Ensure Healthy Lives and Well-Being for All:

UCL Institute of Health Equity

UNDP

Empowered lives. Resilient nations.

Addressing Social, Economic and Environmental Determinants of Health and the Health Divide in the Context of Sustainable Human Development

Analysis of the Project Portfolio of the UNDP Regional Bureau for Europe and the Commonwealth of Independent States

Ensure Healthy Lives and Well-Being for All: Addressing Social, Economic and Environmental Determinants of Health and the Health Divide in the Context of Sustainable Human Development

Analysis of the Project Portfolio of the UNDP Regional Bureau for Europe and the Commonwealth of Independent States

All rights reserved ©2014 UNDP
July 2014

Authors:
Ruth Bell, Laura Grobicki, Christoph Hamelmann

Contact: r.bell@ucl.ac.uk; christoph.hamelmann@undp.org

Disclaimer: The content, analysis, opinions and policy recommendations contained in this publication do not necessarily reflect the views of the United Nations Development Programme.

Design and layout by Phoenix Design Aid A/S, Denmark.
ISO 14001/ISO 9000 certified and approved CO2 neutral company –
www.phoenixdesignaid.com

Table of Contents

Forewords **7**

Executive Summary **9**

PART A: INTRODUCTION AND RATIONALE **12**

1. Introduction **12**
2. Rationale for the Project **13**
2.1 Responding to challenges and opportunities for a multi-sectoral approach to health 13
2.2 The post-2015 development agenda and Rio +20 13
2.3 UNDP's corporate strategies and SEEDs of health and health equity 15
2.4 Communicable and noncommunicable diseases (NCDs) and development 16
2.5 Health 2020 16
2.6 Assessing SEEDs of health and health equity in a development context 17

PART B: METHODOLOGY **18**

1. Learning from Existing Methodologies for Health Equity Impact Assessment **18**
2. Expert Review Group **20**
3. Selection Criteria of Projects **21**
4. Analysis Tools **24**
4.1 Key project details and summary 24
4.2 Analysis summary 24
4.3 Analysis framework 24
4.4 Analysis tool validation 27
4.5 Strengths and limitations of the tool 28

5. Stakeholder Interviews **29**
5.1 Background information 29
5.2 Purpose of the stakeholder interviews 29

PART C: KEY FINDINGS **30**

Section A: Tool Analysis **30**

1. Health Aspects **30**
2. Equity Aspects **36**
3. Monitoring and Evaluation **39**
4. Sustainability **42**

Section B: Key Informant Interviews **43**

1. Health Aspects **43**
2. Equity Aspects **53**
3. Integrating the SEEDs of Health and Health Inequity Approach into Development Projects **55**
4. Capacity Building **56**
5. Validation of the Analysis Tool **56**

PART D: LESSONS LEARNED 57

1. **Untapped Opportunities** 57
2. **Equity** 57
3. **Monitoring** 58
4. **Multi-Agency Implementation** 58
5. **Capacity Building** 58
6. **Tool** 59
7. **Synergies and Cross-Fertilization** 59

PART E: RECOMMENDATIONS 60

ANNEX TABLES and FIGURES 62

REFERENCES 69

Abbreviations

CD	Capacity Development
CPR	Crisis Prevention and Recovery
CSDH	Commission on Social Determinants of Health
DG	Democratic Governance
E&E	Energie and Environment
ECOSOC	Economic and Social Council (United Nations)
ESSP	Environmental and Social Screening Procedure
GHG	Greenhouse Gas
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
H/HE	Health and Health Equity
HEIA	Health Equity Impact Assessment
HHD	HIV, Health and Development
HIA	Health Impact Assessment
HIV	Human Immunodeficiency Virus
IHE	Institute of Health Equity
MDGs	Millennium Development Goals
MSM	Men who have sex with men
NCDs	Noncommunicable diseases
NGOs	Non Governmental Organisations
PR	Poverty Reduction
RBEC	Regional Bureau for Europe and the Commonwealth of Independent States
SDH	Social Determinants of Health
SEEDs	Social, economic and environmental determinants
TB	Tuberculosis
UCL	University College London
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organisation

Acknowledgements

Ruth Bell, Laura Grobicki (UCL Institute of Health Equity, London) and Christoph Hamelmann (UNDP RBEC) were lead authors of this report.

Christoph Hamelmann and John Macauley with support from Helena Hedencova (all UNDP RBEC) initiated and facilitated the project.

Ruth Bell, Ellen Bloomer, and Laura Grobicki (UCL Institute of Health Equity) and Helen Buttivant (Health Education England - Wessex) devised the methodology and carried out analyses of the project documents.

Jorgen Engmann made the ACCESS database, and generated tables and figures.

Ruth Bell and Laura Grobicki conducted the interviews with UNDP project managers.

We would like to thank all participating UNDP country offices and practices of RBEC. We are grateful to all UNDP RBEC staff who facilitated the project by providing project documents, and to UNDP RBEC staff who participated in the interviews about their project.

We are grateful to our peer review panel: Kristine Blokhus, Special Assistant to the Director, Regional Bureau for Europe and CIS, UNDP; Gina Lucarelli, Post 2015 team, Europe and Central Asia Coordination Lead, UNDP; Sonia Roschnik, Operational Director NHS Sustainable Development Unit, Cambridge, UK; Chris Brown, WHO Europe Office for Investment for Health and Development, Venice; Peter Goldblatt, Deputy Director, UCL Institute of Health Equity, London; Michael Marmot, Director, UCL Institute of Health Equity, London.

We would like to thank Douglas Webb, Cluster Leader: Mainstreaming, Gender and MDGs, HIV, Health and Development Group, UNDP for insightful comments on a draft of this report.

Foreword

'The challenge is to re-think development', as the UNDP Strategic Plan 2014 – 2017 states. The authors of this report have accepted this challenge and demonstrate that re-thinking what we do as development practitioners, stepping aside from our routines and allowing ourselves a moment of self-reflection can deepen our understanding of complex development problems and open new opportunities to increase our impact.

Addressing social, economic and environmental inequities and imbalances that threaten our societies and our living conditions on the planet, striving for good governance, peace and security, and accepting intergenerational responsibilities – we know this well as development practitioners in our continuous quest for sustainable human development solutions.

Doing this in the right way and taking a life-course approach on board – and we will improve health and health equity; this is what health practitioners know since the Global Commission on Social Determinants of Health, established by WHO and chaired by Professor Michael Marmot.

By looking into the realities of UNDP's work on the ground, the report shows us how closely interlinked the work on health and development is, to what degree we as development practitioners are aware about it, and suggests how a more conscious strategy to optimize the impact on health and health equity through our development work could become the blueprint for UNDP for its contributions to a multi-sectoral, rights-based approach to health and human well-being.

Cihan Sultanoglu
Assistant Administrator and Director of the Regional Bureau
for Europe and the Commonwealth of Independent States (RBEC)

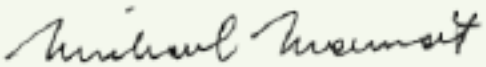
Foreword

In the intervening years since the Commission on Social Determinants of Health (CSDH), which I chaired, I have been telling audiences, globally, about the evidence on the social determinants of health and calling for action to reduce health inequities. A typical reaction is: 'This is all very interesting but how do we make it practical?'

Much has happened. The Regional Director of the WHO in the European Region asked me to develop the findings of the CSDH in a form that can be applied in the variety of contexts that characterise the great diversity of countries in the European Region of WHO.

At a meeting of senior UNDP staff in Jan 2013 in Zagreb, Croatia. I struck a chord when I said 'what you do in your day job impacts on health and health inequities'. This led to the initiative to do the study reported here – to investigate how UNDP's programmes and projects potentially impact on social, economic and environmental determinants of health and health equity.

I welcome this report as a bridge between the often parallel practices of health and development. It highlights the potential synergies that can be created by applying knowledge on the social, economic and environmental determinants of health and health inequity in development planning. As such, the work provides a timely stimulus for UNDP, in view of UNDP's commitment to contribute to a multisectoral, equity oriented approach to health in the context of sustainable human development.



Michael Marmot
Director UCL Institute of Health Equity

Executive Summary

Social, economic and environmental factors are embedded in development practice as the three interlinking pillars of sustainable human development. They also, to a large extent, determine population health and the distribution of health. In order to maximise potential co-benefits for both health and development, and to prioritise areas for action, it is necessary to take specific steps to integrate health and development. This project provides key insights into how this can be achieved.

This project, initiated by UNDP Regional Bureau for Europe and the Commonwealth of Independent States (RBEC) in 2013, is a systematic analysis of whether, how and in which ways UNDP's development projects address social, economic and environmental determinants (SEEDs) of health and health equity (H/HE).

The initiative responds to challenges increasingly made evident through research and practical evaluation across the health, social, economic and environmental domains, including entrenched social and economic inequities, differential exposure and vulnerability to climate change risks and environmental degradation, and persistent or widening health inequities in the region. The project represents a first step in the development of a methodology to systematically integrate the SEEDS of H/HE approach into development policies and programmes—with the aim of optimising synergies between development and health—and in providing a practical approach for UNDP to fulfil its mandate and responsibilities for multi-sectoral strategies for health—thereby realizing co-benefits for sustainable human development.

50 projects were reviewed overall on the basis of agreed selection criteria. Projects were selected from 20 countries with UNDP representation in the region, and from each of UNDP's practice domains (Democratic Governance; Poverty Reduction; Energy and Environment; HIV, Health and Development; Crisis Prevention and Recovery; Knowledge, Innovation and Capacity Development; Partnerships; and Gender).

The methodology developed for the project included 1) a desk based review of project documents against a checklist of SEEDs, and a checklist of dimensions of inequity; and 2) semi-structured interviews with project managers.

Main findings and implications

Key Finding 1: SEEDs of health and health equity were identified in all of the projects analysed.

Strategic implication of Key Finding 1: UNDP's development projects in all practices potentially impact health and/or the distribution of health.

Key Finding 2: Project analyses observed that the potential impact on health had not been noted in the project documentation for 76% of SEEDs identified.

Strategic implication of Key Finding 2: The potential impact of UNDP's development projects on health and health equity is broadly underrecognised across projects, other than HIV, Health and Development (HHD) practice projects.

Key Finding 3: SEEDs identified in the analysis act variously at different levels of social organization (individual, community, regional, national, transnational – i.e. across countries).

Strategic implication of Key Finding 3: UNDP's development projects provide the opportunity to create an enabling environment for action to improve health and the distribution of health at different levels of social organization.

Key Finding 4: The majority of UNDP's development projects had an implementation strategy that was universal (i.e. impacts across the whole of society) or universal and targeted (i.e. contains elements that impact across the whole of society and has targeted activities). Fewer projects had a solely targeted approach, and none was universally proportionate (i.e. impacts across society proportionate to needs).

Strategic implication of Key Finding 4: Implementation strategies that are universal imply that they impact across the whole of society, while targeted strategies are implemented amongst a particular social group identified as having particular needs, risks and risk exposures. Often, UNDP projects have both universal and targeted elements, which is a strength if the focus is on specific high-risk groups. Such approaches do not necessarily act across the whole of the social gradient (i.e. they are not universal and proportionate to need across society), a key element of the social determinants of health (SDH) approach.

Key Finding 5: For most SEEDs, the project analyses identified a primary disadvantaged target group (dimension of inequity). The primary dimensions of inequity most frequently identified for SEEDs were place of residence (namely rural), marginalised groups and gender. The analysis also identified secondary dimensions of inequity (i.e. dimensions of inequity relating to groups that were mentioned in the project documents as being targeted but were not the primary target group), the most frequent being gender (specifically female).

Strategic implication of Key Finding 5: Taking an equity focus has been identified as essential in supporting inclusive development, so it is not surprising that UNDP's development projects target disadvantaged groups. While a recurrent focus on rural settings was found in this analysis, as countries undergo economic and social development, it will also be important to assess factors associated with migration to urban areas and the needs of urban populations.

Key Finding 6: Only 17% of all SEEDs identified by the analysis were measured by indicators disaggregated by dimensions of inequity.

Strategic implication of Key Finding 6: There is scope for further disaggregation of indicators by relevant dimensions of inequity in order to monitor progress towards the development of inclusive and just societies.

Key Finding 7: 85% of the SEEDs were measured by an indicator, but only 13% were measured by a combination of input, output and outcome indicators. For some projects, both the SEEDs and the health outcome were measured by indicators.

Strategic implication of Key Finding 7: Input, output and outcome indicators are all important in monitoring what is being put in place, the effects of these inputs and the intended outcomes that are achieved. Where SEEDs are identified in the project development phase it may be possible, where appropriate, to monitor all three types of indicators. It is not possible to be prescriptive about which indicators should be included; indicators should be developed in discussion with project partners and aligned to UNDP's strategic plan, and are subject also to the level of available funding, and the requirements of the relevant funding organizations. However, the choice of indicators should include measures of SEEDs of H/HE, considered by project partners to be important and achievable focusing on co-benefits for development and health. A practical system to monitor and evaluate progress on these key indicators is required.

Key Finding 8: Capacity building is an integral part of the projects analysed.

Strategic implication of Key Finding 8: Capacity building is a major strength of UNDP's development practice. It is carried out at all levels of governance and among all sectoral stakeholders. This supports sustainability of development processes. It may also present potential platforms to introduce dialogue and/or trainings on SEEDs of H/HE within partner countries.

Key Finding 9: Many of the projects analysed aimed to address structural determinants of health.

Strategic implication of Key Finding 9: Tackling structural determinants that shape differential vulnerabilities and exposures will have a long-term impact on H/HE outcomes.

Key Finding 10: Every project involved multi-sectoral implementation.

Strategic implication of Key Finding 10: This gives UNDP tremendous strength in addressing development issues in a holistic way, and underlines the immense opportunities for UNDP to fulfil its health and development mandates and responsibilities through the integration of SEEDs of H/HE into all its development projects and into national multi-sectoral development planning as a joint effort of UN country teams.

Overall conclusion:

We found broad support among interviewed stakeholders within UNDP for enabling the realisation of co-benefits of development projects for health.

In wider discussions with health and development stakeholders within and outside the UN system, we found a high level of interest and support for RBEC's pioneering steps to translate a multi-sectoral whole-of-government strategy on H/HE into effective and efficient development programming.

Bearing in mind the growing recognition globally and within countries of the need for a multi-sectoral and equity focus in health, the time is right for integrating the SEEDs of H/HE approach into existing development programmes, projects and processes. UNDP can lead by example. The United Nations Development Assistance Frameworks (UNDAF) and the formulation of the post-2015 development agenda, which will ultimately guide future social, economic and environmental development, provide excellent opportunities to integrate a holistic, multi-sectoral approach to health into concepts, strategies and action towards sustainable human development and the realisation of the right to the highest attainable standard of health.

Recommendations:

Next steps in integrating health into development programming for UNDP and development partners:

i. Fully integrate SEEDs of H/HE into UNDP programming under UNDP's Strategic Plan 2014-17 and Regional Programme Documents;
ii. Integrate health aspects into project design, monitoring and evaluation from the start in order to maximise co-benefits for health. This will require mechanisms to systematically identify potential impacts of development projects/programmes on a) SEEDs of health, b) social, economic and environmental inequities, and c) health and the distribution of health, by developing a standard methodology for project approval and implementation processes;
iii. Monitor implementation of a systematic approach to addressing SEEDs of H/HE in future UNDP project portfolios;
iv. Support capacity development for integrating SEEDs of health approaches in the context of development;
v. Work with partners in countries to include the SEEDs of H/HE framework in the discourse on the right to health, the national development plans, the UNDAF and the post-2015 sustainable human development agenda.

A. Introduction and Rationale

1. Introduction

Social, economic and environmental factors are embedded in development practice as the three interlinking pillars of sustainable human development. They also, to a large extent, determine population health and the distribution of health. Yet, there is a common perception that health is the responsibility of individuals, and the realm solely of the healthcare sector. Overturning this misconception, the WHO Commission on Social Determinants of Health(1) (CSDH) concluded that health inequities (that is: systematic differences in health between groups that are avoidable by reasonable means) are caused by inequalities in conditions in which people are born, grow, live, work and age and the inequities in money, power and resources that create these unequal conditions. It is increasingly understood that while universal health coverage (UHC) is essential, the healthcare sector acting alone cannot address the social determinants of health (SDH). It is also apparent that while individuals are responsible for making decisions that impact their health, those decisions are constrained by the political, social, economic, environmental and cultural conditions in which they live.

The CSDH used the term 'social determinants of health,' to include political, social, economic, environmental and cultural factors that shape health. Social, economic, and environmental determinants (SEEDs) have an impact on the burden of communicable and non-communicable diseases (NCDs), play a critical role in the efforts to achieve the Millennium Development Goals (MDGs) and are playing an increasingly dominant role in the post-2015 global debate on development and health (see Box 1).

Development and health are inextricably linked. To improve health and the distribution of health, it is necessary to address social, economic, and environmental factors that constitute SDH. Doing this is core business for sustainable human development. Yet, despite the demonstrable causal chain between social, economic and environmental conditions within the development domain and health, health is often not among the main considerations, or even given any consideration, in development projects, with the notable exception of health-specific projects, or as part of institutionalised environmental and social impact assessments.

The United Nations Development Programme (UNDP), as the development agency of the UN, takes a manifestly multi-sectoral approach to development. Therefore, what it does through its development programmes and projects acts directly or indirectly on SEEDs of health. In order to achieve specific health and development aims in a particular context, and to avoid adverse consequences, it is necessary to take into account how policies, programmes and interventions outside the health sector impact directly or indirectly on the health of the groups affected, and on the distribution of health.

This project was initiated by UNDP Regional Bureau for Europe and the Commonwealth of Independent States (RBEC) in 2013 to review how and in which ways its current development portfolio of projects acts directly or indirectly on SEEDs of health and health equity (H/HE), in the context of global discussions about SDH, UHC, and health in the post-2015 sustainable human development agenda. While the project was initiated by the HIV, Health and

Development (HHD) Practice, it reached out to engage all UNDP's thematic practices across 20 countries: Democratic Governance; Poverty Reduction; Energy and Environment, HIV, Health and Development; Crisis Prevention and Recovery; Knowledge, Innovation and Capacity Development; Partnerships; and Gender. Cross-practice and country office support enabled this project to achieve the first systematic analysis of the potential impact of UNDP's programmes and projects on H/HEs in any region of the world.

2. Rationale for the project

2.1 Responding to challenges and opportunities for a multi-sectoral approach to health

The initiative to set up this project was guided by the desire of UNDP RBEC to address expectations, mandates and responsibilities related to its role of advocating and facilitating a multi-sectoral whole-of-government and whole-of-society approach to H/HE in the context of sustainable human development. It responded to challenges increasingly made evident through research and practical evaluation across the health, social, economic and environmental domains, including entrenched social and economic inequities, differential exposure and vulnerability to climate change risks and environmental degradation, and persistent or widening health inequities in the region (1-5). Addressing these challenges requires action across multiple sectors, supported by good governance (6), rule of law, and the promotion of fundamental freedoms and human rights—all of which are embedded in UNDP's Strategic Plan 2014-2017 (7).

At the same time, the initiative to set up the project responded to opportunities made explicit in regional and global processes as summarized in the following sub-sections.

2.2 The post-2015 development agenda and Rio +20

Health is at the centre of sustainable human development: social, environmental and economic development impacts H/HE, and health impacts sustainable human development. Therefore, it is critical to reflect health not only in the focus area on health of the post-2015 development agenda, but also in all the other focus areas under consideration in the post-2015 process. All future development practice in the post-2015 era will be guided by what emerges from the post-2015 process. This project explores how H/HE is reflected, monitored and evaluated in actual development practice, and shares findings and recommendations which can feed into the debate about the positioning of health in the post-2015 agenda.

There is a consensus that the development agenda will be universally inclusive, and no longer include only developing countries, and that the new goals will be comprehensive and holistic, aiming to address all the challenges of human sustainable development. The new set of goals will build on the MDGs and will be consistent with existing UN resolutions, declarations and conventions. These include the World Health Assembly (WHA) 2009 Resolution on reducing health inequities through action on the SDH(8), the Rio Political Declaration on Social Determinants of Health in October 2011(9) endorsed by the 65th WHA resolution in 2012 (10), the UN Resolution on Global Health and Foreign Policy in December 2012 (11), and the political declaration following the UN High-Level Meeting on the Prevention and Control of Noncommunicable Diseases (NCDs) (12). Most recently, the WHA 2014 has adopted a resolution on contributing to social and economic development: sustainable action across sectors to improve H/HE (13). All of these resolutions and declarations highlight the importance of social, economic and environmental impacts on health and the distribution of health.

This project is relevant to the post-2015 development phase, which will be cross-sectoral in nature in order to address all the challenges of human sustainable development. Specific and practical connections between economic, social and environmental development and health, particularly health equity, need to be made explicit in order for health gains to be realised for all. Making the connection between

Box 1: 'The Future We Want' – the Post-2015 development agenda and Rio +20

Among the first steps in the process of building the global post-2015 development agenda was the creation of the UN System Task Team on the Post-2015 UN Development Agenda[1] in January 2012 by the UN Secretary General. Its mandate is to coordinate system-wide preparations for the post-2015 development framework in consultation with all stakeholders. The UN Task Team 's first report, '*Realizing the Future We Want for All*' (14) was widely disseminated in preparation for the UN Rio+20 Conference on Sustainable Development held in June 2012 (15).

One of the main outcomes of the Rio +20 conference was the creation of an Open Working Group (OWG) on Sustainable Development Goals (16). The outcome document of the Rio+20 discussions was integrated into the UN General Assembly Resolution 2012, entitled '*The Future We Want*', agreed upon by Heads of State and Government and high-level representatives, who affirmed their commitment to '*sustainable development and to ensuring the promotion of an economically, socially and environmentally sustainable future for our planet and for present and future generations*' (17).

At the UN General Assembly Special Event on MDGs in September 2013, world leaders initiated a process of intergovernmental negotiations to culminate in a high-level summit in September 2015 to adopt a new set of Goals, building on the MDGs and responding to new challenges. The intergovernmental process will include '*inputs from all stakeholders including civil society, scientific and knowledge institutions, parliaments, local authorities, and the private sector*' (18).

By July 2014, the OWG presented an outcome document proposing 17 Sustainable Development Goals to be achieved by 2030, each of them representing one focus area considered relevant to the future development agenda. Although only one of them specifically focuses on health, all other goals and most of their respective indicators are addressing determinants of health and inequities, underlining the importance of maximising the impact on health as a central theme of sustainable human development (19).

The Secretary General will synthesize the full range of inputs in a report that will be available before the end of 2014. In September 2015, heads of state will meet at the UN General Assembly in New York to adopt the new final set of goals.

development projects across multiple sectors and health is the core motivation behind this project.

2.3 UNDP's corporate strategies and SEEDs of health and health equity

Within UNDP's internal processes, the initiative by UNDP RBEC to set up the present project on SEEDs of H/HE links directly with the multi-sectoral approaches to development embedded within the new UNDP Strategic Plan 2014-2017 and the new RBEC Regional Programme Document 2014-2017. In particular, the initiative connects with UNDP's strategic vision of poverty eradication and simultaneous significant

1 The UN System Task Team on the Post-2015 UN Development Agenda is co-chaired by the UN Department of Economic and Social Affairs and UNDP

reduction of inequality and exclusion, and with its highest level of goals and key outcomes (20) (Figure 1).

The regional programme for RBEC in the period 2014-2017 (21) seeks to contribute to four development outcomes:

- '*Growth and development are inclusive and sustainable, incorporating productive capacities that create employment and livelihoods for the poor and excluded.*'
- '*Citizen expectations for voice, development, the rule of law and accountability are met by stronger systems of democratic governance.*'
- '*Countries are able to reduce the likelihood of conflict and lower the risk of natural disasters, including from climate change.*'
- '*Development debates and actions at all levels prioritize poverty, inequality and exclusion, consistent with our engagement principles.*'

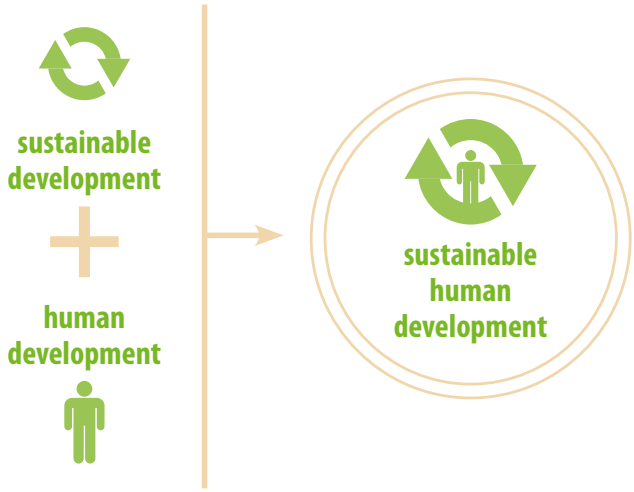
These outcomes, framed in the development context, are fully consistent with the SEEDs of H/HE perspective and subsequent multi-sectoral action. Integrating the SEEDs of H/HE perspective into project appraisals and assessments can enable the realisation of potential multiple co-benefits across sectors.

2.4 Communicable and noncommunicable diseases (NCDs) and development

Communicable diseases have long been recognized as a challenge for development, and are embedded in the MDGs. UNDP, as joint UNAIDS co-sponsor, and also as the principal recipient for the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), is active in the control and prevention of these diseases under a defined division of labour among UN agencies. Demographic ageing and changing social and economic contexts contribute to changing epidemiological profiles in many countries. While the threat from communicable disease persists and infectious disease challenges re-emerge, the burden of NCDs, including mental health, is increasingly recognised as a development issue.

The UN General Assembly High Level Meeting on prevention and control of NCDs put a global spotlight on NCDs as an issue for development in 2011. The UN Political Declaration on NCDs, issued at the meeting, calls upon the WHO and '*all other relevant United Nations system agencies, funds and programmes, the international financial institutions, development banks and other key international organizations to work together in a coordinated manner to support national efforts to prevent and control noncommunicable diseases and mitigate their impacts' (18).*

Figure 1: UNDP Strategic Plan 2014-2017



The process of enlarging people's choices by expanding their capabilities and opportunities in ways that are sustainable from the economic, social and environmental standpoints, benefiting the present without compromising the future.

The UN Economic and Social Council (ECOSOC), in a resolution co-signed by 104 member states, requested the Secretary General to establish a UN Interagency Task Force on the Prevention and Control of NCDs (22). This was set up with 6 objectives:

- '*To raise the priority accorded to the prevention and control of NCDs in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy*';
- '*To strengthen national capacity, leadership, governance, multi-sectoral action and partnerships to accelerate country response for the prevention and control of NCDs*';
- '*To reduce modifiable risk factors for NCDs and underlying social determinants through creation of health-promoting environments*';
- '*To strengthen and orient health systems to address the prevention and control of NCDs and the underlying social determinants through people-centred primary healthcare and universal health coverage*';
- '*To promote and support national capacity for high-quality research and development for the prevention and control of NCDs*';
- '*To monitor the trends and determinants of NCDs and evaluate progress in their prevention and control (22).*'

Under the draft division of responsibilities, the key lead areas for UNDP include strengthening national capacity, leadership, governance, multi-sectoral action and partnerships to accelerate country response for the prevention and control of NCDs (23).

A discussion paper published by UNDP emphasises that addressing NCDs requires taking an SDH approach with multi-sectoral action (24). Addressing NCDs through multi-sectoral action on SEEDs of H/HE was a further theme that informed the initiation of this project, because of the potential relevance of the project's findings to the UNDP's mandated roles and obligations on NCDs, including those obligations relating to the Framework Convention on Tobacco Control.

2.5 Health 2020

Health 2020 is the new policy framework and strategy for health and wellbeing in the European Region, introduced by WHO Regional Office for the European Region in 2013 (25). It has two linked strategic objectives: improving health for all and reducing health inequalities, and improving leadership and participatory governance for health (25). Achieving these objectives requires taking action on the SEEDs of H/HE, and improving governance systems to enable the creation of partnerships for multi-sectoral action. This project is relevant in the context of the Health 2020 Strategy, because it aims to reveal whether, how and in which ways UNDP projects in the RBEC region impact on SEEDs of H/HE at national and municipal levels of governance.

Two reports, commissioned by the WHO Regional Office for the European Region, informed the development of Health 2020: Governance for Health in the 21st Century (26), and the Review of Social Determinants of Health and the Health Divide in the European Region (3).

The Review of Social Determinants of Health and the Health Divide in the European Region adapted the conceptual framework of the CSDH to the European context, and gathered new evidence to make specific recommendations for action by countries at all stages of development. This project is grounded in the same conceptual understanding about SDH elaborated by the CSDH, and the WHO Review of Social Determinants of Health and the Health Divide in the European Region (3).

2.6. Assessing SEEDs of health and health equity in a development context

This project is unique in that it is examining SEEDs of H/HE in development projects across countries in a region and across institutional practices. A web-based search carried out for this project did not find

any evidence that systematic assessments of projects from a health equity perspective have been carried out previously in the context of development programmes[2]. A systematic analysis of whether, how, and in which ways UNDP's development projects address SEEDs of H/HE has never previously been done. However, methodologies for Health Impact Assessments (HIA) and Health Equity Impact Assessments (HEIA) are well described in developed country contexts, including Australia, Canada, New Zealand, the United Kingdom and other European countries (see section 3.1). Variations in context across European countries have resulted in different forms of implementation and different dynamics of developing HIA in the region (27). Stephen Gunther has prepared a series of practical guides on how to analyse equity in the policy HIA process for the European Union (28).

While the present project is not an HIA or HEIA, because it did not attempt to apply to 50 projects the depth of analysis that would be possible to apply to a single intervention, and because it was carried out retrospectively on projects, the methodology for this project was developed based on learning from existing HEIA (section 3.1). The tool developed for this project can be described as a health equity screening tool.

2 Websites of the World Bank, WHO and UNICEF were searched using the search function, including the terms: 'health equity impact assessment' 'impact assessments' 'project documentation' 'equity impact assessments' 'health impact assessment'. A Google search was carried out with terms: 'health equity impact assessment development programme', 'health equity impact assessment tool', 'health equity impact assessment'

B. Methodology

1. Learning from existing methodologies for health equity impact assessment

The initial step in the project was to design a systematic methodology to identify SEEDs of H/HE from a desk review of the project documents made available by RBEC. The methodological design draws on a number of recent HEIA methodologies adapted to meet the aims and suit the context of this project. It is firmly grounded in the ecological model of health that emphasises the importance of social, economic, and physical environments on health across the life course, as articulated by the CSDH.

HIA is a management tool used to examine potential positive and negative impact of proposals, including policies, programmes or projects, on health. It is designed to be used before the proposal is initiated, in order to guide decisions on how the proposal can be implemented in such a way as to protect or enhance health (29).

A systematic review of HIA found two distinct theoretical underpinnings for HIAs depending on their origins (30). Early HIAs, based on Environmental Impact Assessments, tended to 1) focus on assessing projects and 2) use a biomedical model of health. More recently, HIAs were designed to 1) use on policy proposals and 2) apply an ecological model of health (30). A key component in HIAs is stakeholder or community participation. However, the extent of community participation is highly variable (30).

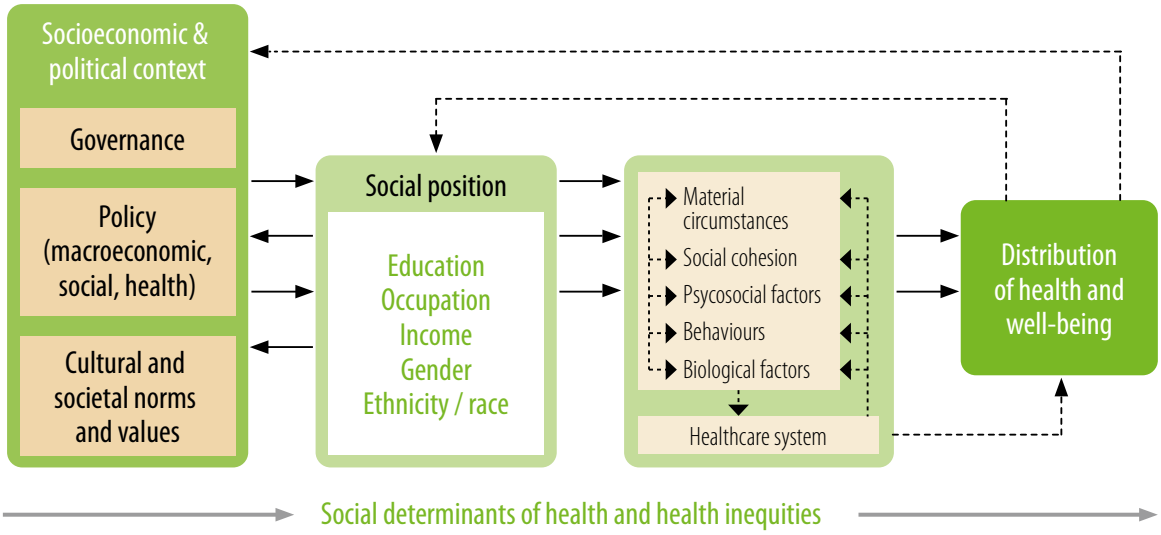
Harris-Roxas et al. (31) carried out a process evaluation of whether a rapid HEIA in Australia on a health promotion policy implementation plan—carried out over four days and drawing on an expert panel and limited review of the literature – made a difference to the decision making process, or whether policy makers would have made health recommendations anyway because they are common sense. The conclusion was that a rapid HIA process may provide a practical way of assessing the '*potential health equity impacts of proposed initiatives*' (31) that might not otherwise be considered in the decision making process.

A cross-country analysis of the institutionalization of HIA concluded that HIA are important methods to mainstream SDH and are increasingly being used to do so (32). The analysis looked at: Australia (South Australia), Canada (Quebec), Finland, Lithuania, the Netherlands, Slovakia, Switzerland, Thailand, the United States of America and the European Commission. WHO supports the use of HIAs to further prioritise health in the policy agenda, and, in particular, to address SDH (32).

HIAs can look at the potential distributional effects of proposals on different groups (i.e. they can have an equity focus). However, a study by the IMPACT group at the University of Liverpool concluded that the equity focus of existing HIA methodologies needs to be strengthened in order to address policy impacts on health equity (33).

Designated HEIA, with a specific focus on health equity, have been designed (34-37). Table 1 outlines the HIA and HEIA used to develop the tool used in this project.

Figure 2: Explaining the CSDH conceptual framework



Global and national economic and social policy, processes of governance at the global, national and local level, as well as biases, norms and values within society shape and are influenced by the magnitude and scale of inequity along social dimensions including education, occupation, income, gender and ethnicity/race.

Different exposures to disease-causing influences in early life, the social and physical environments and work are associated with social dimensions of inequity. Such different exposures create different experiences of material conditions, psychosocial support and different behavioural options, which make people more or less vulnerable to poor health. Social inequalities also cause different experiences of health promotion, disease prevention and treatment put in place by the health system.

The CSDH called for all national and international policies and programmes to be assessed with a specific equity focus in order to improve policy coherence on health equity through action on the social determinants of health.

Source: CSDH Final Report (1)

One example, the Gradient Evaluation Framework (36), describes a Gradient Equity Lens designed for policy makers to use. Grounded in the CSDH conceptual framework, the Gradient Evaluation Framework guides users through two stages (dimensions). Dimension one has a traffic light system applied to eight key areas: proportionate universalism, inter-sectoral tools for all, a whole systems approach, scale and intensity, life course approach, social and wider determinants, non-geographic boundaries and gradient friendly indicators. Dimension two guides the user through 6 steps: '*Describe the Policy and its Related Action, Engage Stakeholders, Focus Evaluation Design, Collect Relevant Data, Analyse, Interpret and Synthesise Data, and Disseminate and Feedback*'. The Gradient Evaluation Framework tool categorises social determinants under five broad headings: wider socio-economic factors, social and cultural factors, physical and social

Table 1: Source documents used in developing methodology

Authors	HIA or HEIA?	Main location	Key points
Mahoney et al. 2004 (35)	HEIA	Australia	Developed a strategic framework to assess the health inequalities of public health-related policies, plans, strategies, decisions, programs and services. Example of framework of HEIA.
Abrahams et al. 2004 (38)	European Policy HIA	EU	Study highlights the commission's aim of synthesising a generic methodology on HIA for use in EU policy development and then piloting, synthesising and amending the HIA.
Ontario, Ministry of Health, 2012 (34)	HEIA	Canada	HEIA tool
Public Health Advisory Committee NZ 2005 (39)	HIA	New Zealand	HEIA tool guide
Department of Health – Western Australia, 2010 (40)	Health risk assessment	Western Australia	Health risk assessment guide
International Finance Corporation, World Bank, 2009 (41)	HIA	non-specific, focus on LMICs	Provides general guidance on how to provide HIA and evaluate effect on a community from the effects of project development.
Howard and Gunther, 2012 (42)	Health equity	European Union	Two parts to report: 1) Literature review of 'Health in all policies' and the opportunities and barriers to introducing 'health in all policies' in countries of the EU. 2) Qualitative interviews of key stakeholders
Mendell et al, 2012 (37)	HEIA	Canada	This guide presents tools and approaches used specifically to reduce (or at least to not exacerbate) health inequalities.
Davies and Sherriff, 2012 (36)	HEIA	non-specific	Overview of the health gradient, user guide for the Gradient Evaluation Framework (GEF), interaction aspects of the tool. Includes assessment of proportional universalism, focus on the life course, and practical examples.

environment, population based services (access to, and quality of services) and individual and behavioural factors.

The methodology developed for this project shares some elements with HEIA, most notably in its application of a SEEDs checklist, and its analysis of dimensions of inequity. However, as pointed out in Part A, Section 2.6, the methodology used in this project is not an HEIA per se, because it was used to analyse projects across countries and across practices, rather than a proposed policy or single project. In addition, it was applied retrospectively (i.e. while projects were still in progress) rather than prospectively (i.e. before they were implemented). This was done with the aim of learning from the past in order to make informed recommendations about future steps to strengthen the connections between development practice and SDH.

2. Expert review group

A group of experts from both within and outside UNDP was consulted. The expert group included:

- Kristine Blokhus, Special Assistant to the Director, Regional Bureau for Europe and CIS, UNDP
- Gina Lucarelli, Post 2015 team, Europe and Central Asia Coordination Lead, UNDP
- Sonia Roschnik, Operational Director NHS Sustainable Development Unit, Cambridge, UK
- Chris Brown, WHO Europe Office for Investment for Health and Development, Venice
- Peter Goldblatt, Deputy Director, UCL Institute of Health Equity, London
- Michael Marmot, Director, UCL Institute of Health Equity, London

Before finalising the methodology, input on the methodological design was requested from members of the expert review panel in response to two questions: 1) Does it capture all the information you would like to see coming out of the study? 2) Are there any changes you would make to improve the methodology? The methodology was adjusted to take account of comments from the expert panel, where practicable.

Members of the expert review group were also invited to review the draft report, with respect to the following questions: 1) Is the rationale for the project clearly explained? 2) Is the methodology clearly explained? 3) Are the main findings clearly articulated and supported by evidence? 4) Are the strategic implications drawn out from the key findings appropriate? 5) Would you propose any clarifications or additions to any of the sections?

3. Selection criteria of projects

A total of 50 projects were selected out of the RBEC portfolio. At the request of UNDP, the following selection criteria were applied:

A. Large budget projects were prioritised (above US $ 10 million priority, then above US $ 2 million) within constituencies applied (see below).
B. Where certain practice domains (practices are listed under E below) had no projects with budgets over US $ 10 million/2 million, projects with the highest budget were selected within each practice domain. Out of the projects in 20 countries, we analysed 11% of the portfolio by budget.
C. Projects were screened by relevance of title (content criterion) and chosen if they appeared to be especially innovative, strong and interesting from a SEEDs of H/HE perspective, and link to driving forward the UNDP corporate strategy.
D. Availability of background documents: Project Document and Results and Resources Framework were the minimum criteria.
E. Constituencies:
    a. All countries of the RBEC portfolio shared project documents with the study team. Therefore, at least one project from each country was included.
    b. At least 5 regional projects were included in order to cover practice areas at the regional level.
    c. All thematic practices were included from across the RBEC portfolio: Democratic Governance; Poverty Reduction; Energy and Environment; HHD; Crisis Prevention and Recovery; Knowledge, Innovation and Capacity Development; and Gender.
    d. Projects that were still in the pipeline were generally excluded, except for particularly high value ones.
    e. GF projects were included with a selection across the projects addressing malaria, tuberculosis (TB) and HIV/AIDS.

The final selection of projects can be seen in Table 2. Two of the GF projects have not been recorded under the HHD practices. This is because all UNDP GF

projects are contracted on a country level, and some countries do not have a full HHD practice. As such, those countries utilise their discretion as to with which practices the GF projects are associated.

UNDP's largest projects often relate to 'heavy/hard' issues such as infrastructure. Smaller projects (in terms of $ value) typically deal with legislative and policy changes, capacity development, and institutional strengthening. There are exceptions to this, and often projects have a mixture of activities. It is possible that smaller projects may have a larger impact in terms of SEEDs than larger projects. Our study did not examine this possibility because the study was not an evaluation of actual impact, but a screening for potential or likely impact.

Table 2: List of selected projects

Practice	Country	Number	Project Title	Project Number
CD	Turkmenistan	18	Border Management BOMCA 8	79457
CD	RBEC	32	Capacity Development for Effective Public Institutions	63174
CPR	Azerbaijan	29	Further Strengthening and Expanding Mine Action Capacity in Azerbaijan	85205
CPR	Georgia	58	Human Security – IDPs Samegrelo	71389
CPR	RBEC	31	Implementation of Central Asia Regional Risk Assessment	84151
DG	Armenia	7	Modernization of Border Crossing Points	83816
DG	Azerbaijan	1	Capacity Building for the State Social Protection Fund	11285
DG	Georgia	21	UN Joint Programme to Enhance Gender	81311
DG	Kyrgyzstan	9	Operationalizing Good Governance	80308
DG	Moldova	5	Parliament of Moldova	71949
DG	Tajikistan	2	Border Management in Northern Afghanistan (BOMNAF)	77375
DG	Turkey	7	Mehmetcik	83916
DG	Turkmenistan	1	Global Fund Tuberculosis	75647
DG	Turkmenistan	2	National Capacities on Human Rights	62152
DG	Ukraine	5	Local Communities Capacity	79107
DG	Uzbekistan	5	Local Governance Support Project	74296
DG	RBEC	2	Local Environmental Governance Initiatives	78544
E&E	Belarus	20	Landscape Approach to Management of Peatlands Aiming at Multiple Ecological Benefits	82884
E&E	Croatia	20	Greening Coastal Development	50301
E&E	Cyprus	24	Upgrade of Local and Urban Infrastructure Phase 2	58605
E&E	Georgia	42	Flood Management	76540
E&E	Kazakhstan	8	Almaty Sustainable Transport	76355

Table 2: List of selected projects (cont.)

Practice	Country	Number	Project Title	Project Number
E&E	Kyrgyzstan	25	Land Management	71171
E&E	Moldova	31	Biomass: Heating System	77341
E&E	Montenegro	27	Spatial Planning Support	54791
E&E	Tajikistan	35	PIMS 4324: Technology Transfer and Market Development for Small-Hydropower in Tajikistan	77414
E&E	Ukraine	48	Dnipro Basin Programme	63430
E&E	RBEC	17	Climate Risk Management in CA	74378
E&E	RBEC	24	PIMS 3273 BD FP: Supporting Country Early Action on Protected Areas	56124
Gender	Armenia	5	Women in Local Democracy	81881
Gender	Montenegro	41	Gender Equality Programme	56612
Gender	Turkey	38	UNJP for Promoting the Human Rights of Women	84616
HHD	Bosnia & Herzegovina	32	HIV/AIDS Programme	76377
HHD	Kyrgyzstan	41	Reduction of HIV Infection Spread	79839
HHD	Tajikistan	40	Malaria Elimination in Tajikistan for 2009-2014	72827
HHD	Tajikistan	41	Tuberculosis Prevention and Control Program 2009-2011	72835
HHD	Uzbekistan	42	Continuing Scale Up of the Response to HIV in Uzbekistan	80864
PR	Albania	24	Vulnerable Local Communities	75040
PR	Belarus	25	Stop TB Strategy Phase I	76939
PR	Bosnia & Herzegovina	7	Youth Employability and Retention Programme (YERP)	62851
PR	Bosnia & Herzegovina	11	Srebrenica Regional Recovery	71025
PR	Croatia	9	People With Disabilities	53230
PR	Georgia	34	Support to Development of Agriculture in Ajara Autonomous Republic	84902
PR	FYR of Macedonia*	8	Promote Sustainable Employment	81921
PR	Moldova	18	Local Governance and Development	85492
PR	Turkey	22	Diyarbakır Batman Siirt Rural Development Project	57993
PR	Turkey	26	Sivas Erzincan Rural Development Project – Phase II	61749
PR	Uzbekistan	16	Support to Reform Process in Uzbekistan	45192
PR	RBEC	6	Aid for Trade: Economic development along trade corridors	77202
PR	Serbia	22	Local Development South Serbia	75685

*: FYR of Macedonia – Former Yugoslav Republic of Macedonia

4. Analysis Tool

A tool was designed to analyse the projects in the RBEC region to understand how and in which ways the projects address the SEEDs of H/HE. This tool was designed using an Access database for inputting data and data analysis. Specific components of the tool are described below:

- Key project details and summary
- Analysis summary
- Analysis framework
- Analysis tool validation
- Strengths and limitations of analysis tool

4.1. Key project details and summary

The tool component includes key aspects related to the project. These include:

- Project aims
- Project objectives
- Rationale for the project (including information about the intended beneficiaries)
- Degree of multi-sectoral implementation
- Documents used in the analysis
- The type of monitoring and reviewing processes that were utilised
- The degree to which capacity building was a main or subsidiary elements of the project
- Details of the project, including project budget and timeframe
- Implementation strategy of the project

The analysis assessed the implementation strategy based on the population likely to be impacted as one of the following: Proportionate universalism; universal; targeted; or universal and targeted.

This is based on an understanding of the strategic approaches required to tackle health inequities through action on the SDH (3). These strategic approaches respond to the challenge of the 'social gradient in health' identified by epidemiological studies. The social gradient in health refers to the distribution of health outcomes across society, i.e. that for many health outcomes, health is progressively better the higher the socioeconomic position of people and communities (3).

Proportionate universalism refers to strategies that act across the whole social gradient (i.e. they are universal) but they are implemented at a scale and intensity of action that is proportionate to need.

Universal implementation implies that the policy impacts across the whole of society (e.g. clean air legislation, use of energy efficient fuels).

Targeted strategies are implemented amongst a particular social group identified as having particular needs, risks and risk exposures.

Universal and targeted was selected when one part of the project's implementation strategy had the potential to benefit the whole of society, and another part of the project targeted a particular group/s at a specific site or sites.

4.2. Analysis summary

Key findings of the analysis were summarized using the following structure:

- The main SEED(s) identified
- The main dimensions of inequity and an analysis of the indicators
- Recommendations regarding potential changes to further support the project's impact on the SEEDs of H/HE

4.3. Analysis framework

For the analysis, we drew up a list of social, economic and environmental factors that, as evidence has shown, directly or indirectly impact on health outcomes (i.e. SEEDs). Table 3 shows the list of SEEDs of health used in the analysis.

Table 3: List of SEEDs of Health

Social	Environmental	Economic
Drug abuse	Food hygiene	Access to affordable housing
Early childhood development	Access to rural green spaces	Business development services
Excess alcohol consumption	Access to urban green spaces	Food security
Family composition	Energy efficiency	Fuel poverty
Food security	Flood defences	Income level / poverty
Lack of control over individual family planning	Food security	Income protection at the family level
Maternal health and wellbeing	Fresh water security	Job creation
Physical inactivity	Housing quality	Lifelong learning
Poor nutrition	Indoor air quality	Offender rehabilitation
Risky sexual behaviour	Industrial building quality	Investments in community development
Tobacco smoking	Information technology connectivity	Welfare policy for social protection
Treatment adherence	Land use	Child poverty
Community participation	Outdoor air quality	Economic accountability in governance
Cultural participation	Public building quality	Trade
Exposure to violence	Rural conservation	Wealth distribution / poverty reduction
Level of crime	Soil pollution	
Perception of safety	Public amenities	
Social cohesion	Urban planning	
Social isolation	Transportation infrastructure	
Social support/ community networks	Waste management	
Workplace safety	Water and sanitation	
Access to childcare	Biodiversity	
Access to education	Greenhouse gas emissions	
Access to healthcare		
Access to leisure services		
Access to social services		
Childhood education		
Child protection		
Effective policing		
Healthcare infrastructure		
Healthcare quality		
Job security (temporary / no contract)		
Psychosocial working conditions		
Social policy		
Conflict (armed)		
Discrimination / stigma		
Energy efficiency		
Exposure to hazardous substances (chemical, physical, radiation, pollution, pathogens, other)		
Human rights		
Participatory processes		
Post-conflict reconstructions		
Transparency and accountability in governance		

Note: SEEDs categorised as social, environmental and economic, in alphabetical order under secondary grouping with colour code for:

Individual level determinants
Community level determinants
Service level determinants
Structural level determinants

Individual SEEDs are interconnected across social, economic and environmental dimensions and therefore classifying them under 'social', 'economic' and 'environmental' categories was difficult because some could potentially be classified under multiple categories. However, we decided to classify most within one category unless there were substantial aspects of the determinants that differed. This was the case for *food security*, *fuel poverty* and *energy efficiency*. *Food security* was included under all three categories because the social, economic and environmental reasons for food security, or food insecurity, can be quite different, although all may apply in some regions. *Fuel poverty* was classified under the 'environmental' and 'economic' categories, and *energy efficiency* was categorised as 'social' and 'environmental'.

We included *exposure to hazardous substances* under the 'social' category because while hazardous substances are an environmental risk, exposure to hazardous substances is considered to be caused by social arrangements, and those most likely to face exposure to hazardous substances are more likely to be the poor or socially marginalised. We included environmental risks such as *indoor air quality* and *outdoor air quality* under the 'environmental' determinants category.

4.3.1 Dimension of inequity

In order to reduce health inequities, it is essential to tackle their structural determinants. This aspect of the analysis identified the social groups that a particular SEED affects. We termed this 'the dimension of inequity'. Dimensions of inequity include attributes that individual possess such as their age (life course stage); identities that society and social institutions ascribe to individuals, such as those relating to gender norms and gender relations; sexuality; ethnicity; nationality (migrant status); disability and marginalisation; and material conditions relating to, for example, socioeconomic status and geographical place of residence (rural/urban) (3).

The analysis found that some of the SEEDs had primary target population groups, which were categorised in the tool as the 'Primary Focus of Dimension of Inequity'. In addition, other dimensions of inequity were noted in the project documents, and these were categorised as 'Secondary Target Groups' because, while they were mentioned in the documents, they did not appear to be the primary focus of the projects. Annex Table 2 summarises the dimensions of inequity.

Note that for this analysis, 'marginalized groups' included prisoners, homeless people, vulnerable migrants and sex workers. In cases that did not include these categories, it was possible to code 'other' and provide an explanation in the project summary.

4.3.2 Analysis of potential impact and scale

The tool aimed to enable entries to be made about the likely potential impacts of the SEEDs. This included direction of impact on inequities, and the scale of the impact. In practice, analysts were not in a position to interrogate the evidence available to the level needed to make a judgement on the likelihood of adverse impact on inequities. The likely impact on inequities was coded either as likely to be positive (based on identification of dimensions of inequity), or that there was insufficient information to judge. We have not included this in the results section.

Assessing the scale of impact was also difficult. Analysts made decisions about the scale of impact, i.e. whether the potential impact was at the individual, community, regional, national or transnational (i.e. multi-country in UNDP's terminology) level, based on reading the projects documents. Analysts based their coding on the scale of the project described in the documents; for example, a project engaged in improving a cross-border post would be identified as transnational in terms of scale of impact. While the SEED might also have national, regional and community level impacts, the Access tool only allowed one level to be selected, and the highest potential level of impact was selected in these cases. Note that analysts were not looking at any measurements or evaluations of actual impacts of projects at different levels.

4.3.3 Project indicators

Analysis of the indicators which were used in the projects was conducted through an H/HE lens. Project indicators, and the nature in which they relate to the identified SEEDs, were categorised as being input, output or outcome indicators, based on the indicator framework proposed for a strategic approach to tackling health inequities through action on the SDH (3, 43) (see Figure 3). Hence, the indicators classified

within project documentation as input, output and outcome were reclassified for this analysis along the following criteria:

Input: What is being put in place to achieve the intended goals of the strategy (i.e. inputs and processes).

Output: The direct effects of the inputs/processes.

Outcome: The intended outcomes themselves (i.e. improvement in key indicators of socioeconomic disadvantage, of SEEDs, and of health).

Layering a new classification of indicators onto a set of indicators not originally intended to be viewed with a SEEDs of H/HE lens presented some difficulties in maintaining consistency. Any future exercise to integrate SEEDs into development projects should engage with all partners in the project to agree on an appropriate set of input, output and outcome indicators disaggregated by appropriate dimensions of inequity within a SEEDs framework.

The analysis reviewed the extent to which the impact on the SEEDs of H/HE is identified by answering the following questions:

- Is the impact that the SEED has on health mentioned in the project document? (the least explicit)
- Are there indicators to measure the effect of the project on the SEED?
- Are the data for the indicators of the effect on the SEED disaggregated by a dimension of equity? (the most explicit)

4.4. Analysis tool validation

The tool was validated via two methods:

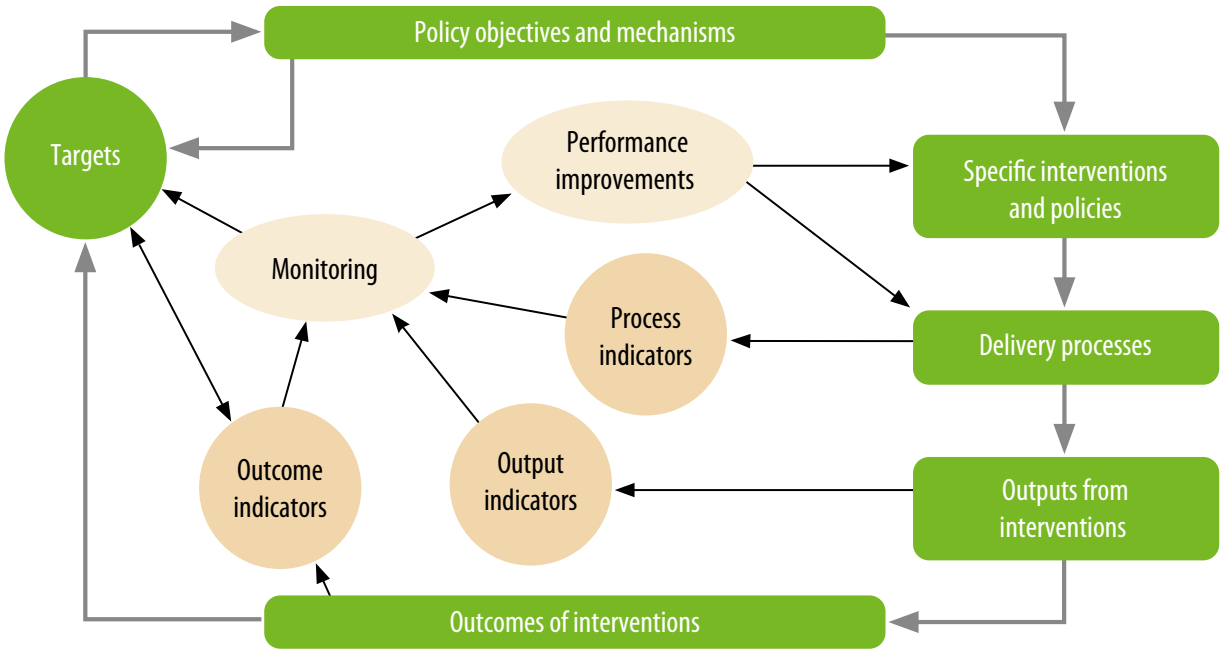
1. Blind peer analysis
2. Key informant interviews

4.4.1. Blind peer analysis

Two kinds of blind analysis were carried out.

At the beginning of the analysis period, five projects were analysed simultaneously by all researchers on

Figure 3: Indicator framework



Source: Adapted from Marmot Review 2010 (43)

the project. Researchers independently analysed the projects and then compared their findings before coming to a consensus regarding the final outcomes of the analysis. While some minor differences were noted regarding the less evident SEEDs, all researchers had identified the most important SEEDs and dimensions of inequity, and agreed on what is meant by the scale of impact in the context of this analysis.

At the midpoint of the analysis period, two of the projects were analysed independently by two researchers. The findings were then compared and scored. On both occasions, the most apparent SEEDs were identified by both researchers and the differences that were identified pertained to the less evident SEEDs or dimensions of inequity.

4.4.2. Stakeholder interviews

Interviews with UNDP project managers or leaders about their own projects provided the opportunity to validate the SEEDs and dimensions of inequity that had been identified in the projects by the study team. Twenty-five interviews were carried out, representing half the projects. Of these projects and all the SEEDs identified in them, only two SEEDs were incorrect (1.3%) and an additional 11 SEEDs out of 151 (7.3%) were included.

4.5. Strengths and limitations of the tool

4.5.1. Strengths

1. The tool identifies SEEDs and whether the impact on health is either mentioned in the documents, or is monitored by indicators (input, output and outcome from health equity perspective);
2. The tool identifies sectors involved in project implementation;
3. The tool identifies the implementation strategy – whether targeted, universal, universal and targeted, or proportionate universalism;
4. Indicators are identified and, as such, contribute to the understanding of whether and how SEEDs of H/HE are addressed;
5. The tool identifies whether the project seeks to impact long-term structural processes/ trends (such as gender equality, participatory processes, stigma, discrimination, employment/ unemployment, lack of educational opportunities) or reduce exposure and vulnerability to health risks.

4.5.2. Limitations

1. The tool attempts to systematically identify SEEDS of H/HE in projects not primarily intended to impact H/HE, so the information needed to complete the tool was sometimes hard to find and to code.
2. In creating the tool for this pilot, the disaggregation level was rather high in order to improve the understanding of complexity. On the down side, the increasing complexity of the tool created more coding decisions for the analysts, with implications for time taken for each analysis and reliability of more difficult to code fields.
3. Initially, we identified indicators from the project documents; however, these documents are developed before the projects are implemented, and during implementation there may be changes in the indicators used. For the sake of thoroughness, we then reviewed other project documents, including monitoring and evaluation documents that were made available to us. However, not all documentation was available for every project.
4. Some coding decisions were more difficult than others, for example:
    a. SEEDs that were identified from what appeared to be a minor element of a large and complex project;
    b. Many SEEDs have social, economic, and environmental dimensions. As explained in section 4.3, we decided to classify SEEDs under only one grouping (social, economic or environmental), except for food security, fuel poverty, and energy efficiency which were classified under more than one grouping each because the social, economic and environmental aspects of each are quite distinct. However, this classification proved to be too fine-grained to be carried through the analysis for technical reasons explained below. Therefore, for the analysis tables and figures in this report we counted SEEDs that appear at multiple places in the framework once per category of social, environmental or economic groupings. For example, food security is a SEED that falls under more than one category and it was counted as one SEED for social, economic or environmental categories in the analyses. One of the main aims of the exercise was to capture which dimensions of inequity were associated with particular SEEDs in the

projects analysed. However, the Access tool was designed so that when there was more than one dimension of inequity identified, the analyst had to enter the SEED each time for each dimension of inequity. To avoid over-counting SEEDs with multiple dimensions of inequity, the analysis was set up to count each SEED once for Figure 4 and Table 4.

5. Stakeholder Interviews

5.1. Background information

Stakeholder interviews were carried out to add qualitative insights to the desk-based analysis. The study team sought the participation of project and programme managers as key informants with expertise in their projects. The aim was to cover all practice areas, all countries, and regional projects. Twenty-five interviews were conducted in a semi-structured format. Notes of the interviews were sent to interviewees for review and subsequently revised accordingly. Written consent to use the material from interviews in this report was obtained from interviewees.

5.2. Purpose of the stakeholder interviews

1. To gather further information about the projects that was not available in the project documents;
2. To validate the tool through project leaders validating the SEEDs and dimensions of inequity that were identified by the analysis;
3. To gather opinions and input of project managers on the need and best method for capacity building/training on the SEEDs of H/HE;
4. To gather suggestions and opinions from project managers on the best methods for systematically addressing SEEDs of H/HE, and whether a tool may be able to be utilised in order to achieve this.

Box 2 shows the interview template used in the semi-structured interviews.

Box 2: Interview Template

1. BACKGROUND OF PROJECT AND COUNTRY
- Health Aspects
- Equity Aspects

2. SOCIAL, ENVIRONMENTAL AND ECONOMIC DETERMINANTS (SEEDs) OF HEALTH
- SEEDs that the study team found in the project
- Further clarification from project manager regarding SEEDs
- SEEDs that were potentially overlooked in the analysis by the study team

3. DIMENSIONS OF INEQUITY
- Dimensions of inequity identified by the study team
- Further clarification from project manager regarding dimensions of inequity

4. CAPACITY BUILDING/TRAINING
- Project managers' views on need for capacity building/training on SEEDs

5. IMPLEMENTING SEEDS TOOL
- Project managers' views on applying a SEEDs tool during the project development process

C. Key Findings

Section A: Tool analysis

In this section, we identify key findings from the analysis of documents, and comment on what we consider to be the strategic implications of selected key findings. Key findings are illustrated, where relevant, with reference to projects for which we held interviews with stakeholders (including project managers and/or team leaders).

1. Health aspects

Key Finding 1: *SEEDs of H/HE were identified in all of the projects analysed.*

Strategic implication of Key Finding 1: *UNDP's development projects in all practices potentially impact health and/or the distribution of health.*

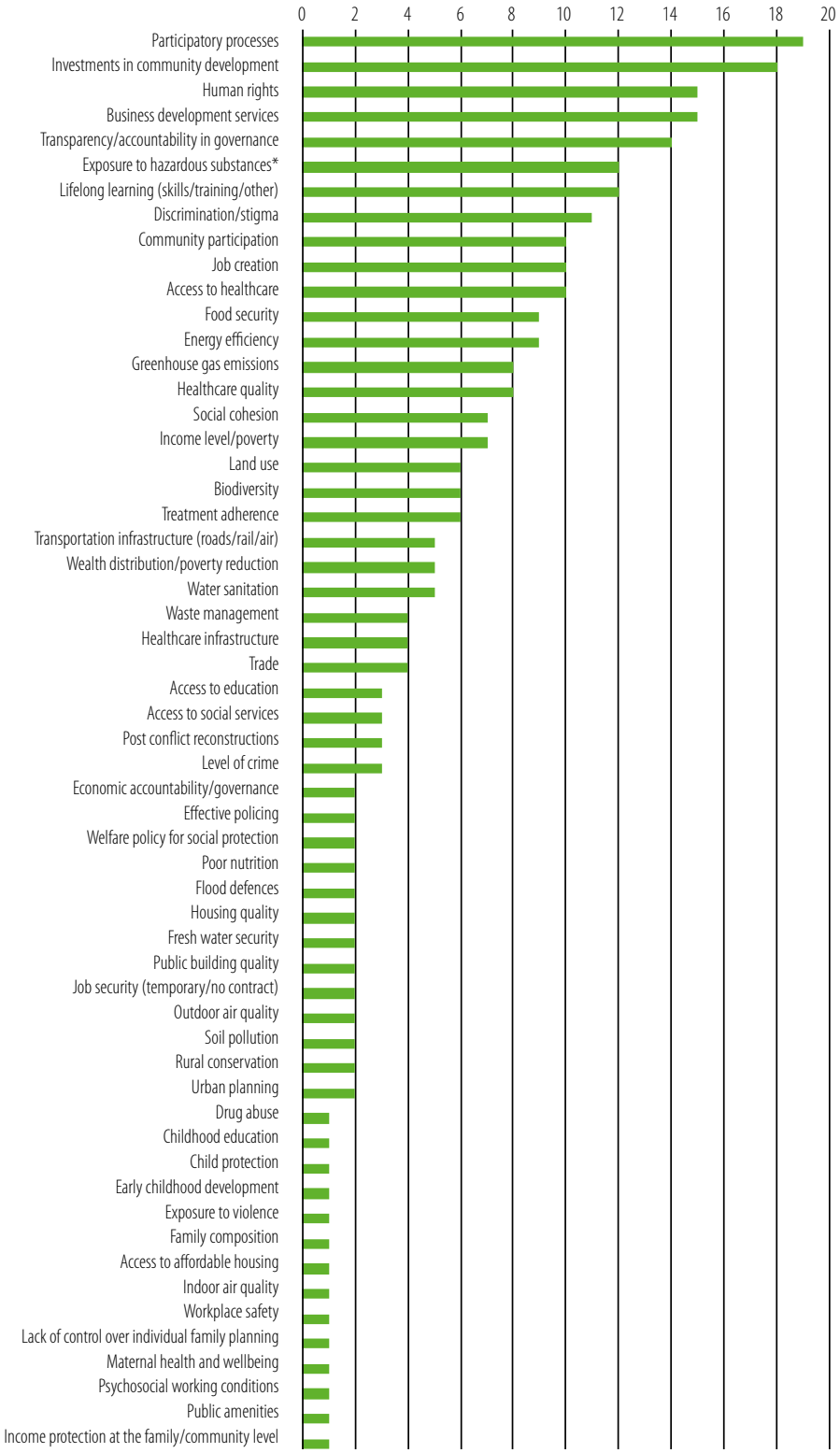
The most frequently identified SEEDs across all projects are shown in Figure 4. 'Participatory processes' emerged from the analysis as the most frequent SEED. This is not surprising because participatory processes are common territory between development and the SDH approach. Participatory processes, a subset of which is community participation, are identified within the SDH literature as contributory to increased equity (1). Participatory processes at the community level were coded as community participation. Added together, they emerge as by far the most frequent SEED in the analysis.

Table 4 shows the frequency of SEEDs per project by UNDP practice area. This contributes to one of the main findings from the analysis – that projects across all practices directly or indirectly affect health. The analysis found that Poverty Reduction and Energy and Environment practices had more SEEDs per project than the HHD practice. It is worth noting here that the HHD practice projects analysed were GF projects that primarily focus on downstream factors including quality of healthcare and access to healthcare.

Key Finding 2: *Project analyses observed that the potential impact on health had not been noted in the project documentation for 76% of SEEDs identified.*

Strategic implication of Key Finding 2: *The potential impact of UNDP's development projects on H/HE is broadly under-recognised across projects, other than HHD practice projects.*

Figure 4: Number of SEEDS in all projects analysed



*Note: Exposure to hazardous substances refers to substances that may be chemical, physical, radiation, pollution, pathogens or others

Table 4: Frequency of SEEDs by practice

Practice	Number of projects	Frequency of SEEDs	Frequency of SEEDs per project
Poverty Reduction	13	90	6.9
Energy and Environment	12	77	6.4
HIV, Health and Development	5	29	5.8
Democratic Governance	12	68	5.7
Gender	3	12	4.0
Crisis Prevention and Recovery	3	9	3.0
Knowledge, Innovation and Capacity Development	2	6	3.0

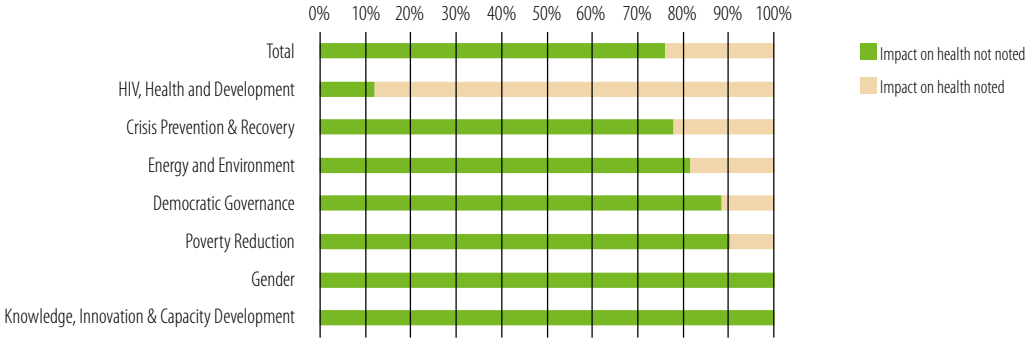
Figure 5 shows the percentage of SEEDs for which the impact on health was mentioned in the documentation by practice. Not surprisingly, the HHD practice noted the impact on SEEDS considerably more than other practices.

With regard to these key findings, it is worth noting here that the analysis was not designed to assess actual impacts on SEEDs or on H/HE, so it is not possible to make any statements about the size or direction of effects. The aim of the analysis was to highlight quantities and types of SEEDs in order to create an awareness of these. It lays the ground for further work to develop mechanisms to monitor the intensity and direction of impact of projects on SEEDs of H/HE and on health.

Figure 5 highlights the important finding that projects from practices other than HHD do not always note the impact on health, despite the links being quite direct in some circumstances, such as access to social services or transportation infrastructure. This is to be expected, because currently co-benefit analysis for impacts on SEEDs of H/HE is not a required part of UNDP's project monitoring and evaluation processes. To our knowledge at the time of writing, there are no international development programmes that include screening for impacts on SEEDs of H/HE (see Section 2.6). Environmental and social screening, which include aspects of health, are part of UNDP's project development processes (44).

Case Study 1 illustrates how a project in the Energy and Environment practice has potential impacts on health and the distribution of health that could be monitored and evaluated.

Figure 5: Percentage of SEEDS for which the potential impact on health had not and had been noted, by Practice



Case Study 1: Almaty Sustainable Transport (Kazakhstan)

The project aims to reduce the growth of the transport-related greenhouse gas emissions in the city of Almaty whilst simultaneously improving urban environmental conditions.

Bike race for children organized by Velo-Almaty (Case Study 1).
© CAST Project (UNDP)

About the project

The project is part of Almaty's sustainability strategy – a 10 years strategy to address poor air quality and road safety in the biggest city of Kazakhstan. An important activity is capacity building to convert transport to natural gas, e.g. shifting from old diesel buses to more environmentally friendly types of fuel.

The project aims to improve efficiency of public transport (through Bus Rapid Transit) and light rail trams, and promote non-motorized transport. Half of the project is funded for pilots and developing feasibility studies on creating bus rapid transit (BRT). The aim is to then scale up the pilots.

One pilot project to be implemented aims to increase the share of non-motorised transport. This relates directly to health through increased physical activity (increasing walking and cycling).

A 5km cycle path will be piloted together with the municipality of Almaty. The project will work together with other agencies like WHO, UN Economic Commission and the Pan European Programme on Transport, Health, Environment, which incorporates the notion of integrating these three sectors. There is a direct link between air quality and health. Health is not the main focus of the project. The project indirectly reduces air pollution via the reduction of private car usage, which reduces gasoline usage, thus decreasing air pollution. The aim is to increase the uptake of public transport and active transport through improving active transport infrastructure and improving public transport. The project does not monitor air quality (which is a national government activity); rather, it is a municipal government project aiming to show how cities can improve public transport.

SEEDs identified

- Transportation infrastructure
- Greenhouse gas (GHG) emissions

Dimensions of inequity identified

There are no dimensions of inequity noted in the project documentation.

Strategic value of considering health implications

Making connections with health would be of strategic value by adding weight to justify expenditure on the project by municipalities, or to diversify funding from more donors.

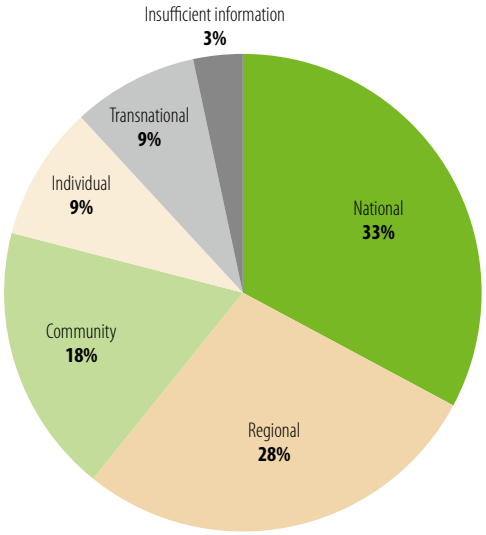
Transport impacts health in various ways, directly (e.g. road traffic accidents cause death and disability) and indirectly (e.g. air pollution causing lung diseases). However, there is no measurement of the impact of the project on health. While no H/HE issues have been examined yet, there is potential to do so. Different social groups experience different exposures and vulnerabilities to transport-related risks to health; therefore, disaggregation of indicators would be helpful to review progress in reducing inequity.

Annex Table 1 shows the frequency of SEEDs that note the impact on health by individual SEED. The table shows that the five SEEDs for which the project documentation most commonly noted the impact on health all relate to the healthcare sector or exposure to substances or pathogens that will directly impact on health such as the HIV.

Key Finding 3: *SEEDs identified in the analysis act variously at different levels of social organization (individual, community, regional, national, transnational – i.e. across countries).*

Strategic implication of Key Finding 3: *UNDP's development projects provide the opportunity to create an enabling environment for action to improve health and the distribution of health at different levels of social organization (24).*

Figure 6: Level of impact of SEEDs



Upper: Public transport buses line up in Almaty (Case Study 1). © CAST Project (UNDP)
Lower: Clothing designer Jelena Kostovska participates in the Self-Employment Programme (Case Study 2). © Ljubomir Stefanov (UNDP)

Figure 6 shows that of the SEEDs identified, they were likely to act at various levels of social organisation including individual: 9%; community: 17%; region (i.e. subnational): 28%; national: 32%, and transnational (i.e. across a number of countries): 9%. Analysts categorised the level of impact by SEEDs. Therefore, some projects had SEEDs that have impacts at different levels (e.g. individual level for some business enterprise initiatives and community level for the community development element of the project) at the same time. UNDP works across all levels of social organisation and with all levels of government.

Case Study 2 illustrates how UNDP projects may influence different layers of governance, by working with national government ministries, and governmental and non-governmental agencies within municipalities. The project partners included the Ministry of Labour and Social Policy, Employment Service Agency, Ministry of Education and Science, Centre for Vocational Education and Training, Adult Education Centre, Agency for Promotion of Entrepreneurship, Roma Information Centres, Centres for Social Work, and public and private educational institutions as training providers.

Other projects may act also across countries (transnational influence); for example, Case Study 7: Implementation of Central Asia Regional Risk Management, and Case Study 9: Aid for Trade.

Case Study 2: Promoting Sustainable Employment (Macedonia)

This project aims to promote sustainable employment and support the government in implementing Active Labour Market Measures (ALMMs).

Dairy farmer Hysni Demiri participates in the Self-Employment Programme (Case Study 2). © Ljubomir Stefanov (UNDP)

About the project

Job creation and lifelong learning are the two major aspects of the project. The project targets vulnerable groups. The project focused at first on rural areas or underdeveloped regions. Now, it has become more interested in sustainable businesses and is a nationwide programme. Citizens from all municipalities are able to participate in the programme. There are beneficiaries in rural areas, but there is scope to improve the project in these areas to increase opportunities provided to them. This includes agricultural activities/businesses.

There is a potential trade-off between sustainability and involving more vulnerable groups, meaning that there is a tension between involving vulnerable population groups and achieving targets and sustaining activities. Selection of applicants is based on three criteria: the unemployment rate in the area, number of applications and previous experience of the applicants. Municipalities with higher unemployment rates have higher number of places within the programme.

SEEDs identified

- Business development services
- Lifelong learning
- Investments in community development
- Job creation

Dimensions of inequity identified

No primary dimensions of inequity were identified.

Secondary dimensions of inequity:

- Marginalised groups – vulnerable groups (meaning, in this case, people, including youth, who are unemployed and face difficulties entering the labour market)
- Ethnicity – Roma

Strategic value of considering health implications

Promoting sustainable employment supports poverty reduction with potential consequent benefits to health. Employment that provides fair conditions of employment and healthy working conditions is beneficial for heath (1, 3). ALMM not only promote employment, but they have also been identified as a way of tackling the negative impact of long-term unemployment on mental health (45). Mental health is relatively neglected in development practice, but mental disorders put an immense burden on individuals, families and communities. Calls have been made for the integration of mental health into all development efforts (46, 47).

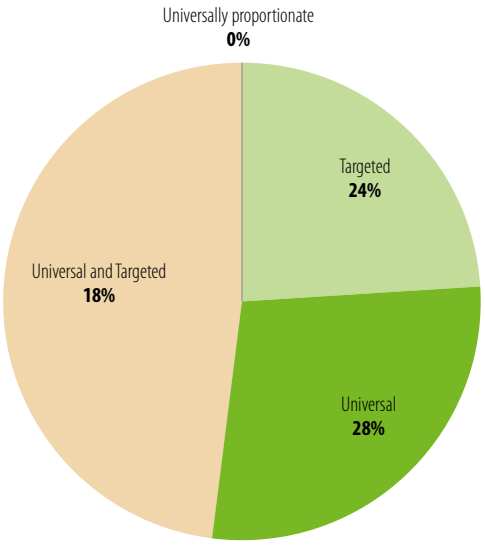
2. Equity aspects

Key Finding 4: *The majority of UNDP's development projects had an implementation strategy that was universal or universal and targeted. Fewer projects had a solely targeted approach and none was universally proportionate.*

Strategic implication of Key Finding 4: *Implementation strategies that are universal imply that they impact across the whole of society, while targeted strategies are implemented amongst a particular social group identified as having particular needs, risks, and risk exposures. Often, UNDP projects have both universal and targeted elements, which is a strength if the focus is on specific high-risk groups. Such approaches do not necessarily act across the whole of the social gradient (i.e. they are not universal and proportionate to need), a key element of the SDH approach.*

Figure 7 illustrates that the implementation strategies employed in the projects were most commonly universal AND targeted. This shows that, while projects aimed to have some aspects with universal benefits, specific population groups were also targeted. The analysis found that projects with targeted implementation strategies most commonly targeted rural and female groups. This is not a surprising finding, as this responds to the development challenges in the region, where a high proportion of men have left rural areas to seek work. Rural development is a development priority, to reduce the push factors for out migration. UNDP's development projects potentially provide a platform and enabling environment for the work of other agencies to deliver improved services for health in rural areas, including healthcare services, but also for multi-sectoral work related, for example, to educational and other social services.

Figure 7: Implementation strategy of projects



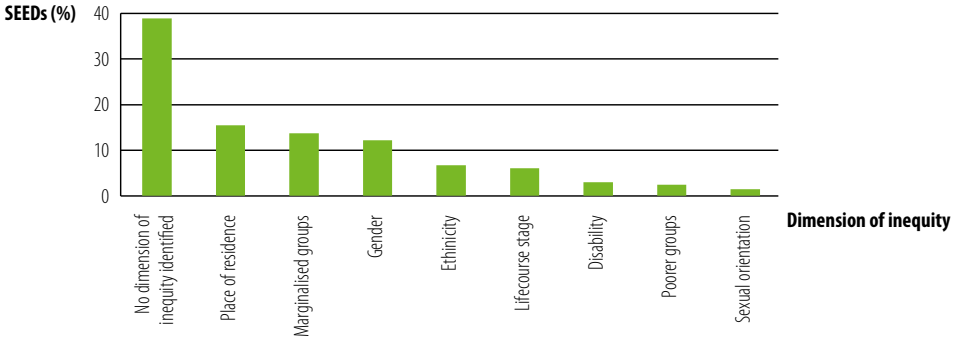
Key Finding 5: *For most SEEDs, the project analyses identified a primary disadvantaged target group (dimension of inequity). The primary dimensions of inequity most frequently identified for SEEDs were place of residence (namely rural), marginalised groups and gender.*

Strategic implication of Key Finding 5: *Taking an equity focus has been identified as essential in supporting inclusive development. While a major focus on rural settings was found in this analysis, as countries undergo economic and social development, it will be important to assess factors associated with migration to urban areas and the needs of urban populations.*

Where we identified SEEDs in projects, we noted from the documentation which particular groups were reported to be the main beneficiaries (these were called 'primary dimensions of inequity'). Most SEEDs did have primary dimensions of inequity (61%). Figure 8 shows in what proportion of SEEDs each primary dimension of inequity was identified. The analysis included all dimensions of inequity that were reported in the project documentation as targets of the identified SEEDs. The targeted dimensions of inequity were coded separately in the analysis, notwithstanding that groups often face multiple dimensions of inequity; for example, they might be poorer AND women.

Annex Table 4 shows all identified SEEDS and which dimensions of inequity they aimed to address. Certain SEEDs such as *Access to healthcare* aimed to target many dimensions of inequity whilst SEEDs such as *soil pollution* did not, for obvious reasons.

Figure 8: Proportion of SEEDs by primary dimensions of inequity identified



Case Study 3 illustrates how taking an equity-focused approach to prevention and treatment is implemented in a project funded by the GF. It demonstrates how the programme addresses differential risks and vulnerabilities to HIV/AIDS through access to healthcare.

Case Study 3: HIV/AIDS programme (Bosnia and Herzegovina)

The programme aims to significantly strengthen and scale up the HIV/AIDS response in Bosnia and Herzegovina to most-at-risk populations.

About the project

Bosnia and Herzegovina has a low incidence of HIV. The aim of the project is to maintain a low incidence rate and to provide essential services to those living with HIV. A network of 22 voluntary and confidential testing centres has been established, and thousands of people have been tested. Healthcare quality has been addressed via health system strengthening through providing training on best practices for nurses and other healthcare professionals. Antiretroviral medicines are funded by the government, and the survival rate has been much improved. Treatment adherence, care and support are further provided by non-governmental organisations (NGOs), including to family members as needed.

This programme responds directly to equity. One of the aims is to try to address stigmatization and discrimination. One of the ways this is done is through working with civil society and NGOs and making referrals to health centres. The project aims to keep most beneficiaries protected from public discrimination, and public relation campaigns have been introduced in order to reduce stigma. Men who have sex with men (MSM) are supported, and specialised NGOs are working with over 1,000 MSM.

The project also pioneered the introduction of centres for sex workers, people who inject drugs and other at-risk groups. Working with government officials, the project has 8 opiate substitution treatment centres with educated staff. More than 1,000 people are enrolled in the opiate substitution treatment centres.
The services are easy to access and are free of charge. In this way, the programme ensures higher service utilization, including for prisoners and Roma communities, and therefore addresses stigmatization. The project is also working at border controls through education campaigns for truck drivers. This project addresses human rights issues and tries to ensure equal rights for those with HIV. Campaigning for equal rights is extended to the right to work for HIV positive people. Much has already been achieved regarding labour law.

Case Study 3: HIV/AIDS programme (Bosnia and Herzegovina) cont.

SEEDs identified

- Exposure to hazardous substances (chemical, physical, radiation, pollution, pathogens, other)
- Access to healthcare
- Treatment adherence
- Healthcare quality
- Discrimination/stigma

Laboratory training in Bosnia and Herzegovina (Case Study 3). © UNDP

Dimensions of inequity identified

Primary dimensions of inequity:

- Marginalised groups – Prisoners, sex workers, vulnerable migrants, people living with HIV, people who inject drugs, 'internally displaced persons' and 'returning refugees', youths,
- Sexual orientation – Homosexual/bisexual
- Life course stage – Transition between education and employment
- Ethnicity – Roma

Secondary dimensions of inequity:

- Socioeconomic status/ household wealth – Poorer groups
- Gender – Males and females

The programme acts directly on health, and provides a good example of how specific populations groups are targeted. In addition, while the project targets marginalised groups regarding access to healthcare and treatment for HIV, further attempts are made to address equity issues, such as tackling discrimination/stigma and advocating for human rights regarding labour laws.

Strategic implications

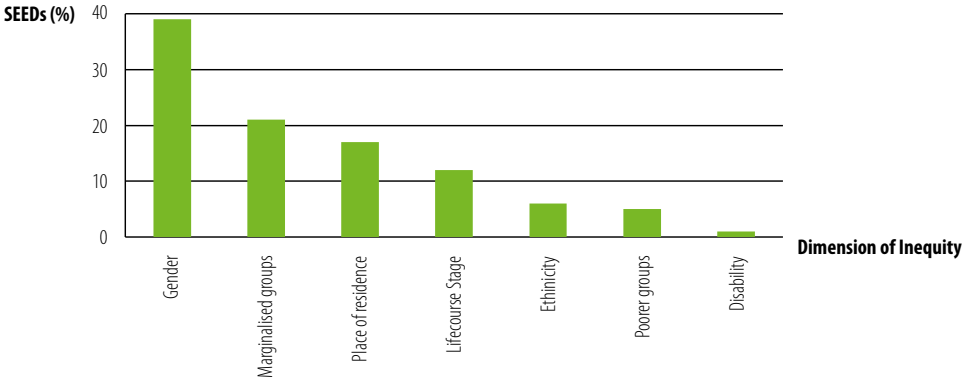
An important lesson from HIV/AIDS is that it is necessary and achievable to address social determinants in order to get prevention and treatment services to the most-at-risk groups. This is essential in the prevention and control of all diseases, including NCDs.

Key Finding 5a: *Of the secondary dimensions of inequity (i.e. dimensions of inequity relating to groups that were mentioned in the project documents as being targeted but were not the primary target group), the most frequently identified was gender (specifically female) (see Figure 9).*

For the identified SEEDs, it was noted which groups were mentioned in the project documents as being targeted while not being a primary target group (these were called 'secondary dimensions of inequity' to distinguish them). Of these groups, the most frequent was gender (namely female). While these groups were mentioned as being targeted, the indicators were not systematically disaggregated, e.g. by gender.

Celebration of AIDS Candlelight Memorial Day in Bosnia and Herzegovina (Case Study 3). © UNDP

Figure 9: Proportion of SEEDs by secondary dimensions of inequity identified*



*'Secondary dimension of inequity' is used to describe a group that was mentioned in the project documents as being targeted while not being specifically identified as a primary target group.

3. Monitoring and evaluation

Key Finding 6: *Only 17% of all SEEDs identified by the analysis were measured by indicators disaggregated by dimensions of inequity.*

Strategic implication of Key Finding 6: *Many projects aim to target inequities; however, often the indicators were not disaggregated to measure the impact on different groups. There is scope for further disaggregation of indicators by relevant dimensions on inequity in order to monitor progress towards the development of inclusive and just societies.*

Table 5 shows the percentage of identified SEEDs whose indicators were disaggregated by a dimension of inequity (either primary or secondary). It shows that, of the SEEDs that identified dimensions of inequity, only 17% had indicators that were disaggregated.

Table 5: SEEDs disaggregated by dimensions of inequity in indicators*

SEED	Frequency of SEED identified	Frequency of indicators disaggregated	SEED with disaggregated indicators (%)
Access to education	3	3	100
Child protection	1	1	100
Early childhood development	1	1	100
Maternal health and wellbeing	1	1	100
Job security (temporary/no contract)	2	1	50
Welfare policy for social protection	2	1	50
Exposure to hazardous substances	20	9	45
Post conflict reconstructions	3	1	33
Treatment adherence	6	2	33
Lifelong learning (skills/training/other)	13	4	31

Table 5: SEEDs disaggregated by dimensions of inequity in indicators* cont.

SEED	Frequency of SEED identified	Frequency of indicators disaggregated	SEED with disaggregated indicators (%)
Access to healthcare	23	7	30
Community participation	10	3	30
Social cohesion	7	2	29
Access to social services	4	1	25
Healthcare quality	8	2	25
Trade	4	1	25
Job creation	10	2	20
Participatory processes	20	4	20
Wealth distribution/poverty reduction	5	1	20
Discrimination/stigma	14	2	14
Business development services	16	2	12
Human rights	18	2	11
Investments in community development	19	2	11
Access to affordable housing	1	0	0
Biodiversity	6	0	0
Childhood education	1	0	0
Economic accountability/governance	2	0	0
Effective policing	2	0	0
Energy efficiency	13	0	0
Exposure to violence	1	0	0
Family composition	1	0	0
Flood defences	2	0	0
Food security	10	0	0
Fresh water security	2	0	0
Greenhouse gas emissions	8	0	0
Healthcare infrastructure	4	0	0
Housing quality	2	0	0
Income level/poverty	7	0	0
Income protection at the family/community level	1	0	0
Indoor air quality	1	0	0
Lack of control over family planning	1	0	0

Table 5: SEEDs disaggregated by dimensions of inequity in indicators* cont.

SEED	Frequency of SEED identified	Frequency of indicators disaggregated	SEED with disaggregated indicators (%)
Land use	7	0	0
Outdoor air quality	2	0	0
Poor nutrition	2	0	0
Public amenities	1	0	0
Public building quality	2	0	0
Transparency/accountability in governance	14	0	0
Transportation infrastructure (roads, rail, air)	5	0	0
Urban planning	2	0	0
Water sanitation	5	0	0
Workplace safety	1	0	0
Drug abuse	1		
Level of crime	3		
Psychosocial working conditions	1		
Rural conservation	2		
Soil pollution	2		
Waste management	4		
Total	329	55	17

*Note: The SEEDs that have no dimension of inequity identified are blank in 'Indicator disaggregated' column.

Key Finding 7: *85% of the SEEDs were measured by an indicator, but only 13% were measured by a combination of input, output and outcome indicators. For some projects, both the SEEDs and the health outcome were measured by indicators.*

Strategic implication of Key Finding 7: *Input, output and outcome indicators are all important in monitoring what is being put in place, the effects of these inputs and the intended outcomes that are achieved. Where SEEDs are identified in the project development phase it may be possible, where appropriate, to monitor all three types of indicators. It is not possible to be prescriptive about which indicators should be included; indicators should be developed in discussion with project partners and aligned to UNDP's strategic plan, and are subject also to the level of available funding, and the requirements of the relevant funding organizations. However, the choice of indicators should include measures of SEEDs of H/HE, considered by project partners to be important and achievable focusing on co-benefits for development and health. A practical system to monitor and evaluate progress on these key indicators is required.*

Table 6 indicates that output indicators are the most frequently used type of indicator for SEEDs (78%), followed by outcome (34%) and input (33%) indicators. While 15% of SEEDs were not measured by any indicator, only 13% of SEEDs were measured by all 3 types of indicators.

Table 6: Frequency of presence of input, output and outcome indicators per SEED

Presence of type of indicator per SEED			Frequency of SEEDs measured by combination of input, output or outcome indicators	%
Input indicator	**Output indicator**	**Outcome indicator**		
Present	Present	Present	44	13%
Present	Present	Absent	55	17%
Present	Absent	Present	3	1%
Present	Absent	Absent	8	2%
Absent	Present	Present	51	16%
Absent	Present	Absent	106	32%
Absent	Absent	Present	14	4%
Absent	Absent	Absent	48	15%

In some of the projects, the impact on SEEDs and the effects on health outcomes were measured (not shown). This occurred in the GF projects of the HHD practice; see Case Study 3.

Note on project reporting: The study found that a complex system of reporting exists with requirements for both internal (within UNDP) and external (to donors) reporting. Of the fifty projects analysed, thirty five had both internal reporting documents and external reporting documents that were made available for analysis. We noted in the analysis tool whether indicators were reported in the internal documents, external documents or both. We found that the internal and external document indicators sometimes differed, perhaps reflecting the different priorities of funding organizations. This increases the workload for project partners involved in monitoring, evaluation and reporting. It should be possible to simplify and further systematise the project reporting procedures.

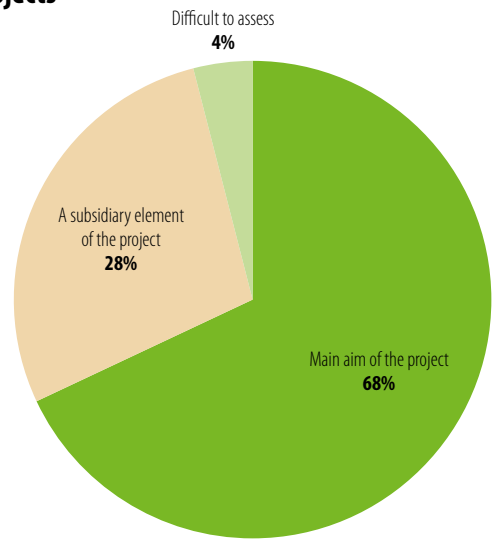
4. Sustainability

Key Finding 8: *Capacity building was an integral part of the projects analysed.*

Strategic implication of Key Finding 8: *Capacity building is a major strength of UNDP's development practice. It is carried out at all levels of governance and among all sectoral stakeholders. This supports sustainability of development processes. It may also present potential platforms to introduce dialogue and/or trainings on SEEDs of H/HE within partner countries.*

68% of projects had capacity building as a main aim of the project and 28% had capacity building as a subsidiary aim of the project as shown in Figure 10.

Figure 10: Capacity Building as part of UNDP projects



Key Finding 9: *Many of the projects analysed aimed to address structural determinants of health.*

Strategic implication of Key Finding 9: *Tackling structural determinants that shape differential vulnerabilities and exposures will have a long-term impact on H/HE* outcomes.

Analysts coded whether the projects address structural determinants, such as gender inequality or exclusionary processes faced by Roma groups. While many projects aimed to address structural determinants of health, this analysis was unable to make a judgement on whether structural determinants were addressed at the scale and intensity required to make a difference over the longer term.

Key Finding 10: *Every project involved multi-sectoral implementation.*

Strategic implication of Key Finding 10: *This gives UNDP tremendous strength in addressing development issues in a holistic way, and underlines the immense opportunities for UNDP to fulfil its health and development mandates and responsibilities through the integration of SEEDs of H/HE into all its development projects and into national multi-sectoral development planning as a joint effort of UN country teams.*

UNDP programmes and projects are frequently complex and multi-layered in the following ways:

- engaging with or responding to one or more of global/regional/national/ municipal planning processes or donor priorities;
- working with different partners – governmental (national and/or municipal), NGOs, private sector, communities;
- working across sectors to address complex problems – for example, education/training/ employment;
- working simultaneously at the policy level and operational level.

Section B: Key informant interviews

In this section, the findings are discussed under the key categories explored in the interviews: health aspects, equity aspects, capacity building on SEEDs of H/HE within UNDP, and the use of a tool for systematic integration of SEEDs of H/HE in project planning.

1. Health aspects

Considerations about health often revolve around the quality, availability and accessibility of healthcare. This is of course absolutely vital. However, studies on SEEDs of health show that population health and the distribution of health in society are determined to a large extent by factors other than healthcare. Respondents are engaged in projects that impact aspects of social, economic and environmental development identified as strategic priorities, defined within particular practice areas. Respondents understand, as a 'given', that social, economic and

Community mobilization workshop in Poti City, Georgia (Case Study 4).
© Tsira Kakubava (UNDP)

environmental factors impact on health. However, this understanding often appears to exist parallel to, or consequential to, their knowledge and understanding of the intended impacts of the project or programme on which their work is focused. Unless the project is a specific health project, there is no felt 'need' to make either conceptual or practical connections between the objectives of their project and health; as such, the connections are not necessarily made. Analysis of responses to questions that invited reflection on the impact of the projects/programmes on health revealed three approaches: initial scepticism, strategic realism and facilitating.

Initial Scepticism

When invited to speak about the project and how it impacts health, several respondents were initially sceptical because they felt that their projects had nothing or very little to do with health. The two case studies cited here illustrate how projects that may not have a specific health focus may nevertheless encompass specific activities that may impact on health.

Case Study 4: Promoting human security in an area with a high number of internally displaced persons (Georgia)

The project aimed to promote human security in an area with a high number of internally displaced persons.

About the project

In the geographical area that was the focus of the project, subsistence farming is significant and therefore, people are vulnerable to shocks which pose risks to the level of food security in households. Improved agricultural practices might protect farmers from shocks. Hazelnuts are a cash crop and are vulnerable to a pest called the White American butterfly. Therefore, part of the project incorporates pest reduction and supporting agricultural practices through training and the provision of microfinance loans. Vocational training was provided for those who previously had limited education or training. This included education in accountancy and computer skills, which help to build the capacity of small farmers. These elements of the project may reduce poverty at the household level.

Construction of a pedestrian bridge in Mazandara, Georgia (Case Study 4). © Tsira Kakubava (UNDP)

A further element of the project involves small-scale infrastructure projects, which aim to improve community relationships and human security. This included rehabilitating some kindergartens on the administrative boundary line, building bridges and water supply systems. All project activities allow the community to participate in decision making throughout the process. Projects are implemented based on their decisions.

The project plays a role in bridging relationships between local communities and municipalities to collaborate and to implement the projects jointly. Training interventions also jointly improve confidence.

Case Study 4: Promoting human security in an area with a high number of internally displaced persons (Georgia) cont.

In addition, the project bridges between communities/municipalities and higher level government through advocating for vulnerable groups, thereby contributing to the regional development strategy.

SEEDS identified

- Post conflict reconstruction
- Participatory processes
- Human rights
- Business development services
- Lifelong learning (skills / training)
- Food security (household level)

Dimensions of inequity identified

Primary dimensions of inequity:

- Marginalised groups – internally displaced persons

Secondary dimensions of inequity:

- Place of residence – rural

Strategic value of considering health implications

The integrated approach taken by the project through empowering people and communities, strengthening livelihoods, and improving service provision in education and infrastructure embeds participatory processes and empowers communities to control and improve their living conditions in ways that are likely to benefit health. Identifying potential synergies between the project's *raison d'être* and health could potentially open new opportunities for partnerships and cross-sectoral planning in post-crisis situations to create co-benefits for health and development.

In the second example, the respondent was initially sceptical. The project aimed to strengthen the capacity of the Afghan Border Police in managing the border crossing between Afghanistan and Tajikistan. However, as the discussion flowed and the study team read out the SEEDs that they had identified in the project, the respondent identified connections between the project and SEEDS of H/HE, and noted that there is further potential for the project to support basic needs (energy, water, sanitation) and health of communities in the border area (Case Study 5).

Afghan residents improve infrastructure along the Afghan-Tajik border (Case Study 5). © UNDP EU-BOMNAF

Case Study 5: Border Management in Northern Afghanistan (border with Tajikistan)

The aim of the project is to reinforce border management capacity and trans-border cooperation in the Northern Provinces of Afghanistan. The project involves a strategy to enable travellers to easily cross the border so people can benefit from increased trade and availability of trade and economic opportunities.

Weekend trade at Afghan-Tajik cross-border market (Case Study 5). © UNDP EU-BOMNAF

About the project

The objective of the project is to strengthen the capacity of the Afghan Border Police (ABP) rather than the local community. However, UNDP does promote ease of travel at border crossings, including for the local impoverished communities. While the project is based in Tajikistan, the respondent works entirely in Afghanistan. It is the only project from UNDP Tajikistan that works across the border.

Gender is a consideration, through training for women, and teaching Afghan men about gender equality. Attempts have been made to bring Afghan women for training but social constraints usually forbid travel outside their immediate domestic circumstances unless accompanied by a male blood relative (uncle, brother) or husband. The Commander of ABP agreed to allow training for Afghan women and the ABP employs women.

Surrounding communities on both sides of the border are extremely poor and often without access to basic services (e.g. most have no running water, schools, or healthcare facilities). Some have to walk two kilometres to collect water. There is a huge river, but access to the water's edge is restricted due to geography, such as cliffs and insurmountable rocks. The terrain is difficult, and land travel is slow.

There is almost no mains electricity in rural Northern Afghanistan, and there are water shortages. This is an inequity which could result in local conflict, because the needs of local communities for basics (water and energy) are not always met. However, water and energy shortages are not always taken into account. Without electricity, development is not achievable. UNDP brings environmentally sustainable energy to the border crossing. Initially, the local communities were siphoning water and electricity from supplies meant only for the project beneficiaries. UNDP now partners with other organisations (e.g. Mission East, an international NGO) to assist them in providing electricity and water.

Case Study 5: Border Management in Northern Afghanistan (border with Tajikistan) cont.

There are landmines in specific places on both sides of the Tajikistan-Afghanistan border. Some are being removed by Mine Action teams, but for some mined areas, there is so far no funding to permit clearance.

SEEDs identified

- Level of crime
- Exposure to hazardous substances – narcotics are a major local and regional issue
- Transportation infrastructure – improving roads in difficult terrain
- Trade – safe passage of legitimate goods and people across the border
- Human rights – including training border staff (re: human rights of refugees, political refugees and asylum seekers) and targeting human trafficking

Dimensions of inequity identified

No primary dimensions of inequity were identified.

Secondary dimensions of inequity:

- Marginalised groups – vulnerable migrants

Strategic value of considering health implications

There is further potential for the project to support basic needs (energy, water, sanitation) and health of communities in the border area. In addition, the project provides a platform for further cross-border cooperation.

Strategic realism

The majority of respondents recognised the strategic importance of health in relation to the projects/programmes on which they worked. One way for this to happen is for achievements in an area outside health to act as catalysts for action in the health sector. For example, a project to develop capacity for the State Social Protection Fund in Azerbaijan has built capacity for systems and processes that could be applied to the development of a health insurance system (Case Study 6). In addition, while not directly targeting health as an outcome, this project will improve living standards among the beneficiaries, and therefore is likely to act indirectly on health.

Afghanistan border police officers practice navigation (Case Study 5). © UNDP EU-BOMNAF

Pensioners from Agdash District, Azerbaijan (Case Study 6). © SSPF

Case Study 6: Capacity building for the State Social Protection Fund (SSPF) (Azerbaijan)

This project aims to contribute to better governance in pensions and the social insurance system through further development and implementation of the State Social Protection Fund (SSPF)'s automated management system.

About the project

Growing income allowed the government of Azerbaijan to reconsider its policy regarding social protection. It was decided to give priority to social protection and start reforms in the area of social insurance (pension, social allowances) and unemployment issues. The major reason for starting with social insurance rather than health insurance was that a social protection system is more straightforward and clear for understanding and management compared with health insurance and healthcare management issues. Besides, social protection increases living standards and provides some type of income. As a side effect, the government will develop a centralized record-keeping system with personal data of employees, employers, pensioners, unemployed people, disabled people and others who need state assistance. Health insurance could be built on the basis of the social protection system at the next stage of development. The pensions system was a starting point.

In some regions, especially for elderly people, their only income is their pension. Developing the social protection system contributes to decreasing the level of poverty in the country and improves quality of life. During 2010-2012, the average pension amount was increased over 40%. A ten year report has produced data related to social protection. The average pension for the last 10 years increased 9 times over 10 years from 18.4 to 166 Azerbaijani Manat (AZN). The minimum pension increased 7.1 times from 14 to 100 AZN. Replacement rate (compensation of salary after retirement) increased from 29 to 45%. Therefore, pensions contribute significantly towards income.

Case Study 6: Capacity building for the State Social Protection Fund (SSPF) (Azerbaijan) cont.

The informal sector is still a large challenge. The population involved in the informal sector of the economy is estimated at around 45-50% of the existing labour force. Previously, this was 60-70%, so it has improved. People who are not registered do not pay tax and social contributions; this hinders social welfare redistribution. The government plans to change the situation and stimulate active participation of people in the social insurance system.

Now, there is a centralised record-keeping system with more than 3 million people registered.
The new automated system enables people to apply for social insurance or pension, submit personal data and financial reports, and make payments over the internet. They can also access and verify personal accounts, and check the balance of social savings over the internet. All the mentioned initiatives and undertakings have significantly increased the level of transparency of the system and consequently have increased the level of trust and participation of people in the social insurance-pension system. UNDP provided significant assistance, both consultative and financial, for the development of the new system and realization of the social protection reform. Along with UNDP, SSPF has actively collaborated with the World Bank and the International Social Security Association.

SEEDs identified

- Welfare policy for social protection
- Economic accountability/governance

Dimensions of inequity identified

Primary dimensions of inequity:

- Life course stage – retirement

Strategic value of considering health implications

Building capacity for systems and processes for pensions has an indirect impact on the health of older people through the provision of income. The systems and processes developed create a solid technological ground for building a health financing management system as well.

While not directly targeting health as an outcome, this project will improve living standards among the beneficiaries, and therefore is likely to act indirectly on health. Social protection for older people was identified by the WHO European Review of Social Determinants of Health and the Health Divide (3) as one of a set of key actions to improve health and address health inequities.

Inspectors from the Agcebedi branch office of SSPF use new software (Case Study 6). © SSPF

In Kyrgyzstan, people work on improving city infrastructure (Case Study 7). © UNDP

Another way to connect health and development is for sectors outside the health domain to build strategic alliances with the health sector, and vice versa. This has potentially two benefits:

- to help build the case for prioritisation of action in sectors outside the health sector;
- to create the policy space for multi-sectoral approaches with co-benefits for specific development goals and for health (e.g. Case Study 7).

Case Study 7: Implementation of Central Asia Regional Risk Management (CARRA) (RBEC)

The aim of the programme is to identify and address critical risks and capacity and knowledge gaps in risk management. As CARRA transitions to a greater focus on implementation within a risk management framework, the aim is to move from ad hoc planning and funding to a formal structure with dedicated resources.

About the project

CARRA was started as an ad hoc initiative of RBEC. It was set up in 2008 in response to regional challenges including severe winter weather, drying out of reservoirs, insufficient energy, economic crises (fewer remittances), and food security problems. Until 2011, it was a high level capacity building forum; since then, there have been more initiatives on the ground.

Four areas were identified as priorities – disaster risk reduction, food/agriculture, social protection and water. It would be possible to create strategic alliances with health partners in the next phase. Coordination across sectors was identified as a real strength. Partners include OHCHA, UNICEF, WHO, UNFPA, UNWomen, as well as NGOs and other relevant stakeholders.

SEEDS identified

Analysis of the project documents available at the time of analysis did not identify any SEEDs, primarily because the programme is in a transition phase. The new phase of the programme is in the pipeline. However, it is evident that in the operational phase of the project disaster risk reduction strategies are likely to impact on H/HE. Therefore, the potential impact of the project on SEEDs became apparent in the interview because the priority areas of disaster risk reduction, food/agriculture, social protection and water all impact on health.

Strategic value of considering health implications

Disaster risk reduction is directly relevant to health, because disasters are frequently detrimental to health. The poorest communities are the most vulnerable to disaster risk. Health is strategically important to create an enabling environment for disaster risk reduction. In addition, health strategy on the ground facilitates the achievement of the broader mandate of resilience.

A woman volunteer trains for rescue operations in Kyrgystan (Case Study 7). © UNDP Pakistan

Other respondents identified that making connections with health would be of strategic value by adding weight to justify expenditure on the project by municipalities, or to attract funding from donors. This was raised by several respondents (e.g. Case Study 1).

Facilitating

A project targeting vulnerable local communities in Albania aims to increase participation and access for Roma and a specific group of Roma people who identify themselves as of Egyptian origin. The respondent described the project work across multiple sectors in a way that aims for social inclusion. As such we describe it as facilitating action on SEEDs of H/HE (Case Study 8).

Case Study 8: Vulnerable communities (Albania)

The goal of the project is to improve the human security and access to socioeconomic and civic rights of vulnerable communities (Roma and Roma people of Egyptian origin) of Albania.

About the project

The project is part of joint UN initiatives involving UNDP, UNICEF, UNFPA, and United Nations High Commissioner for Refugees (UNHCR). UNDP leads this programme and therefore is responsible for implementing the largest number of components of the project. The focus is on community development, participation, neighbourhoods and specifically on increasing the participation and access for Roma and Egyptian people. These groups are targeted because they are discriminated against and disadvantaged. Roma speak their own language (Romanes) and are recognised as a linguistic minority, while Egyptians speak Albanian and do not have the minority status. The term 'gypsy' was used to refer to Roma assuming they were Egyptians, until the linguistic studies evidenced their Indian origin. Studies show that the Egyptian group migrated earlier than Roma, and distanced themselves from the Roma-speaking groups, in order to avoid prejudice and discrimination against newcomers that persisted in the host countries. Despite the cultural differences between the Roma and Egyptians, the government has recently acknowledged the need for the social inclusion of Egyptians, increasingly involving them in special protection programmes along with the Roma.

After the fall of communism, Roma people started to move and migrate more – and were not adequately supported by social services. Many children and adolescents are not registered, so do not benefit from having legal status. This disadvantages them from accessing public services including health, education, and social services. One of the main aims of the project is therefore to promote registration in order to improve access to healthcare and schooling. There are further effects, such as impact on employment for youth.

Case Study 8: Vulnerable communities (Albania) cont.

The strengthening of networks of Roma mediators working in health or education also has direct impacts on health through facilitating peer-to-peer learning among Roma. For example, training has been performed to help spread information about family planning, vaccinations and other health services. Isolated communities are not reachable by the mainstream health professionals.

More indirect impact on health is achieved through capacity development and implementation of vocational education, training for self-employment in markets or to sustain a living. Some have now attained entrepreneurial jobs (opened small businesses) and some others have found paid employment.

In addition, the project contributes to Roma civil society strengthening – adding to skills and support to become actively engaged. UNDP works with NGOs and civil society who support Roma and Egyptian vulnerable groups. These NGOs might struggle to obtain other sources of funding.

The project impacts on health both directly, via increasing knowledge and enabling improved access to health services, and indirectly through increasing civil registration, improving livelihoods and strengthening Roma civil society.

Roma children in Albania at advocacy event for preschool education (Case Study 8). © EVLC project (UNDP)

SEEDs identified

- Human rights
- Social cohesion
- Community participation
- Discrimination/stigma
- Child protection
- Access to education
- Access to healthcare
- Access to social services
- Effective policing
- Early child development
- Investments in community development
- Lifelong learning

Dimensions of inequity identified

The primary dimensions of inequity:

- Ethnicity – Roma and Egyptian population groups

Strategic value of considering health implications

The project shows how it is possible to work across sectors to tackle exclusionary processes that affect Roma and Egyptian population groups.

2. Equity aspects

Many projects have a strong capacity building element that is likely to have universal benefits across society. They also target specific dimensions of inequity. Such projects were then classified as having universal and targeted implementation strategies.

Where SEEDs in programmes and projects have a focus on dimensions of inequity, it is most frequently through the focus on groups that are described as 'vulnerable', 'marginalised' and 'poorer' (often rural), a focus on Roma people, and through work to promote gender equity.

Mothers at breastfeeding promotion event in Durres, Albania (Case Study 8). © EVLC project (UNDP)

Case Study 9: Aid for Trade – Economic development along trade corridors (RBEC)

The project aims to support inclusive growth in the region through the promotion of trade and the enhancement of participating countries' production capacities to support countries' efforts to reduce poverty and improve people's lives.

About the project
In Central Asia, the programme works predominantly with small farmers to improve productive capacities. Several pathways were noted whereby the project might impact directly on health and indirectly via improving livelihoods:

Indirect impact on health through poverty reduction: Activities include processing across the whole production chain; for example, beneficiaries now have cold storage (e.g. for vegetable produce) and can keep produce for longer and make bulk sales at better prices. Some pilot activities on vegetable production for schools were also tested in Armenia.

Direct impact on health: Previous work with the International Labour Organisation Decent Work Initiative included setting up capacity development for business activities, which involved a health and safety training for safe handling of equipment and fertilisers in Kyrgyzstan and Tajikistan.

Gender equity: The respondent noted that getting women into the activities is difficult but achievable. In certain rural areas, women are not expected to attend workshops outside the village. Questions of security for women to travel to oblast (regional) capitals are commonly raised. Women may be reluctant to participate and it is logistically difficult for them to leave their children. However, flexible arrangements can be identified, such as dedicated women receiving master trainings and then training the rest of the village, or alternatively trainings can be held in the village to address the concerns of women and to accommodate their needs.

Case Study 9: Aid for Trade – Economic development along trade corridors (RBEC) cont.

Poorer groups: The respondent noted that the project tries to engage a mix of very poor people and small entrepreneurs. The small entrepreneurs have a certain level of knowledge already and it will be easier to create new jobs through supporting these small entrepreneurs. The support to the very poor populations targets additional income generation through job creation. In order for this to be successful in the short time frame of two years, the project targets individuals already possessing a little experience in entrepreneurship. For example, in order to target poorer sections of the population, the project targeted small cooperatives. Through pooling resources with the farmers, the impact and income generation was higher than it could be through working with individuals. Through micro-processing plants, income is increased for cooperative members, and employment opportunities are created in the community. Using this approach the project has created over 1600 new employments.

SEEDs identified

- Trade
- Poverty
- Business development services
- Workplace safety

Dimensions of inequity identified

Primary dimensions of inequity:

- Gender – female

Secondary dimensions of inequity:

- Place of residence – rural

Strategic value of considering health implications

Given that the project has potential impacts on health as well as on development, it could be of strategic relevance to measure and demonstrate the impact these modifying measures have on the health status and health protection of the people/communities involved. There may be potential for projects operating in rural areas to provide a platform to optimise synergies between development and health through partnership working and dialogue. For example, projects that work with the rural poor in one dimension (income generation) may open up opportunities for inter-sectoral working with partners in other dimensions identified by communities, such as health and education. In addition, as the project is part of a global Aid for Trade initiative, it provides a potential conduit for the transfer of knowledge and experience gained at the local level to the global arena.

A member of cooperative "Mol Tushum" displays her harvest (Case Study 9). © Aid For Trade (UNDP)

3. Integrating the SEEDs of health and health equity approach into development projects

Interviews with stakeholders showed that there is broad support for enabling the realisation of co-benefits of projects for health, providing that any proposed tool/ methodology:

- integrates with existing processes, e.g. Environmental and Social Screening Procedure (ESSP);
- is practical;
- is supported by health partners where necessary.

The majority of respondents (24 of 25) stated that a tool such as a checklist or score card to enable SEEDs of H/ HE to be systematically addressed in UNDP projects would potentially be of interest. Ten respondents gave nuanced responses, tempering their expressions of interest with comments on how any tool would need to be practical, compatible with existing project approval processes and should be integrated with existing tools, such as UNDP's ESSP.

UNDP has introduced the ESSP with two aims: to enhance the environmental and social sustainability of a proposed project, and to identify and manage environmental and social risks that could be associated with a proposed project (44). The outcome of the screening is a categorization of the project into one of three categories:

- No further action is needed.
- Environmental and social sustainability elements need to be integrated into the project design because there are possible environmental and social benefits, impacts and/or risks associated with the project (or a project component), but these are predominantly indirect or very long-term and thus extremely difficult or impossible to directly identify and assess.

Farmers learn about micro-finance activities in Tajikistan (Case Study 9). © Aid For Trade (UNDP)

- Further environmental and social review and management is needed because potential environmental and social impacts or risks are associated with the project (or a project component) and it is possible to identify these with a reasonable degree of certainty.

Respondents offered a range of ideas based on their expertise and practical experience, which will be used to inform the development of a tool in the next phase of the SEEDs of H/HE project (see Recommendations section).

4. Capacity building

The majority of respondents expressed interest in capacity building on SEEDs of H/HE. For example, one respondent commented that it would be interesting to find out more about the SEEDs of H/HE, and to attend training if it was available.

Some respondents identified the need for capacity building in countries, and also among partners. One noted the need to discuss the SEEDs of health approach amongst the ministry and government to see what priorities would be the most useful within the country.

5. Validation of the analysis tool

The key informant interviews provided the opportunity to validate the SEEDs and dimensions of inequity that had been identified by the Institute of Health Equity (IHE) team. Twenty five interviews were carried out, representing just over half the projects. Of these projects and all the SEEDs identified in them, only two (1.3%) were incorrect and an additional 11 SEEDs out of 151 were included (7.3% SEEDs added).

D. Lessons Learned

1. Untapped opportunities

SEEDS of H/HE emerge as an under-exploited unifying theme across projects. Some projects do more than others vis à vis addressing SEEDs of H/HE.

Considering the potential impact that projects have on H/HE, these aspects are not considered systematically. Although measuring the impact on health might not be feasible for all projects, measuring the determinants of health could be beneficial, because it would inform future decisions about how to design projects with potential co-benefits for health and development, enabling greater efficiency in resource allocation and greater effectiveness in terms of intended outcomes.

In addition, it may be possible to build partnerships with stakeholders in the health arena to develop a framework of measurable indicators across SEEDs of H/HE and health outcomes. There is agreement in principle among international development partners that SEEDs of H/HE should be among the development priorities and need to be addressed. Our study demonstrates that it would be practical and feasible within the current resource envelope to integrate SEEDs of H/HE into current development practice. This would be more efficient in terms of resources than creating a parallel stream of projects on SEEDs of H/HE, and it would enable UNDP to fulfil its mandate and responsibilities in its new role as member of the UN Interagency Task Force on the Prevention and Control of NCDs, as well as optimizing development synergies under its mandate as UNAIDS co-sponsor.

Two questions could potentially be considered at an early stage: 1) How can projects maximise the positive impacts of the project on SEEDs of H/HE? 2) Is it feasible to embed a minimal form of health equity impact assessment with stakeholders in project development? If there is the choice of alternative project designs, it should be possible to identify and select the design that has the highest potential for positive impact on SEEDs of H/HE.

2. Equity

Many projects aim to target inequities; however, often the indicators were not disaggregated to measure the impact on different groups, especially where the analysis identified 'secondary dimensions of inequity' rather than those that were the primary target of the project (see Key Finding 6).

The GF projects are good examples of projects that aim to target multiple dimensions of inequity, and their indicators are disaggregated (see Case Study 3).

3. Monitoring

There are three major points to be considered:

- Systematic disaggregation of indicators (e.g. by gender) is needed;
- Where a project's impact on a SEED is explicit (e.g. job creation), include indicators (e.g. about the employment and working conditions of the jobs created), and disaggregate indicators systematically;
- UNDP's resources and results frameworks could be reviewed to optimize output and outcome measurement in relation to SEEDs and H/HE.

4. Multi-agency implementation

All the projects involved multiple agencies to some degree, variously involving one or more sectors across government levels and sectors and/or public and private sectors or sub sectors acting together. A key theme that emerged from the study was that such cooperative implementation strategies could be extended to include health agencies, in order to maximise synergies between development and health.

In addition, it was found that project documents are not consistent in terms of the extent to which equity and health aspects are considered. A more consistent and systematic approach at the project development stage would strengthen the inclusion of these aspects throughout the project and create platforms for achieving co-benefits for the primary objectives of the projects and for health.

Projects within practices have influences outside their practice domains and cut across high-level outcomes of UNDP's new corporate strategy. Cross-practice and cross-outcome work on complex development solutions could include a SEEDs of H/HE approach. For example, in Case Study 6, Border Management in Northern Afghanistan (border with Tajikistan), the respondent commented that the project has developed such a depth of knowledge of the Afghanistan border area and how to get things done there, that it could serve as platform for inter-sectoral complex development projects in the future. This would increase the cost efficiency of development investments aiming to improve the living conditions of local communities comprehensively.

UNDP is in a key position to improve both whole-of-government and whole-of-society implementation. UNDP works in partnership with regional, national and municipal levels of governance, NGOs and community members. UNDP projects engage different sectors (for example, education and training, healthcare, business development and civil registration as in Case Study 8). Therefore, UNDP is uniquely positioned, by applying this expertise, to support multi-sectoral collaboration for health.

Joint project development and implementation with other UN agencies such as WHO, UNICEF and UNFPA would provide great opportunities to strengthen the health and development nexus in the region and systematically optimize the impact of work on SEEDs of H/HE, particularly in the context of NCDs. The joint programming and coordination with UNAIDS and the GF with regard to HIV/AIDS could provide some useful lessons learned.

5. Capacity building

The majority of respondents expressed interest in capacity building on SEEDs of H/HE. Some respondents identified the need for capacity building and among partners in countries.

6. Tool

For this pilot, the disaggregation level of the assessment tool was designed to be high in order to improve the understanding of complexity. While it served this purpose well for this pilot assessment, it created more coding decisions for the analysts, with implications for time taken for each analysis. Some coding decisions were more difficult than others, including:

- identification of SEEDs from what appeared to be minor elements of a large and complex project;
- determination of SEEDs that appeared at multiple places of the framework;
- identification of some indicators which were not consistently defined in the project documents.

Some aspects of the tool did not provide the added value as originally anticipated, including:

- The assessment of monitoring and evaluation, because this was often described within project documentation as following UNDP's protocol for monitoring and evaluation;
- The determination of direction of impact on health of SEEDs – in practice, analysts were not in a position to interrogate the evidence available to the level needed to make a judgement on the likelihood of adverse impact on inequities**.** The likely impact on inequities was coded either as likely to be positive (based on identification of dimensions of inequity), or that there was insufficient information to judge.

These aspects were therefore not included in the results and discussion sections of the report.

Overall, the assessment tool used for this study can serve as a good starting point for a simplification process aiming to develop a final tool which can be used in routine project planning, monitoring and evaluation processes.

7. Synergies and cross-fertilization

Development approaches and SEEDs of H/HE action have many consistent elements and some apparent differences. Consistencies include shared values of human rights, social justice, good governance and participatory processes, a multi-sectoral approach, partnership working, capacity building and a common goal of sustainable human development.

The SDH approach of the WHO Commission considers the distribution of social determinants and health across the whole of society, and recommends proportionate universalism: strategies that are universal but at a scale and intensity that are proportionate to need across the whole of society. Development projects, by their nature, often target the poorest and most vulnerable groups. Where particular population groups face disproportionate exposures and vulnerability to disease risks, a combination of universal and targeted initiatives can form part of an overall strategy of proportionate universalism. However, it has been noted that targeted services tend to be low quality (48), and the eligibility cut-off for targeted services may exclude people in need. SDH approaches emphasise action on the exclusionary processes that make people vulnerable, and avoid the tendency to identify groups as vulnerable, which can lead to stigmatisation and can be disempowering (3).

The Human Development Index highlights the critical role of health in development through one of its three dimensions, and uses life expectancy as its indicator. Adding life quality for current and future generations as a further dimension to this indicator puts health in the centre of sustainable human development strategies and underlines the relevance of social, economic and environmental determinants.

E. Recommendations

UNDP programmes and projects routinely integrate action across sectors and across categories of actors. This cooperative or partnership working has been identified as essential for action to improve health and reduce health inequities. Action on SEEDs of H/HE is important in the context of the post-2015 development agenda and for sustainable development. In addition, it responds to global initiatives on tackling NCDs including mental health, and infectious diseases which require both universal health coverage and action on SEEDs of health. To achieve universal health coverage, action on SEEDs is essential.

Our research found that, while many of the development projects examined address a number of SEEDs of health and various dimensions of inequity, they do not always identify or measure potential multiple impacts of projects on SEEDs of health, or on health outcomes, either during the planning or the implementation and evaluation phase. Doing so in a systematic manner will enable potential benefits of projects on health to be realised, and potential negative impacts on health to be avoided.

Interviews with twenty-five programme or project managers revealed broad support for a tool to assess projects using a SEEDs of H/HE lens, provided that it is simple to apply, it provides specific advice about how to measure outcomes, and it can be readily integrated into existing strategic planning processes and existing tools such as the ESSP.

We make the following recommendations for the next steps in integrating health into development programming to UNDP and development partners:

i. Fully integrate SEEDs of H/HE into UNDP programming under UNDP's Strategic Plan 2014-17 and Regional Programme Documents;
ii. Integrate health aspects into project design, monitoring and evaluation from the start in order to maximise co-benefits for health. This will require mechanisms to systematically identify potential impacts of development projects/programmes on a) SEEDs of health, b) social, economic and environmental inequities, and c) health and the distribution of health, by developing a standard methodology for project approval and implementation processes;
iii. Monitor implementation of a systematic approach to addressing SEEDs of H/HE in future UNDP project portfolios;
iv. Support capacity development for integrating SEEDs of health approaches in the context of development;
v. Work with partners in countries to include the SEEDs of H/HE framework in the discourse on the right to health, the national development plans, the UNDAF and the post-2015 sustainable human development agenda.

Towards a practical tool to identify SEEDs of health/health equity in development projects

The tool designed for this project includes many variables to be coded and gives a detailed analysis of potential H/HE aspects of projects/programmes. It can be utilised to screen projects for SEEDs of health and the dimensions of inequity. This has been shown through validation of the tool.

Experience gained in developing the tool used in this project will inform the development of a simplified and, for development practitioners, more user-friendly tool to identify SEEDs of H/HE in development projects. Development of the tool will be guided by the expertise of UNDP project and programme managers through participatory processes. Questions and steps to be considered in the development of the tool include:

- From the checklist of SEEDs of H/HE, which are likely to be impacted directly or indirectly by the project?
- Prioritise SEEDs of H/HE based on agreed selection criteria, including those most relevant in the region in terms of development issues.
- For prioritised SEED(s) of H/HE: Who are the likely beneficiaries (based on the check list of dimensions of inequity)?
- For the prioritised SEEDs of H/HE or groups of SEEDs of H/HE:
  - Is the impact of the programme/project likely to reduce health inequities?
  - Are there any potential negative impacts on health or health equity?
- For prioritised SEEDs of H/HE: which indicators, if any, can be used to monitor the impact of the project on the likely beneficiaries?
- For prioritised SEEDs of H/HE: which indicators, if any, can be used to monitor the impact of the project on health status?
- What level will the impact of the SEEDs of H/HE likely be at: community, local, regional, national, transnational?
- What further information at the project level would support identification of the project's impact on the SEEDs of H/HE?
- Which partners are involved in planning – global or regional agencies, national government, municipal, NGOs, business sector?
- Which partners are involved in implementation – global or regional agencies, national government, municipal, NGOs, business sector?
- Are health sector partners needed to support implementation and monitoring?
- What additional resources are needed to support implementation and monitoring?
- Does the project aim to impact trends in structural determinants (structural inequities) that shape differential exposures and differential vulnerabilities?

The aim is to integrate the SEEDS of H/HE approach into development policies and programmes in order '*to optimise synergies between development and health*',[3] because health and development are mutually dependent. UNDP's mandate as the UN agency primarily responsible for sustainable human development implies a commitment to equity and human flourishing.

As a follow-up to the project reported here, we propose a plan of action including UNDP (to conduct all the internal participatory processes and capacity building, plus the implementation of new strategies and tools) and UCL IHE (for the technical development, applied research and evaluation part) in a partnership. A joint funding proposal by IHE and UNDP to external donors has been prepared, and will be further developed.

3 This phrase is quoted from a speech by Helen Clark, Administrator of the UNDP at the Lambie-Dew Oration, University of Sidney 2013, http://www.undp.org/content/undp/en/home/presscenter/speeches/2013/10/15/helen-clark-speech-at-the-2013-lambie-dew-oration-on-the-world-we-want-health-human-development-in-the-21st-century-/

Annex Tables and Figures

In reading project documentation, analysts noted that, although the primary aim of many projects (except the HHD projects) is not health, health was often mentioned as being affected by the social, economic or environmental issue that was the main area of interest of the project, and used to build the case for the project. Analysts recorded for each SEED whether its potential impact on health was mentioned (noted) in the documentation.

Annex Table 1: Percentage of SEEDs in which the impact on health is noted in the documents

SEED	SEED frequency	Frequency of health noted in documents	Percentage of SEEDs that note health in documents
Maternal health and wellbeing	1	1	100
Treatment adherence	6	6	100
Access to healthcare	23	22	96
Healthcare quality	8	7	88
Exposure to hazardous substances (chemical, physical, radiation, pollution, pathogens, other)	20	17	85
Healthcare infrastructure	4	3	75
Flood defences	2	1	50
Fresh water security	2	1	50
Land use	7	3	43
Food security	10	3	30
Discrimination/stigma	14	5	36
Post conflict reconstructions	3	1	33
Waste management	4	1	25
Water sanitation	5	1	20
Investments in community development	19	2	11
Job creation	10	1	10
Participatory processes	20	1	5
Access to affordable housing	1	0	0
Access to education	3	0	0
Access to social services	4	0	0
Biodiversity	6	0	0

Annex Table 1: Percentage of SEEDs in which the impact on health is noted in the documents cont.

SEED	SEED frequency	Frequency of health noted in documents	Percentage of SEEDs that note health in documents
Business development services	16	0	0
Child protection	1	0	0
Childhood education	1	0	0
Community participation	10	0	0
Drug abuse	1	0	0
Early childhood development	1	0	0
Economic accountability / governance	2	0	0
Effective policing	2	0	0
Energy efficiency	13	0	0
Exposure to violence	1	0	0
Family composition	1	0	0
GHG emissions	8	0	0
Housing quality	2	0	0
Human rights	18	0	0
Income level / poverty	7	0	0
Income protection at the family/community level	1	0	0
Indoor air quality	1	0	0
Job security (temporary / no contract)	2	0	0
Lack of control over family planning	1	0	0
Level of crime	3	0	0
Lifelong learning (skills / training / other)	13	0	0
Outdoor air quality	2	0	0
Poor nutrition	2	0	0
Psychosocial working conditions	1	0	0
Public amenities	1	0	0
Public building quality	2	0	0
Rural conservation	2	0	0
Social cohesion	7	0	0
Soil pollution	2	0	0
Trade	4	0	0
Transparency/accountability in governance	14	0	0
Transportation Infrastructure (roads, rail, air)	5	0	0
Urban planning	2	0	0
Wealth distribution / poverty reduction	5	0	0
Welfare policy for social protection	2	0	0
Workplace safety	1	0	0
Total	329	76	23

Annex Table 2: Dimensions of inequity with sub-categories

Lifecourse stage	Gender	Sexual orientation	Ethnicity	Religion	Place of residence	Area deprivation	Family composition	Educational attainment	Conditions of employment	Occupational category	Socio-economic status / household wealth	Disability	Marginalised groups
Prenatal	Male	Heterosexual	Ethnic majority	Christian	Urban	Most deprived	Married couples with children	Primary	Permanent-full time	Higher managerial, administrative, professional e.g. Chief executive, senior civil servant, surgeon	Poorer groups	Physical Disability	Prisoners
Pre-school	Female	Homosexual/ bisexual	Indigenous minority	Buddhist	Suburban	Least deprived	Married couples without children	Secondary	Permanent-part time	Intermediate managerial, administrative, professional e.g. bank manager, teacher	Other income groups	Sensory Disability	Homeless
School	Both males & females		Minority of European origin	Hindu	Rural	Other	Co-habiting couples with children	Tertiary	Temporary-full time	Supervisory, clerical, junior managerial e.g. shop floor supervisor, bank clerk, sales person		Mental Disability	Vulnerable Migrants
Transition between education and employment	Other		Minority of non-European origin	Jewish			Co-habiting couples without children		Temporary – part time	Skilled manual workers e.g. electrician, carpenter			Sex Workers
Employment			Roma	Muslim			Lone parent households		Self employed	Semi-skilled and unskilled manual workers e.g. assembly line worker, refuse collector, messenger			Other
Retirement				Sikh			Single household no children		Casual	Casual labourers, pensioners, unemployed e.g. pensoiners without private pensions and anyone living on basic benefits			
				Other			Extended family (3 generation household)		Unemployed				
							Other		Retired				

Annex Table 3: Dimensions of inequity for each SEED and their frequency distribution

Dimension of inequity for each seed	Count of dimension	%
Access to affordable housing	1	0.30%
Marginalised groups	1	100.00%
Access to education	3	0.91%
Ethnicity	1	33.33%
Lifecourse stage	2	66.67%
Access to healthcare	23	6.99%
Disability	1	4.35%
Ethnicity	2	8.70%
Gender	1	4.35%
Lifecourse stage	3	13.04%
Marginalised groups	11	47.83%
No dimension of inequity identified	2	8.70%
Place of residence	1	4.35%
Sexual orientation	2	8.70%
Access to social services	4	1.22%
Ethnicity	1	25.00%
Gender	1	25.00%
Lifecourse stage	2	50.00%
Biodiversity	6	1.82%
No dimension of inequity identified	5	83.33%
Place of residence	1	16.67%
Business development services	16	4.86%
Gender	2	12.50%
Marginalised groups	1	6.25%
No dimension of inequity identified	7	43.75%
Place of residence	5	31.25%
Socio economicstatus householdwealth	1	6.25%
Child protection	1	0.30%
Ethnicity	1	100.00%
Childhood education	1	0.30%
Disability	1	100.00%
Community participation	10	3.04%
Ethnicity	1	10.00%
No dimension of inequity identified	7	70.00%
Place of residence	2	20.00%

Dimension of inequity for each seed	Count of dimension	%
Drug abuse	1	0.30%
No dimension of inequity identified	1	100.00%
Early childhood development	1	0.30%
Ethnicity	1	100.00%
Economic accountability/governance	2	0.61%
Lifecourse stage	1	50.00%
No dimension of inequity identified	1	50.00%
Effective policing	2	0.61%
Ethnicity	1	50.00%
No dimension of inequity identified	1	50.00%
Energy efficiency	13	3.95%
No dimension of inequity identified	8	61.54%
Place of residence	5	38.46%
Exposure to violence	1	0.30%
Gender	1	100.00%
Family composition	1	0.30%
Disability	1	100.00%
Flood defences	2	0.61%
Place of residence	2	100.00%
Food security	10	3.04%
Marginalised groups	1	10.00%
No dimension of inequity identified	3	30.00%
Place of residence	5	50.00%
Socio economicstatus householdwealth	1	10.00%
Fresh water security	2	0.61%
No dimension of inequity identified	1	50.00%
Place of residence	1	50.00%
Ghg emissions	8	2.43%
No dimension of inequity identified	8	100.00%
Healthcare infrastructure	4	1.22%
Marginalised groups	1	25.00%
No dimension of inequity identified	3	75.00%

Annex Table 3: Dimensions of inequity for each SEED and their frequency distribution cont.

Dimension of inequity for each seed	Count of dimension	%
Healthcare quality	8	2.43%
Gender	1	12.50%
Marginalised groups	2	25.00%
No dimension of inequity identified	5	62.50%
Housing quality	2	0.61%
Marginalised groups	1	50.00%
Place of residence	1	50.00%
Human rights	18	5.47%
Disability	1	5.56%
Ethnicity	1	5.56%
Gender	7	38.89%
Lifecourse stage	3	16.67%
Marginalised groups	2	11.11%
No dimension of inequity identified	4	22.22%
Income level/poverty	7	2.13%
Gender	2	28.57%
Place of residence	3	42.86%
Socio economicstatus householdwealth	2	28.57%
Income protection at the family/ community level	1	0.30%
Place of residence	1	100.00%
Indoor air quality	1	0.30%
Place of residence	1	100.00%
Investments in community development	19	5.78%
Ethnicity	2	10.53%
Gender	2	10.53%
No dimension of inequity identified	7	36.84%
Place of residence	7	36.84%
Socio economicstatus householdwealth	1	5.26%
Job creation	10	3.04%
Disability	1	10.00%
Gender	1	10.00%
Marginalised groups	1	10.00%
No dimension of inequity identified	4	40.00%
Place of residence	2	20.00%
Socio economicstatus householdwealth	1	10.00%

Dimension of inequity for each seed	Count of dimension	%
Job security (temporary/no contract)	2	0.61%
Marginalised groups	1	50.00%
Place of residence	1	50.00%
Lack of control over individual family planning	1	0.30%
Gender	1	100.00%
Land use	7	2.13%
No dimension of inequity identified	4	57.14%
Place of residence	3	42.86%
Level of crime	3	0.91%
No dimension of inequity identified	3	100.00%
Maternal health and wellbeing	1	0.30%
Gender	1	100.00%
Outdoor air quality	2	0.61%
No dimension of inequity identified	1	50.00%
Place of residence	1	50.00%
Participatory processes	20	6.08%
Gender	7	35.00%
Lifecourse stage	2	10.00%
Marginalised groups	1	5.00%
No dimension of inequity identified	9	45.00%
Socio economicstatus householdwealth	1	5.00%
Poor nutrition	2	0.61%
No dimension of inequity identified	1	50.00%
Place of residence	1	50.00%
Post conflict reconstructions	3	0.91%
Disability	1	33.33%
Marginalised groups	2	66.67%
Psychosocial working conditions	1	0.30%
No dimension of inequity identified	1	100.00%
Public amenities	1	0.30%
Ethnicity	1	100.00%
Public building quality	2	0.61%
Ethnicity	1	50.00%
Place of residence	1	50.00%

Annex Table 3: Dimensions of inequity for each SEED and their frequency distribution cont.

Dimension of inequity for each seed	Count of dimension	%
Rural conservation	2	0.61%
No dimension of inequity identified	2	100.00%
Social cohesion	7	2.13%
Disability	1	14.29%
Ethnicity	3	42.86%
Gender	1	14.29%
Marginalised groups	1	14.29%
Place of residence	1	14.29%
Soil pollution	2	0.61%
No dimension of inequity identified	2	100.00%
Trade	4	1.22%
Gender	1	25.00%
No dimension of inequity identified	3	75.00%
Transparency/accountability in governance	14	4.26%
Gender	2	14.29%
Lifecourse stage	1	7.14%
No dimension of inequity identified	11	78.57%
Transportation infrastructure (roads, rail, air)	5	1.52%
Ethnicity	1	20.00%
No dimension of inequity identified	4	80.00%
Treatment adherence	6	1.82%
Marginalised groups	5	83.33%
No dimension of inequity identified	1	16.67%
Urban planning	2	0.61%
Ethnicity	1	50.00%
Socio economicstatus householdwealth	1	50.00%
Waste management	4	1.22%
No dimension of inequity identified	4	100.00%
Water sanitation	5	1.52%
Ethnicity	1	20.00%
No dimension of inequity identified	4	80.00%
Wealth distribution/poverty reduction	5	1.52%
Ethnicity	1	20.00%
Gender	1	20.00%
Place of residence	3	60.00%
Welfare policy for social protection	2	0.61%
Lifecourse stage	2	100.00%
Workplace safety	1	0.30%
Gender	1	100.00%
Lifelong learning	13	3.95%
Disability	2	15.38%
Ethnicity	1	7.69%
Gender	2	15.38%
Lifecourse stage	2	15.38%
Marginalised groups	2	15.38%
No dimension of inequity identified	2	15.38%
Place of residence	2	15.38%
Discrimination/stigma	14	4.26%
Disability	1	7.14%
Ethnicity	1	7.14%
Gender	5	35.71%
Marginalised groups	5	35.71%
No dimension of inequity identified	1	7.14%
Sexual orientation	1	7.14%
Exposure to hazardous substances	20	6.08%
Lifecourse stage	2	10.00%
Marginalised groups	7	35.00%
No dimension of inequity identified	8	40.00%
Place of residence	1	5.00%
Sexual orientation	2	10.00%
Grand total	**329**	**100.00%**

SEEDs

Dimensions of inequity

Annex Table 4: Dimensions of inequity identified for each SEED

References

1. Commission on the Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization, 2008.
2. Marmot M, Allen J, Bell R, Bloomer E, Goldblatt P. WHO European review of social determinants of health and the health divide. Lancet. 2012;380(9846):1011-29.
3. World Health Organization Regional Office for Europe. Review of social determinants and the health divide in the WHO European Region: final report. Copenhagen: 2013.
4. WHO. Environmental Health Inequalities in Europe. Geneva: 2012.
5. Costello A, Abbas M, Allen A, Ball S, Bell S, Bellamy R, et al. Managing the health effects of climate change. Lancet. 2009;373(9676):1693-733.
6. Ottersen OP, Dasgupta J, Blouin C, Buss P, Chongsuvivatwang V, Frenk J, et al. The Lancet-University of Oslo Commission on Global Governance for Health: The political origins of health inequity: prospects for change. Lancet. 2014.
7. United Nations Development Programme. Draft UNDP Strategic Plan 2014-2017. New York: 2013.
8. World Health Organization. WHA Resolution 62.14 Reducing health inequities through action on the social determinants of health. Geneva: World Health Organization, 2009.
9. World Health Organization. Rio Political Declaration on Social Determinants of Health. 2011.
10. World Health Organization. WHA Resolution 65.8 Outcome of the World Conference on Social Determinants of Health. Geneva: World Health Organization, 2012.
11. United Nations General Assembly. 67th Session: Agenda item 123: Global Health and Foreign Policy. 2012.
12. United Nations. UN Political Declaration of the High Level Meeting on prevention and control of non-communicable diseases. 2011.
13. World Health Assembly. Sixty-seventh World Health Assembly: Resolution EB134.R8. 2014.
14. UN System Task Team on the Post-2015 UN Development Agenda. Realizing the Future We Want for All: Report to the Director General. New York: 2012.
15. United Nations. Rio+20 United Nations Conference on Sustainable Development. Rio de Janeiro: 2012.
16. United Nations. Sustainable Development Knowledge Platform. UN.
17. UN General Assembly. Resolution 66/288. The future we want. 2012.
18. United Nations. Special Event 25 September: Outcome Document: United Nations: 2013.
19. Open Working Group. Introduction to the Proposal of the Open Working Group for Sustainable Development Goals. New York: 2014
20. United Nations Development Programme. UNDP Strategic Plan 2014-2017 - Executive Board DP/2013/40. New York: 2013.
21. United Nations Development Programme. Regional Programme Document for Europe and the Commonwealth of Independent States 2014-2017. 2014.
22. WHO. WHO Discussion paper for the United Nations Interagency Task Force on the Prevention and Control of Noncommunicable Diseases Geneva. 2013.
23. United Nations Interagency Task Force on the Prevention and Control of NCDs. Division of Tasks and Responsibilities. 2013.

24. Bell R, Lutz B, Webb D, Small R. Addressing the Social Determinants of Noncommunicable Diseases. New York: UNDP, 2013.
25. WHO Regional Office for Europe. Health 2020: A European policy framework and strategy for the 21st century. Copenhagen: 2013.
26. Kickbusch I, Gleicher D. Governance for health in the 21st Century. Copenhagen: World Health Organization Regional Office for Europe, 2012.
27. Wismar M, Ernst K, Blau J. Exploring Health Impact Assessment in Europe. Italian Journal of Public Health. 2007;4(3).
28. Gunther S. A series of questions to analyse equity in the policy health impact assessment process: 2011.
29. Birley M. Health Impact Assessment: Principles and Practice. New York: Earthscan; 2011.
30. Mindell JS, Boltong A, Forde I. A review of health impact assessment frameworks. Public Health. 2008;122(11):1177-87.
31. Harris-Roxas BF, Harris PJ, Harris E, Kemp LA. A rapid equity focused health impact assessment of a policy implementation plan: An Australian case study and impact evaluation. Int J Equity Health. 2011;10(1):6.
32. Lee JH, Robbel N, Dora C. Cross-country analysis of the institutionalization of Health Impact Assessment. Social Determinants of Health. Geneva: World Health Organization, 2013.
33. Povall S, Haigh F, Abrahams D, Scott-Samuel A. Health Equity Impact Assessment: Project Report. Liverpool: IMPACT, University of Liverpool, 2010.
34. Ontario Ministry of Health and Long-Term Care. Health Equity Impact Assessment (HEIA) Workbook. Ontario: 2012.
35. Mahoney M, Simpson S., Harris E., Aldrich R., J. SW. Equity Focused Health Impact Assessment Framework. Australia: The Australasian Collaboration for Health Equity Impact Assessment (ACHEIA), 2004.
36. Davies JK, Sherriff N. The gradient evaluation framework (GEF): A European framework for designing and evaluating policies and actions to level-up the gradient in health inequalities among children, young people and their families. Brighton: University of Brighton, 2012.
37. Mendell A, Dyck L, Ndumbe-Eyoh S, Morrison V. Tools and Approaches for Assessing and Supporting Public Health Action on the Social Determinants of Health and Health Equity. Montréal: National Collaborating Centre for Determinants of Health and National Collaborating Centre for Healthy Public Policy, 2012.
38. Abrahams D, Pennington A, Scott-Samuel A, Doyle C, Metcalfe O, den Broeder L, et al. European Policy Health Impact Assessment: A Guide. Liverpool: 2004.
39. Public Health Advisory Committee. A Guide to Health Impact Assessment: A policy tool for New Zealand. Wellington: Public Health Advisory Committee, 2005.
40. Department of Health. Health Risk Assessment (Scoping) Guidelines. Perth: Department of Health, 2010.
41. International Finance Cooporation World Bank Group. Introduction to Health Impact Assessment. Washington: International Finance Cooporation, 2009.
42. Howard R, Gunther S. Health in All Policies: An EU literature review 2006 – 2011 and interview with key stakeholders. Equity Action, 2012.
43. The Marmot Review Team. Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010. London: Marmot Review Team, 2010.
44. UNDP. Environmental and Social Screening Procedure for UNDP projects. 2012.
45. Coutts AP, Stuckler D, Cann DJ. The health and wellbeing effects of active labour market programmes. Chapter 13. In: Huppert F, Cooper CL, editors. Wellbeing: A Complete Reference Guide. VI, Interventions and Policies to Enhance Wellbeing. Oxford: Wiley-Blackwell; 2014.
46. UN(DESA)-WHO. Mental health and development: integrating mental health nto all development efforts including MDGs. 2010.
47. Movement for Global Mental Health. Position statement on mental health in the post-2015 development agenda. 2013.
48. Forde J, Bell R, Marmot M. Improving uptake of essential services: using conditionality as a solution to the problem of low uptake of essential services among disadvantaged communities: a social determinants view. American Journal of Public Health. 2011;101(8).

Empowered lives.
Resilient nations.

UCL Institute of Health Equity