framework for the Assessment of Performance
- Public services agreements and service delivery agreements

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• Tackling Health Inequalities: a plan of activities to address health inequalities published
• Reporting to parliament, and questions to select committees
Work on inequalities was kept on the agenda because priority areas were jointly identified and based on evidence, and because a basket of indicators was developed on which different sectors had a duty to report. These priorities included those listed in the following table.

**Table 5. Priority Sectors and Example Targets**

<table>
<thead>
<tr>
<th>Sector</th>
<th>Example of targets from the suite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>To reduce the number of people sleeping rough by one-third</td>
</tr>
<tr>
<td>Energy</td>
<td>To reduce fuel poverty in vulnerable households by improving fuel efficiency in 600,000 homes</td>
</tr>
<tr>
<td>Transport</td>
<td>To reduce the number of children killed on the roads by 50 percent</td>
</tr>
<tr>
<td>Employment</td>
<td>To ensure 70 percent of lone parents have employment</td>
</tr>
<tr>
<td>Health</td>
<td>To reduce the maximum wait for outpatients to three months</td>
</tr>
<tr>
<td>Education</td>
<td>To reduce truancies by 10 percent</td>
</tr>
<tr>
<td>Home office</td>
<td>To reduce domestic burglary by 25 percent</td>
</tr>
<tr>
<td>Environment</td>
<td>To enable 25 percent of household waste to be recycled</td>
</tr>
</tbody>
</table>

Source: MOCAT Development Team

In initiating the action plan, several potential barriers where identified in the existing system, including the following:
• Weak leadership is disconnected from internal culture issues
• Initiatives remain detached from wider agendas
• Attention is on “early wins” and discrete output projects
• Lack of organizational development and staff involvement champions
• Lack of political steer
• Implementation processes are “invisible” in plans or guidance

In the new action, several assets helped to overcome these barriers, including:
• Sound evidence from the start
• Political will from the top
• A jointly developed cross-sector action plan
• Targets that reflected the core business of the sector and also contributed to addressing health inequalities
• Ministry of Finance was an active partner
• Formal mechanisms for meeting
• Clear role for action
• Extensive consultation with key stakeholders providing wide support for action

However, despite the gains made in several key areas and particularly in child health, the thrust of this action could not survive the change of government in 2010.

Learning from the Case Study

From the experience in England, several barriers were identified. Some, but not all, of these were responsive to change, which helps illuminate the issues where efforts are best placed. The following table illustrates the kind of issues that can more or less be amenable to action.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Amenable to action: high, possible, or unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there sufficient evidence to make a convincing case for action?</td>
<td>High: Evidence generation is possible through research and stakeholder consultation.</td>
</tr>
<tr>
<td>Will politicians act on evidence or is there another political agenda that will prevent them?</td>
<td>Possible: In understanding what their political agenda is, it may be possible to reframe work to form a better fit.</td>
</tr>
<tr>
<td>Is the time scale for achievement in line with political terms of office?</td>
<td>Unlikely: Although it is possible to identify short-term wins to fit in with political imperatives, action on health inequalities needs long-term sustained effort to have a lasting impact.</td>
</tr>
<tr>
<td>Is financing to address the SDH and equity issues coming from the health care budget or separately allocated from the Ministry of Finance?</td>
<td>Possible: If there is political will, it may be possible to separate health care and SDH budgets.</td>
</tr>
<tr>
<td>Is there a formal reporting mechanism to hold sectors accountable and to reward success?</td>
<td>High: It is possible to develop a basket of indicators to demonstrate success, but a clear process of accountability needs to be established at the outset.</td>
</tr>
</tbody>
</table>

Source: MOCAT Development Team

Conclusion

The need for multisectoral working to address the social determinants of health is now well established. While there can be challenges and barriers to success, the rewards in terms of positive health impacts are magnified beyond what is attainable by a single effort — the whole can be greater than the sum of its parts.
PART THREE: MULTISECTORAL IMPLEMENTATION ON AN IDENTIFIED TOPIC

This section looks at data on global health trends in nutrition, as a practical example of the rationale for multisectoral working, and at how some have approached it.

Nutrition: The Double Burden

Background

Paradoxically, while about 104 million children are underweight, 500 million people are obese worldwide.\textsuperscript{10} The simultaneous global presence in countries of obesity (mainly associated in the past with high-income countries) and malnutrition (mainly associated in the past with low-income countries) has been a focus of discussions on issues of equity and justice over the last two decades. The increasingly contemporaneous presence of obesity and malnutrition, with their associated burdens of disease (coronary heart disease, cancer, and diabetes on the one hand, and stunting, impaired development, and diarrheal disease on the other) is now leading to very real difficulties in how to address this double burden in a practical way in low- and middle-income countries.

Global trends in the prevalence of stunting and overweight among children under age five have moved in opposite directions since 1990. While there is some evidence that obesity may be plateauing in higher-income countries, low-income countries are behind the curve; compared to 20 years ago, there are 54 percent more overweight children and 35 percent fewer stunted children worldwide (UNICEF, WHO, and World Bank 2012).

In India, for example, almost 20 percent of the adult population is overweight, and approximately 20 percent of school-age children are obese; at the same time, about 46 percent of children under the age of three are too small for their age, 47 percent are underweight, and 16 percent have wasting.\textsuperscript{11}

In Indonesia, one in three children under the age of five is moderately or severely stunted (36 percent), while at the same time one in seven is overweight (14 percent); UNICEF has highlighted the need for efforts in “double burden” countries to promote good infant and young child feeding practices that support linear growth without causing excessive weight gain (Ibid.).

The following exhibit illustrates the contrasting global trends of overweight and stunting. It illustrates the percentage and number of children under age five who are moderately or severely stunted and who are overweight (Ibid.).

\textsuperscript{10} http://www.who.int/nutrition/challenges/en/
\textsuperscript{11} http://www.who.int/ncd_surveillance/strategy/en/
Figure 6. Contrasting Global Trends in Child Stunting and Overweight

Undernutrition

Poor nutrition in the first 1,000 days of children’s lives can have irreversible consequences. For millions of children, it means they are, forever, stunted.

Smaller than their nonstunted peers, stunted children are more susceptible to sickness. In school, they often fall behind in class. They enter adulthood more likely to become overweight and more prone to noncommunicable disease. And when they start work, they often earn less than their nonstunted coworkers.

It is difficult to think of a greater injustice than robbing a child, in the womb and in infancy, of the ability to fully develop his or her talents throughout life.

Alan Lake, Executive Director, UNICEF, April 2013

The majority of low birthweight babies are born in low-income countries. For example, an estimated 28.00 percent of babies born in Southeast Asia, 13.65 percent in Sub-Saharan Africa (UNICEF 2013), and 15.60 percent in Madagascar have low birthweight. In the United States, 8 percent of babies have low birthweight, and a clear socioeconomic gradient can be identified (Finch 2003). This is of significance as an estimated 60 to 80 percent of neonatal deaths occur among low birthweight babies (UNICEF 2013).

Globally in 2011, an estimated 101 million children under five years of age were underweight, or approximately 16 percent of children under five. Underweight prevalence is highest in South Asia, which has a rate of 33 percent, followed by Sub-Saharan Africa at 21 percent (41 percent in Madagascar [USAID 2005]) (UNICEF 2013). South Asia has 59 million underweight children, while Sub-Saharan Africa has 30 million (Ibid.).

Of the world’s stunted children, 80 percent live in 14 countries, with India contributing most to the global burden (38 percent), significantly ahead of Nigeria, which comes second at 7 percent. In terms of the percentage of the population affected in the two countries, however, the difference is not so great at 48 percent and 41 percent, respectively. Other countries such as Madagascar may have a higher national percentage (50 percent), but they contribute less than 1 percent to the global burden (Ibid.).

In addition to the obvious physical issues, it has been demonstrated that brain development is highly sensitive to external influences in early childhood, starting in utero and with lifelong effects (WHO, CSDH 2008).

This is borne out by the results of a series of longitudinal studies that were carried out in South Africa to assess the impact of severe undernutrition before age two on physical growth and intellectual functioning in adolescence. These studies took account of improvements in the environment and catch-up growth, but they showed that the children who were subjected to chronic undernutrition in early infancy experienced irreversible intellectual impairment; they concluded that improvements in nutrition after age two do not usually lead to the recovery of lost potential (UNICEF 2013).

In addition, data from a five-country study conducted by UNICEF indicate that weight gain during the first two years of life, but not afterwards, improved school performance later on in childhood, underlining the critical importance of this window of opportunity (Ibid.).

In terms of educational performance and intellectual potential, previous research has identified the negative impact of inadequate intake of specific micronutrients such as iron, folic acid, and iodine on the development of the brain and nervous system, resulting in underachievement. The impact of iron deficiency, which reduces school performance in children and the physical capacity for work among adults, has also been documented.

The WHO Commission on the Social Determinants of Health suggests that “Investments in early child development (ECD) are one of the most powerful that countries can make — in terms of reducing the escalating chronic disease burden in adults, reducing costs for judicial and prison systems, and enabling more children to grow into healthy adults who can make a positive contribution to society, socially and economically” (WHO, CSDH 2008, p. 5). It goes on to state that if governments in rich and poor societies were to act while children were young by implementing quality ECD programs and services as part of their broader development plans, these investments would pay for themselves many times over (Ibid.). The benefit of nutritional supplementation is evidenced in a Jamaican study illustrated in the following figure.
In addition to the important connection to the education sector, there are ongoing issues in terms of employment and the ability to make an active economic contribution to society.

Agriculture remains the largest employment sector in many low-income countries, and international agriculture agreements are crucial to a country's food security. Some critics argue that trade liberalization may reduce a country's food security by reducing agricultural employment levels. Concern about this has led a group of WTO member states to recommend that current negotiations on agricultural agreements allow low-income countries to reevaluate and raise tariffs on key products to protect national food security and employment. They argue that WTO agreements, by pushing for the liberalization of crucial markets, are threatening the food security of whole communities.

Food security is built on the following three pillars:

- **Food availability**: sufficient quantities of food available on a consistent basis
- **Food access**: sufficient resources to obtain appropriate foods for a nutritious diet
- **Food use**: appropriate use, based on knowledge of basic nutrition and care, as well as adequate water and sanitation

Given the scope of the issues raised by undernutrition, it is clear that a twofold approach is required that both looks at immediate need and also addresses this in the context of the upstream social determinants of health that require multisectoral action.
Implementing Programs

A framework for action on undernutrition has been developed by UNICEF, which articulates the recommended actions at the important earliest stages of a child’s life. This is illustrated in the following exhibit.

**Figure 8. Actions Recommended by UNICEF on Undernutrition Early in Life**

However, it is also important to reflect on the multiple inputs at differing levels that are needed to address the issue of undernutrition across the whole life course. These are listed in the following table.

**Table 7. Issues Affecting Undernutrition Throughout the Life Course**

<table>
<thead>
<tr>
<th>Issues</th>
<th>Context</th>
<th>Partners</th>
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</thead>
<tbody>
<tr>
<td>• Food security</td>
<td>Trade agreements that impact the choice of crops, employment, and markets</td>
<td>• National government</td>
</tr>
<tr>
<td>• Ability to earn a living wage</td>
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<td>• International NGOs</td>
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<tr>
<td>• Lack of food choices</td>
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<td>• WTO</td>
</tr>
<tr>
<td>• Catastrophic events</td>
<td>National and regional/state policy and legislation on agriculture and rural development support in terms of crisis (infestation, adverse</td>
<td>• Ministries of Agriculture, Rural Development, and Employment</td>
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<tr>
<td>• Crop devastation</td>
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<td>• NGOs</td>
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<td>• Loss of food</td>
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<tr>
<td>Sources/Weather</td>
<td>Donors</td>
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<tr>
<td>• Lack of access to a variety of foods</td>
<td>• Ministries of Transport, Planning, Employment, and Health</td>
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<tr>
<td>• Lack of ability to make a living wage</td>
<td>• Commercial enterprise</td>
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<tr>
<td>• Transport infrastructure allowing movement of food, but in the context of “food miles”</td>
<td>• NGOs</td>
<td></td>
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<tr>
<td>• Ministries of Transport, Planning, Employment, and Health</td>
<td>• Community members</td>
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<tr>
<td>• Renormalization and fortification of food</td>
<td>• Ministry of Health</td>
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<tr>
<td>• Commercial enterprise</td>
<td>• Food manufacturers</td>
<td></td>
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<tr>
<td>• Providing nutrition and fortified food supplements</td>
<td>• Ministry of Health</td>
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<tr>
<td>• Local government</td>
<td>• Health service providers</td>
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<tr>
<td>• Professional and mother education on appropriate feeding</td>
<td>• Health service providers</td>
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<tr>
<td>• Professional training centers/universities</td>
<td>• Community health workers</td>
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<tr>
<td>• Community members</td>
<td>• Schools</td>
<td></td>
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<tr>
<td>• Professional training centers/universities</td>
<td>• Mothers</td>
<td></td>
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<tr>
<td>• Community members</td>
<td>• Community members</td>
<td></td>
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<tr>
<td>• Education and nutrition in schools to teach food skills and provide immediate relief for undernutrition; teach sanitation skills, e.g., hand washing with soap</td>
<td>• Ministry of Education/local policy makers</td>
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<tr>
<td>• Ministry of Health</td>
<td>• Health service providers</td>
<td></td>
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<tr>
<td>• Health service providers</td>
<td>• School management</td>
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<tr>
<td>• Teachers</td>
<td>• Community members</td>
<td></td>
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<tr>
<td>• Parents</td>
<td>• Community members</td>
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<tr>
<td>• Community members</td>
<td>• Health service providers</td>
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<tr>
<td>• Access to health services, including HIV testing, antenatal care, deworming, immunization, and vaccines; therapeutic zinc to treat diarrhea; malaria prevention and treatment</td>
<td>• Ministry of Health and Social Protection</td>
<td></td>
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<tr>
<td>• Policy makers</td>
<td>• Health insurance companies</td>
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<tr>
<td>• Health service providers</td>
<td>• Health service providers</td>
<td></td>
</tr>
</tbody>
</table>
Lack of access to affordable food

Social protection for disabled and older people without means to produce or purchase

Ministry of Social Protection/policy makers

NGOs

Donors

Community members

Lack of clean water and sanitation

Reduce infectious disease; allow safe rehydration; reduce open defecation sites; and reduce diseases that impede absorption

Ministry of Environment/policy makers

Planners

NGOs

Community members

Lack of a health-supportive physical and social environment

Integrated action on SDH

Cross-government ministries and policy makers, including housing, employment, education, finance, transport, environment, and health

Policy makers

Planners

Service providers

NGOs

Community members

Source: MOCAT Development Team

Case Study from India (UNICEF 2013, p.31)

India: Improving Nutrition Governance to Reduce Child Stunting in Maharashtra

More than 60 million children under age five are stunted in India, comprising almost half the country’s children in this age group. They represent an estimated one-third of stunted children worldwide. Even in Maharashtra, the wealthiest state in India, 39 percent of children under age two were stunted in 2005–06. But by 2012, according to a statewide nutrition survey, the prevalence of stunting had dropped to 23 percent. Determined action by the state together with a focus on service delivery contributed to this dramatic decline.

Key strategy: building staff capacity to improve delivery of services

In 2005, in response to reports of child deaths from undernutrition in a number of districts, the state launched the Rajmata Jijau Mother-Child Health and Nutrition Mission. It was initially focused on five primarily tribal districts with the highest incidence of child undernutrition (Amravati, Gadchiroli, Nandurbar, Nasik, and Thane). After the National Family Health Survey of 2005–06, the mission’s mandate was expanded to coordinate efforts to reduce child undernutrition throughout the state, an initiative of enormous significance given that Maharashtra is the second-most populous state in India. The mission was extended to 10 additional districts with a substantial concentration in tribal populations.
in 2006–07, and then to the remaining districts in 2008–09.

The Maharashtra Nutrition Mission is tackling stunting among children under age two statewide, by promoting more effective delivery of interventions through flagship programs for child survival, growth, and development. Four factors are seen as key to the state's success; namely:

- **Remaining focused:** Efforts are concentrated on delivering evidence-based interventions for infants, young children, and their mothers to prevent stunting, while simultaneously addressing adolescent girls’ nutrition, education, and empowerment to improve the start in life for the next generation.
- **Delivering at scale with equity:** Efforts are made to combine services in facilities with outreach and community-based interventions to bring them closer to children under age two, adolescent girls, and mothers. To ensure equity and impact, the focus is on the most vulnerable children, households, districts, and divisions.
- **Improving children’s birthweight:** The approach calls for monitoring pregnancy weight gain at every antenatal care visit, and counseling and supporting mothers to gain adequate weight during pregnancy. In addition, all children are weighed at birth, and children born weighing below 2,500 grams are monitored to ensure they catch up.
- **Coordinating and measuring for nutrition results across sectors:** Planning and management are focused on nutrition results, and indicators of child nutrition are integrated across programs and sectors. Another emphasis is on building strong monitoring and evaluation frameworks to measure program performance.

The State Nutrition Mission began by working to improve the effectiveness of service delivery through the Integrated Child Development Services and the National Rural Health Mission, the national flagship programs for child nutrition, health, and development. Their focus was on filling vacancies in key areas.

In 2012, the government of Maharashtra commissioned the first-ever, statewide nutrition survey to assess progress and identify areas for future action. Results of this Comprehensive Nutrition Survey in Maharashtra indicated that prevalence of stunting in children “a few” months old who were fed a required minimum number of times per day increased from 34 to 77, and the proportion of mothers who benefited from at least three antenatal visits during pregnancy increased from 75 to 90 percent.

**Looking forward**
The provisional results of the Maharashtra survey showed that in spite of more frequent meals, only 7 percent of children age 6 to 23 months old received a minimal acceptable diet in 2012. Too few children are being fed an adequate, diverse diet rich in essential nutrients with the appropriate frequency to ensure their optimal physical growth and cognitive development. A statewide strategy to improve the quality of complementary foods and feeding and hygiene practices is essential to further reduce stunting levels and bring about far-reaching benefits. In addition, efforts are needed to ensure the provision and training of personnel, particularly frontline workers and supervisors, and to improve their motivation and skills to deliver timely, high-quality services in communities. In the second five-year phase, beginning in 2011, more emphasis was placed on improving the nutrition of children under two years of age and their mothers. This shift was made in response to global evidence about the critical 1,000-day window to prevent undernutrition in children.
**Likelihood of Success of the Mission**

The strategy in Maharashtra is set up to tackle areas where barriers are likely to be amenable to action, as set out in following table.

**Table 8. Key Issues and Possibilities To Act - Maharashtra**

<table>
<thead>
<tr>
<th>Issues arising</th>
<th>Amenable to action: high, possible, or unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there conflicting priorities at the government level or between funders?</td>
<td>Possible: research to generate evidence and stakeholder consultation can help with prioritization. The project “remained focused: efforts concentrated on delivering evidence-based interventions for infants, young children, and their mothers to prevent stunting, while simultaneously addressing adolescent girls’ nutrition, education, and empowerment to improve the start in life for the next generation.”</td>
</tr>
<tr>
<td>Is the proposed action appropriate to the target group?</td>
<td>High: Interventions can be both evidence-based and in keeping with the felt need of beneficiaries. A marker of success in this project is “Delivering at scale with equity: efforts made to combine services in facilities with outreach and community-based interventions to bring them closer to children under two years of age, adolescent girls, and mothers. To ensure equity and impact, the focus is on the most vulnerable children, households, districts, and divisions.”</td>
</tr>
<tr>
<td>Is there a clear role for differing sectors to work together?</td>
<td>High: Planning and management are focused on nutrition results, and indicators of child nutrition integrated across programs and sectors. Emphasis was on building strong monitoring and evaluation frameworks to measure program performance.</td>
</tr>
</tbody>
</table>

*Source: MOCAT Development Team*
Case Study from Peru

**Peru: Reaching the Most Disadvantaged by Concentrating on Equity**

Between 1995 and 2005, stunting prevalence among children under five in Peru fluctuated but did not improve substantially. Yet in just a few years following the Child Malnutrition Initiative, begun in 2006, stunting fell by a third — from an estimated 30 percent in 2004–06 to 20 percent in 2011. Stunting prevalence among the poorest children declined from 56 to 44 percent over the same period.

Before 2005, nutrition programs had concentrated on food assistance. However, pilot programs supported by international and nongovernmental organizations began showing the effectiveness of integrated, multisectoral approaches in reducing stunting in rural areas. The Good Start in Life initiative, begun in 1999 and supported by UNICEF and USAID, delivered an integrated package of community-based interventions to more than 200 vulnerable communities in the Andean highlands and Amazon forest. An evaluation found that stunting among children under three years of age in these communities fell from 54 to 37 percent between 2000 and 2004. Similarly, CARE's REDESA (Sustainable Supply Chains for Food Security) project showed promising results in lifting families out of poverty and reducing stunting among children under three years of age, from 34 percent in 2002 to 24 percent in 2006. These pilot programs showed that interventions can be delivered on a larger scale, with good results.

**Key strategy: raising malnutrition on the national agenda**

In early 2006, international agencies and nongovernmental organizations in Peru formed the Child Malnutrition Initiative with the goal of placing nutrition high on the national agenda. They petitioned policymakers to raise their awareness of the magnitude of undernutrition; its impact on national, social, and economic development; and the lack of progress in tackling the problem, pointing to the achievements of small-scale programs as evidence of the potential of low-cost interventions. Before the 2006 presidential election, the Initiative lobbied candidates to sign a “5 by 5 by 5” commitment to reduce stunting in children under five-years old, by 5 percent in five years, and to lessen the inequities between urban and rural areas.

When the new government was formed later that year, the fight against stunting became central to its agenda, and it has remained so. The Child Malnutrition Initiative advocated for more resources and supportive policies for child nutrition, with a focus on the most deprived households and communities. It placed special emphasis on strengthening mechanisms to identify, target, deliver, and monitor efforts to reach the poorest people in rural areas.

In 2007, the government initiated the National Strategy for Poverty Reduction and Economic Opportunities (CRECER), focusing on children and pregnant women in the poorest areas. It sought to improve nutrition by strengthening multisectoral programs at regional and national levels.

Several social protection and poverty-reduction strategies were brought under CRECER's umbrella. The government's targeted the conditional cash transfer program Juntos and shifted toward multisectoral actions to reduce child undernutrition, increase families’ use of maternal and child health care services, and improve children’s school attendance. The Ministry of Women and Social Development consolidated six food distribution programs to optimize its work. A common action framework was created for the Ministries of Women and Social Development, Health, Education, Agriculture, Housing, and Employment, supported by sectoral budgets.

Management, technical, and analytical capacities were strengthened locally, regionally, and nationally.
Results-based financing implemented by the Ministry of Economy and Finance helped mobilize resources, improve operational efficiency, and increase government accountability. Regional governments and districts adopted CRECER and took ownership of local programs.

Over time, age-appropriate infant and young child feeding (IYCF) practices have improved, and in 2011 rates of exclusive breastfeeding were more than twice as high among the poorest children than the richest.

Source: UNICEF 2013, p. 35.
Considering the Gains Made in Peru

In considering the gains made in Peru, it is helpful to reflect on several issues set out in the following table.

**Table 9. Key Issues and Possibilities To Act - Peru**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Amenable to action: high, possible, or unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are the issues on the agenda for national action?</strong></td>
<td>High: In this case, a coalition of international agencies and nongovernmental organizations was created to advocate for a commitment to reducing malnutrition.</td>
</tr>
<tr>
<td><strong>Do political timescales and expediencies match those of the proposed work?</strong></td>
<td>Possible: It may be possible to use the election of a new government as a springboard to innovative work. In this case there was a political window of opportunity in the electoral cycle.</td>
</tr>
</tbody>
</table>
| **Is there sufficient political commitment to the issue and in taking an equity focus?** | Possible: It is possible to work on the issues without this commitment, but this is less likely to be scalable or sustainable.  
In the case of Peru, the following were true:  
  - Strong government commitment: The issue of nutrition was placed under the direct control of the Prime Minister’s Office.  
  - Commitment to equity: This led to the targeting of vulnerable groups and the development of follow-up capacity. |
| **Does the international evidence base support this approach?**       | Possible: Issues of cultural transferability can create a barrier to learning, and there is often a political drive for innovation. However, this project benefited from the evidence from well-designed and evaluated programs. These demonstrated the possibilities for success, and fed into the design of a comprehensive, integrated national strategy. |

*Source: MOCAT Development Team*

**Overweight/Consumption**

Globally, an estimated 43 million children under five years of age are overweight (7 percent). Of children in Sub-Saharan Africa, 10 million are overweight, while 7 million are overweight in East Asia and the Pacific. There has been a substantial increase in the numbers of overweight children in these regions over the past two decades, contributing to an increase of about 50 percent globally, from 28 million children in 1990 (UNICEF 2013).

Prevalence estimates have more than doubled since 1990 in Sub-Saharan Africa (from 3 percent in 1990 to 7 percent in 2011), meaning that more than three times as many children are affected today. A similar trend in estimates of child overweight has been observed in the Middle East and in North Africa (Ibid.).
In global terms, this picture adds to the burden of noncommunicable disease, which currently represents 43 percent of the total burden of disease and is expected to be responsible for 60 percent of the burden of disease and 73 percent of all deaths by 2020. Most of this increase will be accounted for by emerging noncommunicable disease epidemics in developing countries. These new epidemics are associated with increased urbanization and with lifestyle changes, and while smoking is a high-risk factor among these, lack of physical exercise and obesity are also important issues.¹³

While other low-income countries such as Madagascar have extremely low obesity rates, it is worth noting that research in South Africa has shown that undernutrition in childhood can lead to obesity in later life, although the connection is not yet fully understood.¹⁴

Whereas overconsumption in high-income countries is often associated with the lower quintiles of society, in lower-income countries it can be associated with affluence, and therefore, when addressing the social determinants of health through economic growth, this should be kept in mind. In either case, obesity reflects prevailing societal inequalities.

In addition to differences in income group and urban/rural settings, there are also differences in gender, and behavior forms part of that picture. For example, in India, approximately 16 percent of both men and women eat less than one portion of fruit a day. However, 19.7 percent of men living in Delhi slum settings are considered to be inactive, as opposed to 89.9 percent of women.¹⁵

Diving deep below the national level can be of interest in developing a benchmark for the regional or state-level situation. For example, Uttarakhand has 87.9 percent inactive males and 92.7 percent inactive women,¹⁶ which compares unfavorably to the national average and therefore suggests that it is an area for local action.

Comparing rates more broadly with other countries is problematic as food and peoples’ relationship to it not only depends on supply and security, but is also highly culturally defined. However, where a culture has sufficiently similar characteristics, observation of trends can be a foresight tool. For example, the rise in obesity in the United Kingdom closely tracks the pattern in the United States with a five-year gap, and fortunately the same now appears to apply to a plateauing effect.

Obesity is also associated with a rise in cardiovascular disease and hypertension, and diabetes type 2 can be a marker of prevalence. For example, in a country such as Madagascar with a low obesity rate, diabetes type 2 is found in approximately 2.7 percent of the population. In India, however, it is found in as much as 10 percent of the urban and 4 percent of the rural population. Its urban population is close to the average rate across the United States at 10.20 percent and to the average rate of several of the islands in the Caribbean including Dominican Republic, Jamaica, Bahamas, British Virgin Islands, the Cayman Islands, and Cuba that range between 10.20 and 10.40 percent. The highest recorded incidence is in Nauru at 30.90 percent.¹⁷

¹⁵. Development of Sentinel Health Monitor for Surveillance of Risk Factors of Noncommunicable Disease in India, 2003–05:
¹⁷. [http://www.allcountries.org/ranks/diabetes_prevalence_country_ranks.html](http://www.allcountries.org/ranks/diabetes_prevalence_country_ranks.html).
Choices about food and how much we eat are known to encompass a complex range of factors relating to culture and individuals’ perceptions about their place in it, which go far beyond availability and choice; addressing obesity will require action across multiple sectors and domains to encompass this.

In the context of the developing UN framework on NCDs, WHO has tried to identify the areas that are cost-effective in terms of balancing input and outcome; their “best buys” in relation to obesity include those set out in the following table.

**Table 10. WHO “Best Buys” in Relation to Obesity**

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Intervention</th>
<th>Avoidable burden</th>
<th>Cost effectiveness</th>
<th>Implementation cost</th>
<th>Feasibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global burden</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability-adjusted life year (DALY) in millions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unhealthy diet</td>
<td>• Reduce salt intake</td>
<td>5 million for salt</td>
<td>Very cost effective</td>
<td>Very low cost</td>
<td>Highly feasible</td>
</tr>
<tr>
<td></td>
<td>• Replace trans fats</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Promote public awareness of diet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

While these headlines offer a starting point and have been seen to produce positive impacts on national policy, there is considerable local variation in their appropriateness and possible application. For example, salt reduction has been successful in the United Kingdom, France, and Finland by a combination of legislation and voluntary reduction agreements with processed food manufacturers. However, in lower-income communities, while salt reduction may become a feature of urban diets, many people will still rely on home-cooked foods, and education at that level is necessary to effect a change.

Recognizing this complexity, it is important to match carefully the proposed intervention with the intended outcomes, and consider the multisectoral partnership in that context. Examples of sectors appropriate for actions include the following:

- **Community** members on food choices
- **Media** on campaigns using radio, TV, and print
- **Schools** and workplaces on education and healthy canteens
- **Agriculture** on growing healthy food and security
- **Transport** on accessible markets and food miles
- **Retailers** and where food is sold on stocking healthy options
- **Producers** on labeling, reformulation, and salt reduction
The possibility of unintended consequences is increased by a mismatch of method to aim. An example of this is seen in the following case study from Tonga.

**Case Study from Tonga: Mass Media**

A mass (social) marketing campaign (Ma’alahi Youth Project) was implemented as part of the Pacific Obesity Prevention in Communities project between 2005 and 2008. It involved healthy eating messages in advertising, jingles, interviews, banners, T-shirts, newspapers, TV, radio, and print, targeted specifically at adolescents in select villages and schools. The project was evaluated with a longitudinal design. It was found after 2.4 years that fewer teenagers in the intervention schools purchased snack foods from shops after school. However, they also reported reductions in regular breakfast consumption, fruit and vegetable consumption, and lunchtime activity, and increases in sugar-sweetened soft drink consumption. Consumption of several afterschool snacks and the resulting outcomes were more negative in the intervention relative to the control group. Both intervention and comparison groups showed similar large increases in overweight and obesity prevalence, with no significant differences between the groups.


In contrast to the Tonga case, a study from the United States shows a successful community-based approach to healthy nutrition.

**Case Study from the United States: A Community-Based Approach**

A notable community-based program in the United States is the Expanded Food and Nutrition Education Program (EFNEP), delivered by Cooperative Extension services in a variety of sites, clinics, children’s centers, family resource centers, and job clubs, as well as individuals at home. EFNEP is designed to assist “limited-resource audiences in acquiring the knowledge, skills, attitudes, and changed behavior necessary for nutritionally sound diets, and to contribute to their personal development and the improvement of the total family diet and nutritional well-being” (USDA 2009). The program aims to reach low-income adults who are responsible for planning and preparing food at home, especially expectant mothers and those with young children. It also aims to address the nutritional needs of youth through the K–12 classroom settings and extracurricular programs.

The effect of the first EPODE program initiated in France in 1992 to curb childhood obesity has been evaluated using a repeated, cross-sectional study. The evaluation demonstrated reduction in childhood overweight among school-age children (5 to 12 years of age) in the pilot towns over 12 years (Romon et al. 2009). EFNEP has been subject to regular evaluations (USDA 2012). These evaluations have found that over 90 percent of participants receiving nutrition education reported more closely following the United States Food–Based Dietary Guidelines, including an increase of servings of fruits and vegetables. It also found that 88 percent reported improved nutrition practices, such as making healthier food choices and reading nutrition labels. In addition, it showed that 83 percent improved food resource management practices, such as planning meals and shopping with a grocery list (USDA 2010).

Considering the Issues for Successful Outcomes

The issues outlined in the table below are important in securing positive results.

**Table 11. Key Issues and Possibilities to Act - General**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Amenable to action: high, possible, or unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the community feel ownership of the project?</td>
<td>High: Communities feel greatest ownership for issues that they have identified, but full participation in planning and delivery can mitigate this.</td>
</tr>
<tr>
<td>Does the evaluation meet the stated aims?</td>
<td>High: Evaluation needs to be designed, which reflects not only attitude and self-reported behavior, but also objective indicators.</td>
</tr>
</tbody>
</table>

*Source: MOCAT Development Team*

**Conclusion**

The Bank has a record of success in the area of nutrition and is increasingly taking on the issue of the double burden of this disease. While the MOCAT process will help to identify the specific nature of the burden of disease and its upstream determinants, more information on thinking about the Bank’s role in addressing these can be found on the nutrition homepage.
REFERENCES


PILOT TESTING OF THE MOCAT

Three potential sites were identified for the initial pilot testing of the MOCAT: Madagascar, Nagaland, and Uttarakhand. These selections were based on the point reached by the TTLs in developing multisectoral approaches, which could provide an entry point for the MOCAT, and because the TTLs perceived that the process could be supportive to them. However, it was recognized that further pilot testing would need to take place in other cultural settings to inform further iterations of the MOCAT.

Discussions with the TTL for Madagascar and an examination of the work undertaken in that country were very helpful in readying the MOCAT for pilot testing. However, due to shifting political expediencies, a full MOCAT process has not yet been possible in that country.

Missions to both Uttarakhand and Nagaland have, however, taken place and proved useful to understanding how best to use the MOCAT. The mission team was made up of Montserrat Meiro-Lorenzo, Senior Health Specialist; Neesha Harnam, Task Team Leader, Mission Lead, Young Professional; and Maggie Davies, Consultant.

In preparation for the missions, the team followed these steps in the MOCAT process:

- Undertook a review of grey and published literature on the burden of disease and underlying factors
- Considered possible priority areas
- Considered international best practice in relation to these areas

The team took this to be a starting point for dialogue with key stakeholders in the country. The purpose of this was to discover the following:

- Local knowledge that is not apparent through available data
- The feasibility and appropriateness of action in specific areas

The overall aim of the missions was to contribute to the development of the MOCAT through pilot testing.

The objectives were to identify the key priority areas that are amenable to action by the following:

- Refinement and validation of data collected during a desk review prior to the mission
- Interviews and dialogue with key stakeholders from across the public and voluntary sectors
- Meeting with policy leaders from across sectors
- Consideration of evidence-based solutions to local problems from international best practice

The Process in Nagaland

Day One
A meeting was held between the World Bank team and the government counterpart, Dr. Nandira, to clarify the scope and purpose of the mission.

Day Two
Meetings were held with representatives of state departments, service providers, and NGOs to introduce the Bank project under preparation and the MOCAT, and to gather information; to validate initial findings; and to discuss potential next steps. The broad upstream determinants and their impact on health were central to all discussions, which also sought to draw out learning from specific areas of expertise. Among others, meetings were held with the following:

- Dr. Angami and representatives of AIDS and drug use networks focusing on HIV, sexual health, and drug use issues
- Dr. Kika, Health Directorate, focusing on access to services, consultation, and ownership
- Dr. Pongener, epidemiologist, on the availability of data
- Dr. Vizolie, on planning, medical training, and capacity
Dr. David, Naga Hospital Administrator, on management and finance of acute services, service uptake, and hospital attendances
Mothers Union, on the role of women and their health and the voluntary care of HIV-positive orphans.
Dr. Khamo and colleagues on the cancer register

The team participated in the commissioner’s meeting, chaired by Rajun Bausal (principal secretary), which included representatives of planning, communications, power, roads, environment, rural development, and health.

Day Three
Part of the team undertook field visits to Khuzuma, Viswema, and Jakhama villages to understand the perceived and felt needs of the local community. To this end, the team met with village health authorities, women’s groups, village development boards, mothers, health personnel, and angawani (nutrition community) workers; they were accompanied by the director of planning.

A team member separately visited the following government departments for technical-level discussions on issues raised at the commissioner’s meeting:
- Rural development
- Transport
- Employment and craftsman training
- Education (to follow up)

Day Four
The team visited Zion Hospital in Dimapur to gain the perspective of a private, secondary-level health facility. The visit included discussions on local need, the management and finance of acute services, service uptake, and hospital attendance. A team member was shown the available facilities and the physical environment and had an opportunity to consider the range of services and specific areas in more detail.

Preliminary Findings

While some areas identified by the desk search and initial data analysis remained a priority, it became clear that other key issues had not been identified; whereas some were found to be of lesser importance than had been anticipated. The key issues, based on the best data available, are listed below. However, there are many gaps, and some issues may more accurately reflect stakeholders’ perceived needs.

1. Established Burden of Disease Areas
   - Tuberculosis (multidrug resistant)
   - Waterborne diseases, including diarrhea/stunting
   - Cancer (cervical cancer is the most prevalent type in women, while nasopharyngeal, esophagus, stomach, and oropharyngeal cancers are prevalent in both men and women)
   - Malaria (seasonal)
   - Upper and lower respiratory tract infections, particularly in children

2. Increasing Trends
   - Liver disease, including hepatitis B and C and cirrhosis
   - Sexually transmitted infections, including genital warts and an apparently high incidence of HIV
   - Noncommunicable diseases, including stroke, hypertension, and diabetes

3. Upstream Factors
   - Road and transport infrastructure
   - Water and sanitation
   - Employment (educated youth/lack of opportunities)
   - Role of women in making health decisions
   - Lack of inward investment
   - Migration/immigration
• Unventilated houses and shared space
• Alcohol prohibition versus legislation and quality control
• Only sales tax by state (informal taxes)
• On the drug route from the East
• Untrained proxies provide health care and teach
• Reliable and clean energy availability
• Availability vaccines for hepatitis C and cervical cancer
• Access to care

4. Risk Behaviors
• Alcohol use (particularly in unregulated and health-harming forms)
• Tobacco use
• Indoor wood fires for cooking or heating
• Hygiene practices
• High salt diet
• High content of red meat in the diet (urban and more affluent populations)
• Low nutrition diet of rural poor (or poor nutrient uptake/absorption)
• Unprotected penetrative sex (contraception and protection)
• Noncircumcision of men
• Late presentation for testing and treatment (across conditions, including HIV)
• Drug use

5. Potential Areas Amenable to Action

Certain important areas need major commitment and investment by the state; there is potential for supporting advocacy for change in these areas. These areas, which may be amenable to action, include the following:
• Roads
• Water and sanitation
• Energy and power
• Human papilloma virus and hepatitis B and C vaccines, in line with the national Expanded Program on Immunization guidelines

6. Potential Bank Actions Connected to the Project

It is feasible for the Bank to undertake the following actions in connection with its multisectoral project:

a) Data Collection:
• Support to and strengthening of the Health Management Information System’s ability to develop a basket of indicators and proxy markers to understand health impacts of the upstream determinants on the health of the population
• Support to the health service in developing a stewardship role in collecting data from other sectors to demonstrate health outcomes
• Support to use data to develop benchmarking on the key upstream determinants and — where anonymity is not an issue — disease factors from the village up to the state level

b) Transparency:
• Disseminating information and ensuring that the community and direct beneficiaries are aware of the resources available both from the Bank and from other sources, and how they are intended to be used within their community

c) The Hospital as an Agent for Change:
• In the context of the Ottawa Charter and the WHO healthy settings approach:
• Articulate the benefit to the local community of enhanced water and power supplies to health facilities
• Link capacity building in the community with skills gaps in the hospital

d) Community Development: The proposed community focus of the Bank’s project that enables it to respond to felt and perceived needs will be key to ownership and sustainability. It is, therefore, not suggested that the multisectoral community-based element of the Bank’s project be reshaped around disease topics. Rather, it is suggested that part of the criteria for assessment of grant proposals should be their impact on health, and that guidance be provided to applicants on how to make their initiative supportive of health. Examples of this could be building well-ventilated houses or water-harvesting systems. Part of the criteria could be to check proposals against the list of key upstream health-determining factors listed in point 3 above. A further suggestion would be to consider positive discrimination in favor of women-led or all-women projects in grant selection, and to include local women in the decision-making process.

6.i. This has provided valuable learning for the MOCAT process in terms of the relationship between available published data and local knowledge.

6.ii. The possibility of drawing in international learning was flagged in the preparatory work, and the benefit of identifying appropriate examples to meet the local need was reinforced during the mission.

6.iii. There was general interest in and support for both greater convergence at the policy level and the possible engagement of stakeholders from across sectors.

The Process in Uttarakhand

Meetings were conducted with representatives of government and NGOs including the following:

• Mission Director, National Health Mission
• Director-General, Health
• Additional Director, Maternal and Child Health
• Joint Director, National Program, NCDs
• Assistant Director, Health and Nutrition
• Principal Superintendent, Doon Hospital
• Principal Superintendent and Public-Private Partnership (PPP) Facility Director, Coronation Hospital
• Plan India (Dr. Bharati Dangwal and her team, including a water and sanitation specialist and PPP specialist)

Other sector representatives came from water and sanitation, disaster preparedness, and education.

The MOCAT team also participated in multisectoral meetings as part of the larger Bank team.

Priority Issues:

Various priority areas have been identified, including the following:

• Disaster preparedness has been identified as the first priority area, and will form part of the Bank’s overall investment strategy in Uttarakhand. It is also an area that will lend itself to a multisectoral approach and benefit from MOCAT support.

• Road traffic accidents (RTAs) are linked to disaster preparedness and form a second identified priority area. There is a high incidence of morbidity and mortality as a result of RTAs, and connections can be made between the need for trauma services in this respect and the work on disaster preparedness.

• Other key issues that were identified include the following:
  • Respiratory diseases
  • Water-borne and diarrheal disease
• Malnutrition
• Cancer
• Tuberculosis
• Malaria
• The incidence of NCDs is increasing, and the trend is worth noting.

The next step will be a discussion with the TTL on refining the priority areas and considering possible multisectoral solutions that will complement the Bank’s overall project development.
Tobacco

Multisectoral Opportunities and Constraints Assessment Tool: A pointer to supplementary information on tobacco use.

Background: The Multisectoral Opportunities and Constraints Assessment Tool (MOCAT)

The MOCAT has been developed in response to the Bank’s recognition that meeting its twin goals will require a systematic approach across sectors for positive health outcomes.

The primary audience of the MOCAT is TTLs and other Bank staff working in countries with the support of HNP GP.

The purpose of the MOCAT is to do the following:

- Assist in identifying opportunities and constraints to multisectoral work in pursuit of better health equity outcomes in countries.
- Support multisectoral action and work across practices in the Bank to achieve positive health equity outcomes in countries through joint work.

The MOCAT provides a process for understanding the burden of disease in a country, the upstream drivers, the opportunities and constraints in taking a multisectoral approach to addressing these, and whether there are evidence-based examples from international best practice that could be appropriately adapted to the country-specific situation. The MOCAT acknowledges the need to mine published literature as a starting point, but also recognizes the very important need to temper this through stakeholder consultation in a country as well as through locally available grey literature.

In working through the MOCAT process, three to five areas that have the potential to be priority for multisectoral action will be highlighted.

Key areas that significantly add to the burden of disease in low- and middle-income countries have been identified and include the following:

- Transport, road safety, traffic accidents and injuries
- Undernutrition
- Indoor air pollution and household fuel
- Tobacco use

This supplementary information is designed to complement the MOCAT by providing a pointer to content on the issue of tobacco use.

Introduction: Tobacco Use

With six million deaths a year, tobacco is the greatest single reason for mortality, all of it premature (CDC 2014). Unchecked, tobacco-related deaths will increase to more than eight million a year by 2030, with 80 percent of smokers in low-income countries (LICs) and middle-income countries (MICs) (WHO 2014).

Important trends include the following:

- Rapid increase of smoking among girls (in 60 countries girls between 13 and 15 smoke as much as boys).
- Tobacco use is decreasing in high-income countries, but increasing in MICs and LICs.
- In most countries people in the lowest quintiles smoke more than those in the upper quintiles.
• In some low-income countries, smoking will not be the main way of using tobacco, and this may be reflected in the burden of disease.
• Tobacco use takes up a significant part of a low-income household's income — up to 11 percent in Mexico and 15 percent in Indonesia (WHO 2008).


What Works

Highly effective measures and interventions to reduce tobacco control have been identified in terms of cost and impact. Chiefly, these are the following:

• Tobacco tax at a sufficiently high rate to impact sales
• Smoke-free public places legislation
• Graphic warnings on tobacco packs covering over 75 percent of the surface
• Advertising, promotion, and sponsorship bans
• Support to quit tobacco use is also somewhat effective and cost effective, but not at the same level

How-To

Implementing these measures will raise concerns in the industry and among others stakeholders. These include the effect of tobacco control and use reduction on labor markets and farmers in tobacco producing and manufacturing countries, challenges to enforcing legislation, and reduction in sponsorship funding. Stakeholder engagement and awareness raising are useful in promoting acceptance of new measures. Addressing all these concerns requires engagement from multiple stakeholders, for example:

Table 12. Engagement Across Stakeholders

<table>
<thead>
<tr>
<th>Sector</th>
<th>Action</th>
<th>Drivers and opportunities</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>• Legislation</td>
<td>• Healthy and economically active population</td>
<td>• Personal freedom agenda</td>
</tr>
<tr>
<td></td>
<td>• Awareness raising</td>
<td></td>
<td>• Funding from tobacco companies/lobbying</td>
</tr>
<tr>
<td>Employers</td>
<td>• Smoke-free workplaces</td>
<td>• Healthier workforce</td>
<td>• Lack of supportive legislation</td>
</tr>
<tr>
<td>Health services</td>
<td>Advice including</td>
<td>• Cost benefits and reduced demand on services</td>
<td>• Perception as treatment, rather than prevention service</td>
</tr>
<tr>
<td></td>
<td>• Quitlines</td>
<td></td>
<td>• Lack of capacity</td>
</tr>
<tr>
<td></td>
<td>• Nicotine replacement therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Evidence-based health promotion initiatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communities</td>
<td>• Social norms and positive reinforcement</td>
<td>• Mutual support</td>
<td>• Peer pressure to smoke or use tobacco products</td>
</tr>
<tr>
<td>Customs and excise</td>
<td>• Enforce smuggling legislation</td>
<td>• Crime reduction</td>
<td>• Not a priority/lack of capacity</td>
</tr>
<tr>
<td>Education</td>
<td>• Health education for students, staff, and parents</td>
<td>• Healthy next generation</td>
<td>• Pressure on curriculum</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Workforce capacity</td>
</tr>
<tr>
<td>Police and criminal justice</td>
<td>• Enforce smoking legislation</td>
<td>• Healthy workforce</td>
<td>• Not a priority/lack of capacity</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------------------------</td>
<td>-------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>NGOs</td>
<td>• Advocacy for legislation and policy change</td>
<td>• Freedom from political constraint</td>
<td>• Lack of resources</td>
</tr>
<tr>
<td></td>
<td>• Awareness raising and support for local interventions</td>
<td>• Grounded in local culture</td>
<td>• Marginalized by policy makers</td>
</tr>
<tr>
<td>Academia</td>
<td>• Research on cost-effective interventions</td>
<td>• Developing the evidence base and publication</td>
<td>• Agenda too theoretical</td>
</tr>
</tbody>
</table>

Source: MOCAT Development Team

**Donor Contributions**

The connections between low-income countries and individuals and tobacco use are known; addressing this issue could make a significant contribution to the Bank’s poverty-reduction and equity agenda. In cases where a strategic fit can be identified, there may also be added value in working with other donors, for example:

Table 13. Donor Contributions

<table>
<thead>
<tr>
<th>Donors</th>
<th>Action</th>
<th>Drivers and opportunities</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>UN Family, Country aid agencies, such as DFID and AUSAID</td>
<td>• Poverty reduction</td>
<td>• Added value in sharing resources and avoiding duplication</td>
<td>• No fit with priorities and goals</td>
</tr>
<tr>
<td>Foundations, such as the Welcome Trust and the Gates Foundation</td>
<td>• Infrastructure development</td>
<td></td>
<td>• Competition within or between organizations</td>
</tr>
<tr>
<td></td>
<td>• Advice on policy and legislation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Research, data analysis, and dissemination</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Developing evidence-based practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Convening multisectoral forums</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: MOCAT Development Team
Examples of Proven Solutions

There is a growing body of evidence on what works in terms of addressing tobacco use issues. Below are some examples of best practice that may have the potential for transfer.

- Quitlines

- China Case Study: Economic Analysis and Options for Control
  [https://openknowledge.worldbank.org/handle/10986/13636](https://openknowledge.worldbank.org/handle/10986/13636)

- Bangladesh, Brazil, Canada, Poland, South Africa, and Thailand case studies

- Case studies from across regions

- Framework Convention on Tobacco

Indoor Pollution and Household Fuel

Multi-sectoral Opportunities and Constraints Assessment Tool: A pointer to supplementary information on indoor pollution and household fuel.

Background: The Multi-sectoral Opportunities and Constraints Assessment Tool (MOCAT)

The MOCAT has been developed in response to the Bank’s recognition that meeting its twin goals will require a systematic approach across sectors for positive health outcomes.

The primary audience of the MOCAT is the TTLs and other Bank staff working in countries with the support of HNP GP.

The purpose of the MOCAT is the following:

- Assist in identifying opportunities and constraints to multi-sectoral work in pursuit of better health equity outcomes in countries.

- Support multi-sectoral action and work across practices in the Bank to achieve positive health equity outcomes in countries through joint work.

The MOCAT provides a process for understanding the burden of disease in a country, the upstream drivers, the opportunities and constraints in taking a multi-sectoral approach to addressing these, and whether there are evidence-based examples from international best practice that could be appropriately adapted to the country-specific situation. The MOCAT acknowledges the need to mine published literature as a starting point, but also recognizes the very important need to temper this through stakeholder consultation in a country as well as through locally available grey literature.

In working through the MOCAT process, three to five areas that have the potential to be priority for multi-sectoral action will have been highlighted.
Key areas have been identified that significantly add to the burden of disease in low- and middle-income countries, including the following:

- Transport, road safety, traffic accidents and injuries
- Undernutrition
- Indoor air pollution and household fuel
- Tobacco use

This supplementary information is designed to complement the MOCAT by providing a pointer to content on the issue of indoor pollution and household fuel.

Introduction to Indoor air Pollution and Household Fuel

According to WHO, key facts on indoor air pollution and household fuel include the following:

- Approximately three billion people cook and heat their homes using open fires and simple stoves burning biomass (wood, animal dung, and crop waste) and coal.
- Over four million people die prematurely from illness attributable to household air pollution from cooking with solid fuels.
- More than 50 percent of premature deaths among children under five are due to pneumonia caused by particulate matter inhaled from household air pollution.
- 3.8 million premature deaths annually from noncommunicable diseases including stroke, ischemic heart disease, chronic obstructive pulmonary disease (COPD), and lung cancer are attributed to exposure to household air pollution.

Approximately three billion people still cook and heat their homes using solid fuels in open fires and leaky stoves. Most are poor, and live in low- and middle-income countries.

4.3 million people a year die prematurely from illnesses attributable to household air pollution caused by inefficient use of solid fuels (2012 data). Among these deaths are the following:

- Pneumonia, 12 percent
- Stroke, 34 percent
- Ischemic heart disease, 26 percent
- Chronic obstructive pulmonary disease (COPD), 22 percent
- Lung cancer, 6 percent

Pneumonia

Exposure to household air pollution almost doubles the risk for childhood pneumonia. Over half of deaths among children less than five-years old from acute lower respiratory infections (ALRI) are due to particulate matter inhaled from indoor air pollution from household solid fuels (WHO 2014).

Stroke

Nearly one-quarter of all premature deaths due to stroke (that is, about 1.4 million deaths of which half are of women) can be attributed to chronic exposure to household air pollution caused by cooking with solid fuels.

Ischemic heart disease

Approximately 15 percent of all deaths due ischemic heart disease, accounting for over a million premature deaths annually, can be attributed to exposure to household air pollution.

Chronic obstructive pulmonary disease

Over one-third of premature deaths from chronic obstructive pulmonary disease (COPD) in adults in low- and middle-income countries are due to exposure to household air pollution. Women exposed to high levels of indoor smoke are 2.3 times as likely to suffer from COPD than women who use cleaner fuels. Among men (who already have a heightened risk of COPD due to their higher rates of smoking), exposure to indoor smoke nearly doubles (that is, 1.9 times) that risk.
Lung cancer
Approximately 17 percent of annual premature lung cancer deaths in adults are attributable to exposure to carcinogens from household air pollution caused by cooking with solid fuels. The risk for women is higher, due to their role in food preparation.

Other health impacts and risks
More generally, small particulate matter and other pollutants in indoor smoke inflame the airways and lungs, impairing immune response and reducing the oxygen-carrying capacity of blood. There is also evidence of links between household air pollution and low birthweight, tuberculosis, cataract, and nasopharyngeal and laryngeal cancers.

WHO Factsheet 2014; http://www.who.int/mediacentre/factsheets/fs292/en

The Bank is a leader of work on these issues; further information can be found at the website: http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/ENVIRONMENT/EXTENVHEA/0,,contentMDK:21158391~menuPK:4367070~pagePK:210058~piPK:210062~theSitePK:3662880,00.html

The Bank also invites collaboration through https://collaboration.worldbank.org/groups/clean-cooking-and-heating-solutions

Engagement across Sectors and Practices

The MOCAT is designed to consider multisectoral working; possible entry points on these issues could be the following:
### Table 14: Engagement Across Government

<table>
<thead>
<tr>
<th>Across government policy area</th>
<th>Action</th>
<th>Opportunities and drivers</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>• Providing services to those affected&lt;br&gt; • Facilitation of work across sectors&lt;br&gt; • Surveillance and providing data on the burden of disease&lt;br&gt; • Assessing health impacts, monitoring, and providing foresight&lt;br&gt; • Providing health promotion to support change&lt;br&gt; • Raise awareness at the individual and population levels</td>
<td>• Cost benefit in reduced treatment and release of capacity in the health service</td>
<td>• Health sector does not have the ability to facilitate work across government&lt;br&gt; • It sees itself as a &quot;sickness&quot; service and does not acknowledge its role in addressing upstream determinants&lt;br&gt; • It does not have the capacity to analyze data&lt;br&gt; • Data protection limits opportunities to share information</td>
</tr>
<tr>
<td>Environment</td>
<td>• Development of appropriate air quality standards and targets, and measurement of pollution&lt;br&gt; • Management of deforestation</td>
<td>• Health indicators links with that on deforestation to create a common interest</td>
<td>• Installation of chimneys or separate cooking areas does not improve overall air quality</td>
</tr>
<tr>
<td>Housing</td>
<td>• Regulation and provision of housing that is constructed of appropriate materials with adequate ventilation</td>
<td>• Safe housing</td>
<td>• No monitoring of housing stock, particularly in rural areas&lt;br&gt; • No government support for housing</td>
</tr>
<tr>
<td>Energy</td>
<td>• Ensure a supply of clean energy to low-income homes and manage the use of biomass fuels for cooking and heating</td>
<td>• Effective and efficient fuel supply</td>
<td>• Cost of connection to rural areas&lt;br&gt; • Lack of investment in infrastructure</td>
</tr>
<tr>
<td>Employment and trade</td>
<td>• Create opportunities for paid work to lift people out of poverty to afford clean energy/clean stoves</td>
<td>• Economic growth</td>
<td>• Population shift to urban areas, but lack of industry</td>
</tr>
<tr>
<td>Finance and development</td>
<td>• Awareness raising about the importance of household energy for development, integration with poverty alleviation</td>
<td>• Economic growth and social well-being&lt;br&gt; • Credit and finance opportunities</td>
<td>• Silo working prevents links being made between health and economic growth</td>
</tr>
<tr>
<td>Women and gender</td>
<td>• Health, well-being, and education for women</td>
<td>• Woman able to make an economic contribution</td>
<td>• Beliefs about the role of women</td>
</tr>
<tr>
<td>Education</td>
<td>• Awareness raising and skills through education at all levels</td>
<td>• Teaching new ways to young people</td>
<td>• Communities have the knowledge, but not the resources to act on it&lt;br&gt; • Not seen as relevant to curriculum</td>
</tr>
</tbody>
</table>
3. b. Intersectoral

Table 15. Engagement Across Stakeholders

<table>
<thead>
<tr>
<th>Sector</th>
<th>Action</th>
<th>Opportunities</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industry</td>
<td>• Supply and distribution of cleaner fuels (LPG, electricity) and appliances</td>
<td>• Increase in customer base</td>
<td>• Lack of financial incentives to supply the poorest</td>
</tr>
<tr>
<td>NGO</td>
<td>• Advocacy for government action</td>
<td>• Ability to form a bridge between the felt and perceived needs of the community and normative need of professionals</td>
<td>• Lack of capacity or financial resources</td>
</tr>
<tr>
<td></td>
<td>• Support women as decision makers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Exchange information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community members</td>
<td>• Peer education and individual behavior change</td>
<td>• Good community cohesion</td>
<td>• Lack of resources or voice to change environment</td>
</tr>
<tr>
<td>Donors</td>
<td>• Commission research</td>
<td>• Able to add value to government initiatives through knowledge and finance</td>
<td>• Does not match overall strategic aims</td>
</tr>
<tr>
<td></td>
<td>• Poverty-reduction strategies</td>
<td>• Draws upon international experience</td>
<td>• Limited funding</td>
</tr>
<tr>
<td></td>
<td>• Microfinance schemes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Share information</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fund community housing projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academics</td>
<td>• Provide research, evaluation, and data to support action</td>
<td>• Publications</td>
<td>• Lack of practical application of research</td>
</tr>
</tbody>
</table>

4. Proven Solutions

The Bank has a history of work on indoor pollution and household fuel–related issues and is strategically well placed to facilitate a multisectoral response. In addition to extensive input in Bangladesh, the Bank has worked in other high-burden countries such as China, Guatemala, and India on low-cost stove technologies, modern fuel alternatives, and renewable energy solutions.

Some examples of evaluated approaches across levels that could provide a starting point in considering best practice and be amenable to transfer can be found at the following websites:

Pathways to Cleaner Household Cooking in Lao PDR

Indonesia: Towards Universal Access to Clean Cooking
https://openknowledge.worldbank.org/bitstream/handle/10986/16068/792790ESW0P1290ox0377371B00PUBLIC00.pdf?sequence=1

China: Health Impacts of Indoor Pollution at a Glance
One Goal, Two Paths

Road Traffic Accidents

Multisectoral Opportunities and Constraints Assessment Tool: A pointer to supplementary information on transport, road safety, and traffic accidents.

Background: The Multisectoral Opportunities and Constraints Assessment Tool (MOCAT)

The MOCAT has been developed in response to the Bank’s recognition that meeting its twin goals will require a systematic approach across sectors for positive health outcomes.

The primary audience of the MOCAT is TTLs and other Bank staff working in countries with the support of HNP GP.

The purpose of the MOCAT is to do the following:

- Assist in identifying opportunities and constraints to multisectoral work in pursuit of better health equity outcomes in countries.
- Support multisectoral action and work across practices in the Bank to achieve positive health equity outcomes in countries through joint work.

The MOCAT provides a process for understanding the burden of disease in a country, the upstream drivers, the opportunities and constraints in taking a multisectoral approach to addressing these, and whether there are evidence-based examples from international best practice that could be appropriately adapted to the country-specific situation. It acknowledges the need to mine published literature as a starting point, but also recognizes the very important need to temper this through stakeholder consultation in a country as well as through locally available grey literature.

In working through the MOCAT process, three to five areas that have the potential to be priority for multisectoral action will have been highlighted.

Key areas have been identified that significantly add to the burden of disease in low- and middle-income countries including the following:

- Transport, road safety, traffic accidents and injuries
- Undernutrition
- Indoor air pollution and household fuel
- Tobacco use

This supplementary information is designed to enhance the MOCAT by providing a pointer to content; it is not intended to be a comprehensive guide to the topic.

Introduction to Road Traffic Accidents and Transport Issues

Through the MOCAT process, road traffic accidents and transport may emerge as areas for action as these are of particular importance in middle- and lower-income countries where approximately 90 percent of the world's fatalities on the roads occur, even though these countries have only half of the world's vehicles. However,
economic growth often brings about an increase in vehicle ownership, and this can create its own problems. Half of those dying on the world’s roads are “vulnerable road users” — pedestrians, cyclists, and motorcyclists, and the potential increase in noise and air pollution, particularly in rapidly expanding urban areas, can have health impacts in terms of stress and asthma, for example.

While road crashes have been identified as the eighth leading cause of death worldwide, and the number one killer among the 15 to 29 age group, only 28 countries, representing 449 million people (7 percent of the world’s population) have adequate laws that address the five risk factors of speed, drunk driving, helmets, seat-belts, and child restraints. Only 59 countries representing 39 percent of the world’s population have implemented a speed limit of 50 kilometers/hour in urban areas, and 90 countries representing 77 percent of the world’s population have comprehensive helmet laws.

While 88 countries have reduced the number of deaths on their roads, the total number of accidents is deemed by WHO to remain unacceptably high. World Bank and Institute for Health Metrics and Evaluation (IHME) estimates show 1.33 million per year killed, a higher global burden of disease than malaria or tuberculosis.

(The Global Status Report on Road Safety 2013)


This resource sheet is intended to provide pointers to further content related to the specific issues of road safety and transport as upstream determinants of health rather than to replicate it here. Further, as the Bank has worked extensively in this area and is a leading source of information on these topics, the following can serve as a starting point:

• World Bank Road Safety Facility
  http://www.worldbank.org/grsf
• Other key information sources include the following:
  • WHO Road Traffic Injuries home page — www.who.int/violence_injury_prevention
  • International Road Assessment Program: www.Irap.net
  • Global Road Safety Partnership: www.GRSRoadsafety.org

Engagement across Sectors

The Bank has worked closely with other international agencies, such as WHO, thereby providing an example of the benefits of joint working. The context for this work has been the groundbreaking World Bank-WHO World Report on Road Traffic Injury Prevention, which has six recommendations for supportive action with direct relevance to the MOCAT process:

• Identify a lead agency in government to guide the national road safety effort.
• Assess the problem, policies, and institutional settings relating to road traffic injury and the capacity for road traffic injury prevention in each country.
• Prepare a national road safety strategy and plan of action.
• Allocate financial and human resources to address the problem.
• Implement specific actions to prevent road traffic crashes, minimize injuries and their consequences, and evaluate the impact of these actions.
• Support the development of national capacity and international cooperation.

The complex and multifaceted upstream causes and domains for action mean that a multisectoral approach is essential to effectively address the issue of the health impact of road traffic and transport. In the Bank’s
guidelines, developed under the Global Road Safety Facility (GRSF), a systematic results-based approach (the “Safe System”) is promoted that demonstrates the following:

**Figure 9. The Safe System Approach to Road Safety**

The overall strategic framework for global action is contained in the UN Global Plan for a Decade of Action for Road Safety 2011–2020. This covers the following areas:

- Building road safety–management capacity
- Improving the safety of road infrastructure and broader transport networks
- Developing the safety of vehicles
- Enhancing the behavior of road users
- Improving postcrash care

The full framework can be found at the following website: [http://www.who.int/roadsafety/decade_of_action/plan/en/](http://www.who.int/roadsafety/decade_of_action/plan/en/)

The guidelines developed by the Bank/GRSF to address these issues by systematic action across sectors in a country at both the design and project levels are provided in *Road Safety Management Capacity Reviews and Safe System Project Guidelines* (T. Bliss and J. Breen 2013); [http://siteresources.worldbank.org/INTTOPGLOROASAF/Resources/2582140-1371235287855/Road-Safety-Management-Guidelines-EN.pdf](http://siteresources.worldbank.org/INTTOPGLOROASAF/Resources/2582140-1371235287855/Road-Safety-Management-Guidelines-EN.pdf)
Proven Solutions

Road safety and transport are areas known to be amenable to action and high road safety–performing developed countries have been able to demonstrate success through multisectoral and joint work, thereby providing proven solutions that could be considered for their potential transferability.

A case study of the Bank’s work in Argentina is provided as part of the MOCAT toolkit and is referred to in the Road Safety Management Guidelines, along with examples of work in high-income countries. Additional case studies, partner organizations (including those relevant to some of the Bank’s operations regions), and other information can be found at the following websites:


International Road Traffic Accident Database: http://internationaltransportforum.org/irtadpublic/index.html

Global New Car Assessment Program: www.globalncap.org

Latin American Road Safety Observatory: http://www.oisevi.org/a/


Undernutrition

Multisectoral Opportunities and Constraints Assessment Tool: Supplementary information on Undernutrition

Background: The Multisectoral Opportunities and Constraints Assessment Tool (MOCAT)

The MOCAT has been developed in response to the Bank’s recognition that meeting its twin goals will require a systematic approach across sectors for positive health outcomes

The primary audience of the MOCAT is TTLs and other Bank staff working in countries with the support of HNP GP.

The purpose of the MOCAT is to accomplish the following:

- Assist in identifying opportunities and constraints to multisectoral work in pursuit of better health equity outcomes in countries.
• Support multisectoral action and work across practices in the Bank to achieve positive health equity outcomes in countries through joint work.

The MOCAT provides a process for understanding the burden of disease in a country, the upstream drivers, the opportunities and constraints in taking a multisectoral approach to addressing these, and whether there are evidence-based examples from international best practice that could be appropriately adapted to the country-specific situation. The MOCAT acknowledges the need to mine published literature as a starting point, but also recognizes the very important need to temper this through stakeholder consultation in a country as well as through locally available grey literature.

In working through the MOCAT process, three to five areas that are potential priorities for multisectoral action will have been highlighted.

Experience suggests that key areas that significantly add to the burden of disease in low- and middle-income countries include the following:

• Transport, road safety, traffic accidents and injuries
• Nutrition (undernutrition, micronutrient deficiencies, and overweight/obesity)
• Indoor air pollution and household fuel
• Tobacco use

This knowledge sheet is designed to complement the MOCAT by providing pointers to content on the issue of nutrition.

Background to the Issue of Nutrition

• One-quarter (162 million) under-five-year olds around the world were affected by chronic undernutrition (stunting) in 2012, a 35 percent decline from an estimated 253 million in 1990.18
• Of under-five children globally, 15 percent (101 million) are estimated to be underweight in 2012.18
• More than two billion people in the world today are estimated to be deficient in key vitamins and minerals, particularly vitamin A, iodine, iron and zinc. 19
• An estimated 43 million children under five (7 percent) are overweight, a 54 percent increase since 1990.18
• Undernutrition is responsible for nearly half (45 percent) of all deaths for children under five.20
• Poor nutrition causes a range of serious and costly health problems, from impaired cognitive and physical development to illness, disease, and death. The implications extend far beyond health outcomes, affecting educational attainment, workforce capacity and productivity, political stability, and economic progress.
• Addressing nutrition in the critical “1,000 days” window of opportunity from pregnancy through 24 months is vital to prevent irreversible damage.
• World Bank says that scaling up nutrition programs in high-burden countries would cost just US$11.8 billion a year. We know that preventing moderate malnutrition is affordable: US$200 to treat severe child


malnourishment versus just US$40 to US$80 to prevent it (World Bank 2009).

- Copenhagen Consensus (2008) states that five of the top ten most cost-effective solutions for development focus on malnutrition. Nearly one million children (15 percent of under-five deaths) can be saved through scale-up of ten core nutrition interventions, and stunting can be reduced by over 20 percent.21

- Nutrition-sensitive interventions and programmes — those within the context of sector-specific objectives aim to improve the underlying determinants of nutrition such as adequate food access, healthy environments, adequate health services, and care practices — have enormous potential to enhance the scale and effectiveness of nutrition-specific interventions.22

The World Bank has a leading role in addressing nutrition; an overview of our work including recent projects, research, data, and tools can be found at the following website: http://www.worldbank.org/en/topic/nutrition

Current child malnutrition (stunting, underweight, overweight, wasting) data and trends since 1990, a joint effort of the Bank, UNICEF, and WHO; they have been harmonizing data for this purpose since 2011.

Country data can provide the basis for benchmarking and help understand where a country is disproportionately affected by nutrition issues.

- Joint Report: http://www.who.int/nutgrowthdb/estimates/en/
- WHO Global Database on Child Growth and Malnutrition: http://www.who.int/nutgrowthdb
- UNICEF Childinfo Statistics by Area: http://www.childinfo.org

The World Bank Data Dashboard includes the following nutrition-relevant data:

- Child stunting (height-for-age) prevalence: http://data.worldbank.org/indicator/SH.STA.STNT.ZS
- Child underweight (weight-for-age) prevalence: http://data.worldbank.org/indicator/SH.STA.MALN.ZS
- Vitamin A supplement coverage: http://data.worldbank.org/indicator/SN.ITK.VITA.ZS/countries?display=map

Additional country-specific nutrition information is available from the Nutrition Country Profiles for nearly 70 undernutrition high-burden countries:


The background paper on the social determinants of health in the MOCAT toolkit also addresses the issue of nutrition in the context of the triple burden of malnutrition, the co-occurrence of undernutrition, micronutrient deficiency, and overweight/obesity.

In the 2013 Lancet Series on Maternal and Child Nutrition, Bhutta, et al. assessed the effect of scaling up delivery of nutrition-specific interventions on lives saved in the 34 countries with 90 percent of the global burden of stunted children.21 The recommended package includes these 10 cost-efficient nutrition interventions:

- Optimum maternal nutrition during pregnancy
  - Multiple maternal micronutrient supplements
  - Calcium supplementation to mothers at risk of low intake
  - Balanced maternal energy protein supplements as needed
  - Universal salt iodization


• **Infant and young child feeding**
  o Promotion of early and exclusive breastfeeding for 6 months and continued breastfeeding for up to 24 months
  o Appropriate complementary feeding education in food-secure populations and additional complementary food supplements in food-insecure populations

• **Micronutrient supplementation in children at risk**
  o Vitamin A supplementation between 6 and 59 months of age
  o Preventive zinc supplements between 12 and 59 months of age

• **Management of acute malnutrition**
  o Management of moderate acute malnutrition
  o Management of severe acute malnutrition

The *Improving Nutrition through Multisectoral Approaches* series, including guidance notes and briefs providing operational guidance to maximize the impact of agriculture, social protection, and health investments on nutrition outcomes for women and young children. The “Guidance Notes” build on evidence to date on issues of malnutrition, with the aim of providing concrete guidance on how to mainstream nutrition-sensitive interventions.

The *SecureNutrition Knowledge Platform* ([www.securenutritionplatform.org](http://www.securenutritionplatform.org)) aims to address some critical operational knowledge gaps about how to improve the nutrition of vulnerable populations using nutrition-sensitive interventions delivered through agricultural and food security investments, and other key sectors.

*Engaging Stakeholders and the Drivers and Constraints to Multisectoral Approaches to Nutrition Issues*

The MOCAT process is intended to highlight who the key stakeholders are, what they can do to address the identified burden of disease and upstream drivers, and what the opportunities and constraints are to taking action. Below are illustrative entry points in relation to nutrition-related issues.23

**Table 16. Illustrative Entry Points to Nutrition-Related Issues**

<table>
<thead>
<tr>
<th>Sector</th>
<th>Action</th>
<th>Drivers and opportunities</th>
<th>Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td><strong>Prioritize nutrition “best bets”</strong></td>
<td><strong>Utilize existing health sector platforms</strong></td>
<td>• Perception of health sector as providing treatment rather than prevention</td>
</tr>
<tr>
<td></td>
<td>• Breastfeeding promotion and support</td>
<td>• Delivery care</td>
<td>• Limited presence in rural areas where there is greatest need</td>
</tr>
<tr>
<td></td>
<td>• Vitamin A supplementation</td>
<td>• Community outreach</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Therapeutic zinc supplements</td>
<td>• Sick/well child contacts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Iron-folic acid supplementation for pregnant women</td>
<td>• Antenatal care and postnatal care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Treatment of severe acute malnutrition</td>
<td>• Public health campaigns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Complementary feeding promotion</td>
<td>• Routine health contacts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hand washing and hygiene promotion</td>
<td>• Emergency health services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provision of multiple micronutrient powders</td>
<td></td>
<td>• Lack of legislation or voluntary agreement of food supplement</td>
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<td>• Iron fortification of staple</td>
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<tr>
<th>Social Protection</th>
<th>Agriculture</th>
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<tr>
<td>• Target nutritionally vulnerable populations</td>
<td>• Incorporate explicit nutrition objectives and indicators</td>
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<td>• Increase incomes through earnings or transfers</td>
<td>• Assess the context at the local level</td>
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<td>• Promote access and delivery of services</td>
<td>• Target the vulnerable and improve equity</td>
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<td>• Enable households to withstand shocks with greater resilience</td>
<td>• Collaborate with other sectors and programmes</td>
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<td></td>
<td>• Maintain or improve the natural resource base</td>
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<td></td>
<td>• Empower women</td>
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<td>• Facilitate production diversification, and increase production of nutrient-dense crops and small-scale livestock</td>
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<td>• Improve processing, storage, and preservation</td>
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<td>• Expand market access for vulnerable groups</td>
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<td></td>
<td>• Incorporate nutrition promotion and education that builds on existing local knowledge, attitudes, and practices</td>
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<td><strong>Agriculture is the main livelihood for the majority of nutritionally vulnerable people</strong></td>
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<td>• 75 percent of the world’s poor are rural</td>
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<td>• Most of the poor are farmers</td>
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<td>• Trade issues dominate the agenda</td>
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<td>• Not a government funding priority</td>
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<td>• Lack of understanding between the upstream determinants and downstream food issues</td>
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</tbody>
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**Case Studies for Improving Nutrition Outcomes**

Some examples of nutrition-specific and nutrition-sensitive approaches to improving nutrition outcomes from around the world are listed below.

• J. Levinson, Y. Balarajan, and A. Marini. 2013. Addressing Malnutrition Multisectorally: What Have We Learned from Recent International Experience?
• World Bank. 2012. How to Protect and Promote the Nutrition of Mothers and Children: Case Studies in Latin America and the Caribbean. (PDF)
Improving the health of whole populations through action across sectors is at the heart of goals set by the World Bank Group to eradicate extreme poverty and to promote shared prosperity by fostering the income growth of the 40% poorest in every country. The Bank’s 2007 HNP Strategy called for the need to leverage investments and actions in other sectors as an imperative given the shifts in the global landscape (rapid urbanization, rise in non-communicable diseases as the leading cause of death in almost every region, worrisome trends in road traffic injuries, pandemic threats, climate change to name a few), which heighten the importance of coordination between multiple sectors. The KP Building Healthy Societies: Influencing Multisectoral action for health addresses a demand from HNP staff and management and is the first of a series aimed at inducing a paradigm shift that place the responsibility for delivering health outcomes across multiple sectors. The audience for this KP includes not only World Bank task teams but also country policy makers and stakeholders.

The objective is to equip task teams with the tools and best practices to engage more effectively across sectors to improve health outcomes. The main products of the KP are (i) the development of the Multisectoral Opportunity and Constraints Assessment Tool (MOCAT) and (ii) four high level case studies

This first volume provides an overview of the KP and focuses on the description of the MOCAT, its possible uses and the process of developing and testing it in two states of India. It also offers some thoughts and recommendations for its refinement going forward.

ABOUT THIS SERIES:

This series is produced by the Health, Nutrition, and Population Global Practice of the World Bank. The papers in this series aim to provide a vehicle for publishing preliminary results on HNP topics to encourage discussion and debate. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, to its affiliated organizations or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account this provisional character. For free copies of papers in this series please contact the individual author/s whose name appears on the paper. Enquiries about the series and submissions should be made directly to the Editor Martin Lutalo (mlutalo@worldbank.org) or HNP Advisory Service (healthpop@worldbank.org, tel 202 473-2256).

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