BEYOND SECTORS: NEW METHODS FOR INCLUDING HEALTH IN THE SUSTAINABLE DEVELOPMENT GOALS (SDGS)

Over the past 15 years, there has been important progress in the area of health in Europe and central Asia, thanks to advances in a diverse range of areas, from maternal health to the prevention of sexually transmitted infections (STIs). However, inequalities persist between and within countries (1). Achieving sustainable human development and leaving no one behind will require more than just strong health systems – it will also entail creating stronger systems for achieving health outcomes. For instance, universal health coverage – desirable as it is – will not in itself ensure healthy lives and promote well-being for all generations. Instead, we need decisive action on a much broader front (2). The emphasis should be on tackling the social, economic and environmental determinants (SEEDs) of health and the various dimensions of inequity through policies, programmes and approaches that cut across sectors. In short, health in all policies means health in all SDGs (3).

Health equity in the 2030 Agenda for Sustainable Development

The implementation of the 2030 Agenda for Sustainable Development began this year. Having committed to expand people’s capabilities and opportunities while balancing the social, economic and environmental dimensions of sustainable development, the agenda acknowledges that the 17 SDGs, with their deeply interconnected 169 targets, require integrated approaches (4), greater inter-agency work and collaboration across sectors.

For instance, while SDG 10 focuses on reducing inequality within and across countries, SDG 3 focuses on ensuring healthy lives and promoting well-being for all generations. However, in order to achieve both of these goals, health and inequality need to be tackled across a range of different actions that support all goals.

SEEDs of health and health equity

SEEDs of health and health inequity tend to intersect and magnify one other, furthering an unequal distribution of health among population groups (5, 6). In central and eastern Europe, for example, Roma communities experience unfair and avoidable inequities, have less access to healthcare and are disproportionately exposed to the SEEDs of health. They typically have limited access to education and thus achieve lower levels of formal employment and income, while having poorer nutrition (7) and living in sub-standard housing conditions. Health inequities can span entire lives and are even perceptible between Roma and non-Roma communities that live side-by-side*. Roma across all age groups report more chronic illnesses (including asthma, chronic bronchitis, chronic obstructive pulmonary disease or emphysema; hypertension, rheumatism, arthritis; chronic anxiety or depression; and diabetes) than non-Roma people, and have less access to sexual and reproductive health (SRH) services, including family planning, contraception and maternal healthcare services. As a consequence, Roma women have higher fertility rates and rates of teenage and unwanted pregnancies, often resulting in unsafe abortions and STIs, putting them at higher risk of complications during pregnancy than the general population (8).

While ethnicity is a key dimension of inequity, lifelong inequities linked with gender and educational attainment intersect and reinforce each other. Ethnic inequities in self-reported long-standing illnesses increase with age, reaching 70% among Roma people aged 65 and over, compared with 56% among non-Roma in the same age group. Further, among both Roma and non-Roma communities, long-standing illnesses are more frequent among women than men. There are even disparities among Roma communities themselves. For instance, only 15% of the Roma with secondary level education report chronic disorders, compared to 32% of Roma people without any formal education (9).

SRH and Agenda 2030

Agenda 2030 acknowledges health and well-being as outcomes, determinants and enablers of the SDGs (10). As such, the SDG framework provides new momentum for the implementation of Health 2020 across WHO Member States in the European Region (10). There is a close correspondence between recent solutions identified for improving SRH (1) and the new paradigms for Health 2020 in the WHO European Region. As we implement the SDGs, collaboration across different sectors will be critical to improve health and SRH, through increasing commitments, focus and investments.

Collaboration across agencies and sectors

Leadership and participatory governance for health

Governments and especially health ministries are important players in leading and managing governance for health. They set norms, provide evidence and “make the healthier choice the easier choice.” Governance for health must be guided by a framework that includes health as a human right, as a global public good, as a component of human well-being and as a matter of social justice (11).

Implementing the new European Action plan for SRH will therefore require the cooperation of many national and international partners under the leadership of the health ministries (1). By the same token, governments and international agencies should promote inter-sectoral and inter-agency action to achieve more ambitious outcomes in the realm of health and well-being.

More focus through partnerships

Join action across the whole of government and the whole of society must be supported by structures and mechanisms that make it easier to collaborate (11). To that end, the WHO in Europe should seek to better support Member States by strengthening collaboration and coherence among relevant United Nations (UN) agencies at national and regional levels (1).

In Europe and central Asia, the Joint Framework for Action signed by WHO, UNICEF and UNFPA under the auspices
of the Regional UN Development Group (12); the Issue-based Coalition on Health, which reports to the Regional Coordination Mechanism of the UN Regional Directors; and the UNAIDS Division of Labour provide sound platforms for knowledge exchange, as well as structures and mechanisms that enable collaboration to ensure healthy lives, promote well-being for all at all ages and improve SRH.

Aligning national development and health priorities can enable investment
Aligning development and health policy in a “one country, one health” development approach can help create policies that lead to coaction. Opportunities for forging alliances reside in non-health sectors or outside government (11).

Capitalizing on both its partnerships with multiple sectors and its access to the Cabinet of Ministers, UNDP is uniquely positioned to facilitate the “one country, one health” development approach in collaboration with WHO. The UN Resident Coordinator function brings together all UN agencies to advocate for UN system-wide mandates and interests, improve operational efficiency and effectiveness and promote more transformative and strategic support for national plans and priorities (13).

UNDP’s service offering
Pioneering the systematic integration of SEEDs of health and health equity into its development programming, UNDP has been working with WHO and the Institute of Health Equity at University College London (UCL) on a new screening tool for development practitioners, designed to identify, conceptualize and strengthen potential and existing co-benefits for health and development. UNDP’s methodology can now be applied to map multiple health and development benefits from investing in SRH (14).

By accelerating commitments, increasing focus and stimulating investments for health, collaboration across sectors on SEEDs of health and equity is playing a major role in ensuring healthy lives and well-being for all and in improving SRH in the WHO European Region. As we move forward with the SDGs, collaboration across sectors is critical to improve health outcomes, ensure proper health financing and build stronger systems and institutional arrangements for health. Such an approach encourages us to “do more, do better and leave no one behind.”

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* The UNDP/WB/EC survey was conducted in May-July 2011 on a random sample of Roma and non-Roma households living in areas with higher density of Roma populations in the EU Member States of Bulgaria, Czech Republic, Hungary, Romania, Slovakia and the non-EU Member States of Albania, Bosnia and Herzegovina, Croatia, FYR of Macedonia, Montenegro, Republic of Moldova and Serbia. In each of the countries, approximately 750 Roma households and approximately 350 non-Roma households living in proximity were interviewed.

References


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